Acute effects of triiodothyronine on glucose and fatty acid metabolism during reperfusion of ischemic rat hearts

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Acute effects of triiodothyronine on glucose and fatty acid metabolism during reperfusion of ischemic rat hearts. Am. J. Physiol. 275 (Endocrinol. Metab. 38): E392–E399, 1998.—Clinical studies have demonstrated improved myocardial recovery after severe ischemia in response to acute triiodothyronine (T3) treatment. We determined whether T3 improves the recovery of ischemic hearts by improving energy substrate metabolism. Isolated working rat hearts were perfused with 5.5 mM glucose and 1.2 mM palmitate and were subjected to 30 min of no-flow ischemia. Glycolysis, glucose oxidation, and palmitate oxidation were measured during aerobic reperfusion by adding [5-3H]glucose, [U-14C]glucose, or [9,10-3H]palmitate to the perfusate, respectively. During reperfusion, cardiac work in untreated hearts recovered to a lesser extent than myocardial O2 consumption (MV02), resulting in a decreased recovery of cardiac efficiency, which recovered to only 25% of preischemic values. Treatment of hearts with T3 (10 nM) before ischemia increased glucose oxidation during reperfusion, which was associated with a significant increase in pyruvate dehydrogenase (PDH) activity, the rate-limiting enzyme for glucose oxidation. In contrast, T3 had no effect on MV02, glycolysis, or palmitate oxidation. This resulted in a significant decrease in H+ production from glycolysis uncoupled from glucose oxidation (2.7 ± 0.3 and 1.9 ± 0.3 µmol·g dry wt⁻¹·min⁻¹ in control and T3-treated hearts, respectively; P < 0.05), as well as a 3.2-fold improvement in cardiac work and a 2.3-fold increase in cardiac efficiency compared with untreated postischemic hearts (P < 0.05). These data suggest that T3 can exert acute effects that improve the coupling of glycolysis to glucose oxidation, thereby decreasing H+ production and increasing cardiac efficiency as well as contractile function during reperfusion of the postischemic heart.

Extranuclear effects of thyroid hormone are rapid in onset, are not altered by inhibition of protein synthesis, and are mediated by thyroid hormone binding to plasma membrane receptors (see Refs. 16 and 20 for review). Various lines of evidence have demonstrated that T3 can act as a vasodilator and positive inotrope in vitro (15, 16). The recognition of these effects has resulted in treatment strategies using T3 that target specific clinical conditions associated with impaired cardiovascular performance and low serum T3 concentration, including heart failure, cardiac surgery, and acute myocardial infarction (8, 11, 16, 35). In clinical as well as experimental trials, improved myocardial recovery in response to acute T3 supplementation has been demonstrated after myocardial ischemia and cardiopulmonary bypass (13, 28, 35). The mechanisms responsible for the cardioprotective effects of T3 have yet to be defined.

In most clinical situations of reperfusion after ischemia, heart muscle is exposed to high levels of fatty acids (see Ref. 21 for review). When hearts are aerobically reperfused after ischemia, glucose oxidation is suppressed because of high rates of fatty acid β-oxidation. This results in a marked imbalance between rates of glycolysis and glucose oxidation (19, 22). In severely ischemic myocardium, production of protons from the hydrolysis of glycolytically derived ATP is a major contributor to acidosis (9, 29). Clearance of H+ via the Na+/H+ exchanger in aerobically perfused hearts subjected to an intracellular acid load leads to a significant decrease in cardiac efficiency (14, 20). This is due to the exchange of H+ with extracellular Na+ via the Na+/H+ exchanger. The intracellular Na+ can then decrease the efflux of Ca²⁻ via the Na+/Ca²⁻ exchanger during reperfusion, resulting in Ca²⁻ overload and cell death. Our previous studies have shown that reducing the source of protons by stimulation of glucose oxidation or inhibition of excessive rates of glycolysis improves cardiac efficiency (2, 10, 20, 26). As a result, modifying glucose metabolism is one potential mechanism by which T3 could potentially exert its cardioprotective effects. Previous studies have suggested that T3 can modify both glycolysis and glucose oxidation in the heart (3, 32). Whether the cardioprotective effects of T3 are attributable to changes in glucose metabolism or a switch in energy substrate preference has not been determined.

In this study we determined whether acute T3 treatment could improve mechanical function and cardiac efficiency during reperfusion of ischemic hearts by modulation of glucose metabolism. Isolated working rat hearts perfused with high levels of fatty acids were subjected to a 30-min period of global no-flow ischemia, followed by 40 min of aerobic reperfusion. The effects of...
T3 on the recovery of cardiac work, O2 consumption, glycolysis, and oxidative metabolism of glucose and fatty acid were measured. Our results demonstrate that by reducing the production of H+ from glucose metabolism, T3 significantly improves the recovery of mechanical function and cardiac efficiency in the post-ischemic heart.

MATERIALS AND METHODS

Heart perfusions. Rat hearts were cannulated for isolated working heart perfusions as described previously (22). Briefly, male Sprague-Dawley rats (250–300 g) were anesthetized with pentobarbital sodium (60 mg/kg ip), and hearts were quickly excised, the aorta was cannulated, and a retrograde perfusion at 37°C was initiated at a hydrostatic pressure of 60 mmHg. Hearts were trimmed of excess tissue, and the pulmonary artery and the opening to the left atrium were then cannulated. After 15 min of Langendorff perfusion, hearts were switched to the working mode by clamping the aortic inflow line from the Langendorff reservoir and opening the left atrial inflow line. The perfusate was delivered from an oxygenator into the left atrium at a constant preload pressure of 11.5 mmHg. Perfusate was ejected from spontaneously beating hearts into a compliance chamber (containing 1 ml of air) and into the aortic outflow line. The afterload was set at a hydrostatic pressure of 80 mmHg. All working hearts were perfused with Krebs-Henseleit solution containing 2.5 mM Ca2+, 5.5 mM glucose, and 1.2 mM palmitate prebound to 3% bovine serum albumin (fraction V, Boehringer Mannheim).

Spontaneously beating hearts were used in all studies. Heart rate and aortic pressure were measured with a Gould P21 pressure transducer connected to the aortic outflow line. Cardiac output and aortic flow were measured with Transonic T206 ultrasonic flow probes in the preload and afterload lines, respectively. Coronary flow was calculated as the difference between cardiac output and aortic flow. The O2 contents of the perfusate entering and leaving the heart were measured using Yellow Springs Instrument micro oxygen electrodes placed in the preload and pulmonary arterial lines, respectively. Myocardial O2 consumption (MVO2) was calculated according to the Fick principle by use of coronary flow rates and the arteriovenous difference in perfusate O2 concentration. Cardiac work was calculated as the product of systolic pressure and cardiac output. Cardiac efficiency was defined as a ratio of cardiac work to MVO2.

Experimental protocol. Working hearts were initially perfused for a 30-min period under aerobic conditions. Global no-flow ischemia was then introduced by clamping both the left atrial inflow and aortic outflow lines. After 30 min of no-flow ischemia, the left atrial and aortic flows were restored and the hearts were reperfused for a further 40-min period under aerobic conditions. T3 (Sigma) was added at the onset of the 30-min aerobic working heart perfusion at a final concentration of 10 nM. T3 was diluted in 1 N NaOH immediately before use, and the same amount of NaOH was added to the control group.

At the end of reperfusion, hearts were quickly frozen with Wollenberger clamps cooled to the temperature of liquid N2. The atrial tissue was dried in an oven for 12 h at 100°C and weighed. The frozen ventricular tissue was weighed and powdered in a mortar and pestle cooled to the temperature of liquid N2. A portion of the powdered tissue was used to determine the dry weight-to-wet weight ratio. The dried atrial weight, frozen ventricular weight, and ventricular dry weight-to-wet weight ratio were then used to determine the total dry weight of the heart.

Measurement of glycolysis, glucose oxidation, and palmitate oxidation. Glycolysis and glucose oxidation were measured simultaneously by perfusing hearts with [5-3H]U-[14C]glucose (22). Fatty acid oxidation rates were measured with perfusate containing [1-14C]palmitate (19). Total myocardial H2O production and 14CO2 production were determined at 10-min intervals during both the initial aerobic perfusion period and the 40-min period of reperfusion. To measure the rates of glycolysis, H2O in perfusate samples was separated from [3H]glucose and [14C]glucose with Dowex columns (22). Fatty acid and glucose oxidation rates were determined by quantitative measurement of 14CO2 production, including 14CO2 released as a gas in the oxygenation chamber and 14CO2 dissolved as HCO3- in perfusate. The gaseous 14CO2 was trapped in hyamine hydroxide solution through an exhaust line in the perfusion system. The 14CO2 dissolved as HCO3- was released and trapped on filter paper saturated with hyamine hydroxide in the central well of 25-ml stoppered flasks after perfusate samples had been acidified by the addition of 9 N HSO4.

Measurement of pyruvate dehydrogenase activity. Frozen powdered ventricular tissue was divided into two samples (of ~30 mg/sample). One sample was used to determine the active state of pyruvate dehydrogenase (PDH); the other sample was used for determination of the total activity of PDH (PDHt). Tissues were homogenized and used to measure the rate of acetyl-CoA formation from pyruvate, as described by Constantin-Tedosiu et al. (6). The acetyl-CoA was determined as [14C]citrate after condensation with [14C]oxalacetate by citrate synthase (6). PDH4 was measured in homogenates containing NaF and dichloroacetate, and PDHt was measured after preincubation of homogenates with Ca2+, Mg2+, dichloroacetate, glucose, and hexokinase (to completely dephosphorylate PDH) (6, 7).

Calculation of H+ production from glucose utilization. If glucose passes through glycolysis to lactate and the ATP so formed is hydrolyzed, a net production of 2 H+ per molecule of glucose occurs (20, 22). In contrast, if glycolysis is coupled to glucose oxidation, the net production of H+ is zero. Therefore, the overall rate of H+ production derived from glucose utilization was determined by subtracting the rate of glucose oxidation from the rate of glycolysis and multiplying by two.

Calculation of tricarboxylic acid cycle rates. The rate of acetyl-CoA production for the tricarboxylic acid (TCA) cycle was calculated on the basis of 2 and 8 mol of acetyl-CoA being produced from glucose and palmitate oxidation, respectively (19, 20).

Statistical analysis. All data are presented as the means ± SE. Data were initially analyzed with the statistical program Instat 2.01 with the Student’s t-test. When data sets were unevenly distributed, the Mann-Whitney and Wilcoxon non-parametric tests were used to determine the difference between preischemic and postischemic values (when used, this is indicated in the individual tables). Two-way ANOVA was used to compare the preischemic and postischemic values among groups.

RESULTS

Effects of T3 on cardiac mechanical function of isolated working hearts subjected to 30 min of global no-flow ischemia. Figure 1A shows the effects of treatment with 10 nM T3 on the recovery of cardiac work in hearts subjected to 30 min of global ischemia. After severe ischemia, the recovery of cardiac work was...
depressed in control hearts, returning to only 11% of preischemic values after 40 min of reperfusion. During reperfusion, heart rate, systolic pressure, developed pressure, cardiac output, and coronary flow were all significantly depressed compared with preischemic values. MV˙O2 in control hearts recovered to a greater extent during reperfusion than did cardiac work (Fig. 1B), resulting in a significant decrease in cardiac efficiency throughout the entire 40-min reperfusion period (Fig. 1C).

When 10 nM T3 was added at the onset of the aerobic perfusion, there was no significant effect on the mechanical function of perfused hearts under aerobic conditions (Table 1, Fig. 1). However, at the end of 40 min of reperfusion, cardiac work recovered to 35% of preischemic values in T3-treated hearts compared with only 11% in control hearts (P < 0.05). Systolic pressure, developed pressure, and cardiac output also recovered to significantly greater values than in control hearts (Table 1). T3 had no effect on MV˙O2 (Fig. 1B), but because of the enhanced recovery of function, cardiac efficiency was increased during reperfusion compared with control (Fig. 1C).

Because T3 has vasodilatory effects in vitro, it is possible that the beneficial effects of T3 could partly be explained by alterations in coronary flow. However, as shown in Table 1, T3 did not increase coronary flow during either the pre- or postischemic period. Furthermore, the increase in MV˙O2 was less than that in contractile function postischemia (Fig. 1), suggesting that the beneficial effect of T3 seen in these hearts is not due to its vasorelaxant properties.

Effects of T3 on glycolysis, glucose oxidation, and palmitate oxidation during reperfusion of hearts after ischemia. Figure 2 shows cumulative glycolysis (A), glucose oxidation (B), and palmitate oxidation (C). T3 did not have any significant effects on glycolysis (Fig. 2A) and palmitate oxidation (Fig. 2C) but did result in a significant increase in glucose oxidation during the reperfusion period (Fig. 2B). PDH activity (the rate-limiting enzyme for glucose oxidation) was also measured in hearts frozen at the end of the reperfusion period. T3 treatment significantly stimulated PDH activity without affecting PDHt in postischemic hearts (Table 2). Although T3 treatment stimulated glucose oxidation in the reperfusion period, no effect of T3 on glucose oxidation was observed during the initial aerobic perfusion.

The effects of T3 on steady-state rates of glycolysis, glucose oxidation, and palmitate oxidation are shown in Table 3. Steady-state rates were calculated for values between 10 and 30 min of the aerobic period and between 10 and 40 min of the reperfusion period (Fig. 2). In control hearts, glycolysis recovered to preischemic rates. T3 had no significant effect on the rates of

### Table 1. Effects of T3 on recovery of mechanical function of postischemic working rat hearts

<table>
<thead>
<tr>
<th></th>
<th>Control (n = 17)</th>
<th>T3 Treated (n = 22)</th>
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<tbody>
<tr>
<td>Preischemic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart rate, beats/min</td>
<td>246 ± 8</td>
<td>226 ± 5</td>
</tr>
<tr>
<td>Peak systolic pressure, mmHg</td>
<td>107 ± 3</td>
<td>110 ± 2</td>
</tr>
<tr>
<td>Developed pressure, mmHg</td>
<td>26 ± 8</td>
<td>29 ± 8</td>
</tr>
<tr>
<td>Cardiac output, ml/min</td>
<td>49 ± 3</td>
<td>51 ± 2</td>
</tr>
<tr>
<td>Coronary flow, ml/min</td>
<td>27 ± 2</td>
<td>26 ± 2</td>
</tr>
<tr>
<td>Postischemic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart rate, beats/min</td>
<td>96 ± 17†</td>
<td>126 ± 15†</td>
</tr>
<tr>
<td>Peak systolic pressure, mmHg</td>
<td>30 ± 7†</td>
<td>59 ± 9†</td>
</tr>
<tr>
<td>Developed pressure, mmHg</td>
<td>4 ± 7†</td>
<td>17 ± 15†</td>
</tr>
<tr>
<td>Cardiac output, ml/min</td>
<td>10 ± 3*</td>
<td>20 ± 4*</td>
</tr>
<tr>
<td>Coronary flow, ml/min</td>
<td>8 ± 3*</td>
<td>11 ± 2*</td>
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Values are means ± SE; n, no. of hearts. Hearts were subjected to 30 min of aerobic perfusion, 30 min of global no-flow ischemia, and 40 min of aerobic reperfusion. Preischemic values were taken at 30 min of aerobic perfusion. Postischemic values were taken at 40 min of reperfusion. L-3,5,3'-Triiodothyronine (T3, 10 nM) was added at onset of aerobic perfusion. Statistical analysis of heart reperfused after ischemia involved the Mann-Whitney test. Significantly different (P < 0.005) from †preischemic values; *postischemic values in control hearts.
glycolysis during either the aerobic or reperfusion period. The steady-state rate of glucose oxidation in control hearts was substantially lower than the rate of glycolysis (Table 3). This parallels previous observations in isolated working rat hearts perfused with high levels of fatty acid (5, 13, 20, 22). During reperfusion of control hearts, glucose oxidation did not recover to preischemic rates (P < 0.05). Treatment with T3 resulted in a marked increase in the rate of glucose oxidation during reperfusion compared with control hearts (P < 0.05).

The steady-state rates of palmitate oxidation during reperfusion of control hearts did not return to preischemic levels (P < 0.05). T3 had no significant effect on palmitate oxidation rates during reperfusion compared with control hearts.

Effects of T3 on H+ production from glucose metabolism. Figure 3 shows the cumulative H+ production from glucose metabolism during reperfusion of ischemic hearts, calculated from rates of glycolysis and glucose oxidation presented in Fig. 2. Over the course of the 40 min of reperfusion, more than 200 µmol/g dry wt of H+ was produced from glucose metabolism in control hearts. A significant decrease in H+ production was seen in T3-treated hearts compared with control hearts.

### Table 3. Effects of T3 on steady-state rates of glycolysis, glucose oxidation, and H+ production from glucose utilization before and after ischemia

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th>T3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glycolysis</td>
<td>1,270 ± 190 (9)</td>
<td>1,185 ± 183 (13)</td>
</tr>
<tr>
<td>Glucose oxidation</td>
<td>160 ± 18 (9)</td>
<td>142 ± 17 (13)</td>
</tr>
<tr>
<td>H+ production</td>
<td>2,220 ± 100 (9)</td>
<td>2,086 ± 365 (13)</td>
</tr>
<tr>
<td>Palmitate oxidation</td>
<td>1,350 ± 220 (5)</td>
<td>1,140 ± 106 (7)</td>
</tr>
</tbody>
</table>

Values are means ± SE of nos. shown in parentheses, expressed in nmol·g dry wt⁻¹·min⁻¹. T3 (10 nM) was added at onset of aerobic perfusion. Statistical analysis of H+ production rates involved the Mann-Whitney test. Significantly different (P < 0.05) from *postischemic values in control hearts; †preischemic values.

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**Fig. 3.** Effect of T3 on time course of H+ production from glucose metabolism in hearts reperfused after 30 min of no-flow ischemia. Hearts were perfused with [5-3H]- or [U-14C]glucose for simultaneous measurement of glycolysis and glucose oxidation. H+ production from glucose metabolism was calculated as indicated in MATERIALS AND METHODS. Values are means ± SE. Control (○), n = 9; T3 (●), n = 13. *Significantly different from control hearts at corresponding reperfusion time.
Steady-state H⁺ production in aerobic and reperfused ischemic hearts is shown in Table 3. By selectively increasing glucose oxidation rates, T₃ improved the coupling between glycolysis and glucose oxidation, resulting in a significant decrease in H⁺ production during reperfusion.

Effects of T₃ on rates of TCA cycle activity. To investigate TCA cycle activity during reperfusion, the rate of acetyl-CoA production from glucose oxidation and palmitate oxidation was calculated. As shown in Table 4, the total rate of TCA acetyl-CoA production in control hearts was significantly decreased during reperfusion compared with the preischemic value. This was consistent with the poor recovery of cardiac work. Treatment with T₃ did not alter overall acetyl-CoA production from glucose and palmitate oxidation. However, during reperfusion, T₃ increased acetyl-CoA production from glucose.

**DISCUSSION**

Acute treatment with physiological or supraphysiologic concentrations of T₃ has been shown to have cardioprotective actions in experimental models of ischemia and reperfusion, as well as in the rescue of myocardial function after human cardiopulmonary bypass operations (13, 17, 28, 35). Our data also show that acute T₃ can significantly improve the recovery of contractile function of isolated rat hearts subjected to a severe episode of no-flow ischemia. These effects of T₃ were associated with an improvement in the coupling of glycolysis to glucose oxidation, thereby decreasing H⁺ production and increasing cardiac efficiency during reperfusion of the postischemic heart.

**T₃ effects on cardiac energy metabolism.** Few studies have determined directly the effects of acute T₃ treatment on energy metabolism in the heart. A study by Segal (32) showed that physiological concentrations of T₃ (1 pM to 10 nM) significantly stimulate 2-deoxyglucose uptake in rat heart slices after as little as 10 min posttreatment. However, in both aerobic and postischemic hearts, we observed that T₃ treatment was not associated with any significant effects on glycolysis. Therefore, we suggest that the cardioprotective effects of T₃ are not associated with an increase in glucose uptake and metabolism by glycolysis. Possible reasons for the differences between our study and that performed in rat heart slices are that 1) relevant levels of fatty acids were present in our perfusate and not in the rat heart slice studies, and 2) hearts in our study were subjected to physiological workloads. Because circulating fatty acid levels are elevated both during and after clinically relevant conditions of ischemia, and because fatty acids have dramatic effects on glucose metabolism, we felt it necessary to perform our studies in the presence of high levels of fatty acids. In addition, because rates of glucose metabolism are related to workload, all experiments were performed in hearts perfused in the working mode.

Our data show that the primary effect of T₃ on myocardial glucose metabolism is a stimulation of glucose oxidation during reperfusion. A previous study using rat cardiac myocytes also suggested that acute treatment of T₃ directly stimulates glucose oxidation (3). The effects of T₃ on glucose oxidation are unlikely to be due to a generalized increase in oxidative metabolism, because the increase in glucose oxidation seen in T₃-treated hearts was not accompanied by an increase in fatty acid oxidation. Of interest is that the effects of T₃ on glucose oxidation were observed only during reperfusion of ischemic hearts and not under aerobic preischemic conditions.

**T₃ treatment significantly increased nonphosphorylated PDHₐ activity in postischemic hearts.** Because PDHₐ plays an important role in regulation of glucose oxidation (4), our data strongly suggest that T₃ stimulates glucose oxidation and improves coupling of glycolysis to glucose oxidation secondary to a stimulation of PDHₐ activity. In rat hearts, ischemia or reperfusion has previously been shown to lead to an inactivation of PDHₐ under conditions similar to those used in the present study (18, 31). Ischemia is likely to increase intramitochondrial NADH/NAD⁺ and acetyl-CoA/CoA ratios, which would lead to inactivation of PDHₐ; however, the reduced ATP/ADP would balance this to some extent by favoring activation (18). It has been reported that acute T₃ treatment can reduce intramitochondrial ATP/ADP (33, 34), which may contribute to the observed activation of PDHₐ. However, the detailed mechanism of how T₃ regulates PDH activity is still uncertain. Future studies are needed to clarify whether acute T₃ treatment has any effect on PDH kinase or phosphatase, both of which also play an important role in regulating PDH activity (6, 7). PDH activity has also been shown to be stimulated by hyperthyroidism (30), although this is probably due to transcriptional regulation. Because acute treatment of T₃ is unlikely to upregulate protein synthesis, and PDH was not altered, the observed effects of T₃ on PDHₐ in our study were likely the result of changes in the phosphorylated state of PDH.

**Table 4. Effects of T₃ on source of tricarboxylic acid cycle acetyl-CoA production from glucose and fatty oxidation in aerobic and postischemic hearts**

<table>
<thead>
<tr>
<th>Source of Acetyl-CoA</th>
<th>Control</th>
<th>T₃ Treated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preischemic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glucose oxidation</td>
<td>0.32 ± 0.04 (9)</td>
<td>0.28 ± 0.03 (13)</td>
</tr>
<tr>
<td>Palmitate oxidation</td>
<td>10.8 ± 1.7 (5)</td>
<td>9.1 ± 0.8 (7)</td>
</tr>
<tr>
<td>Total TCA cycle activity</td>
<td>11.1 ± 1.7</td>
<td>9.4 ± 0.8</td>
</tr>
<tr>
<td><strong>Postischemic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glucose oxidation</td>
<td>0.19 ± 0.02 (9)</td>
<td>0.46 ± 0.06 (13)</td>
</tr>
<tr>
<td>Palmitate oxidation</td>
<td>5.4 ± 0.7 (5)</td>
<td>6.6 ± 0.8 (7)</td>
</tr>
<tr>
<td>Total TCA cycle activity</td>
<td>5.6 ± 0.7</td>
<td>7.1 ± 0.8</td>
</tr>
</tbody>
</table>

Values are means ± SE of nos. shown in parentheses, expressed in µmol·g dry wt⁻¹·min⁻¹. TCA, tricarboxylic acid. Preischemic values were determined between 10 and 30 min; postischemic values were determined between 10 and 40 min of reperfusion. T₃ (10 nM) was added at onset of aerobic perfusion. Statistical analysis of palmitate oxidation rates involved Mann-Whitney test. Significantly different (P < 0.05) from *postischemic values in control group; †preischemic values.
Recovery of contractile function, energy metabolism, and cardiac efficiency in the postischemic heart. During reperfusion of the severely ischemic control hearts, a significant decrease in the recovery of cardiac function occurred that was associated with a decrease in cardiac efficiency (Fig. 1). This decrease in cardiac efficiency has also been observed in previous studies (19, 20). However, unlike these previous studies, we did not observe a complete recovery of fatty acid oxidation in control hearts during reperfusion. This difference in the recovery of fatty acid oxidation may be related to the severity of ischemic injury observed in the present study. As shown in Fig. 1, cardiac work recovered to 11% of preischemic rates in control hearts compared with 30–40% in our previous studies (19, 20). However, it should be recognized that, despite this poor recovery of cardiac work, fatty acid oxidation in control hearts recovered to >50% of preischemic levels, resulting in a marked increase in fatty acid oxidation per unit work, a finding consistent with our previous studies. Regardless of the degree of recovery of fatty acid oxidation in this study, our data suggest that the beneficial effects of T3 are unlikely to be due to any direct effects on fatty acid oxidation.

It is well-known that long-term hyperthyroidism is associated with high levels of MVO2. However, with acute treatment of T3 this is not the case. A recent study by Klemperer et al. (17) showed that acute T3 treatment improves left ventricular function in isolated rat hearts after ischemia without oxygen-wasting effects. In the present study, we also found that T3 significantly improves the recovery of cardiac work without a concomitant increase in MVO2. Therefore, an improved cardiac efficiency (ratio of cardiac work to MVO2) was observed in the postischemic heart.

Previous studies (13) suggest that the combination of global ischemia and depletion of T3 results in reduced mitochondrial function, inhibition of the TCA cycle, and increased anaerobic metabolism. T3 replacement therapy leads to improved mitochondrial function and increased anaerobic metabolism. In the present study, we observed that acetyl-CoA production from glucose and fatty acid oxidation was significantly inhibited after 30 min of severe ischemia, whereas glycolysis was unaffected. Treatment with T3 dramatically increased acetyl-CoA production from glucose oxidation, with minor effects on fatty acid oxidation (Table 4). This suggests that T3 may directly affect mitochondrial function. Overall acetyl-CoA production was not significantly increased, which suggests that T3 has no effects on the efficiency of energy production. Rather, T3 improves the efficiency of energy utilization. Thyroid hormone exerts two types of effects on mitochondria (see Ref. 27 for review). Within a few minutes of administration, T3 causes a rapid activation of respiration, an effect that is preserved in isolated mitochondria. A direct control of oxidative phosphorylation through binding of T3 to mitochondria is thought to occur (27, 36, 37). This control of oxidative phosphorylation is observed after administration of physiological amounts of T3 and is not altered by inhibition of protein synthesis (27, 33). This binding site has been proposed to be the adenine nucleotide translocase (36, 37), an inner mitochondrial membrane carrier that catalyzes exchange between the extra- and intramitochondrial ADP and ATP (12, 33, 38). Of interest is that shifting the mitochondrial ATP/ADP ratio is also involved in the regulation of PDH activity, thereby controlling pyruvate oxidation and consequently glucose oxidation (33, 34). However, studies identifying the adenine nucleotide translocase as a T3 receptor (as well as the role of adenine nucleotide translocase in short-term activation of respiration) have been questioned (see Ref. 27 for review), and further studies are necessary to clarify this possibility.

In our study, the actual measured TCA cycle rates were lower than predicted TCA cycle rates calculated from measured MVO2 values shown in Fig. 1. The reasons for this discrepancy are not absolutely clear. However, in this study we measured both parameters and found that T3 affects TCA cycle activity (Table 4) and MVO2 during reperfusion of ischemic hearts (Fig. 1) were comparable. That is, T3 increased TCA cycle activity during reperfusion by 27% (from 5.6 ± 0.5 to 7.1 ± 0.8 µmol·g dry wt−1·min−1) and MVO2 by 30% (from 22.6 ± 6.7 to 29.4 ± 5.5 µmol·g dry wt−1·min−1). This suggests that T3 is not acting by altering mitochondrial proton leak, and it supports our hypothesis of an increased cardiac efficiency secondary to decreasing proton production from glycolysis uncoupled from glucose oxidation.

Coupling of glycolysis to glucose oxidation in the postischemic heart. The production of H+ from glucose metabolism is an important contributor to the impaired recovery of mechanism function and to the decrease in cardiac efficiency seen after a severe ischemic episode (19, 20, 22). During reperfusion, treatment with T3 dramatically stimulated glucose oxidation, with no effect on glycolysis. Each molecule of glucose that passes through glycolysis that is not subsequently oxidized results in the production of 2 H+ from the hydrolysis of glycolytically derived ATP (19, 20). In the presence of high levels of fatty acids, glucose oxidation rates are 5-fold to 10-fold lower than glycolytic rates (19, 22, 23). Selective stimulation of glucose oxidation improves the coupling of glycolysis to glucose oxidation, leading to a reduction in H+ production. We have suggested that an increase in H+ accumulation during the critical period of reperfusion may contribute to cardiac inefficiency (21) and the well-documented Ca2+ overload in the postischemic heart that results from an increase in Na+/H+ exchange activity coupled with Na+/Ca2+ exchange (14). Because T3 reduces the H+ production from glucose utilization during reperfusion, the driving force for the Na+/H+ exchange is decreased, and Na+/Ca2+ exchange activity would thus be expected to be reduced during reperfusion. Decreased activity of this exchanger may be responsible for the significant improvement in cardiac efficiency observed during reperfusion.

A number of other pharmacological agents also stimulate glucose oxidation and have a beneficial effect on the
recovery of mechanical function during reperfusion of the postischemic heart (2, 23). One of these agents is dichloroacetate, a potent PDH activator that also improves the coupling between glycolysis and glucose oxidation. This also results in a significant decrease in H⁺ production from glucose metabolism during reperfusion, resulting in a significant increase in cardiac efficiency.

Summary. We demonstrate a significant improvement of recovery in postischemic cardiac function and efficiency in isolated rat hearts by use of moderately supraphysiological amounts of T₃. The cardioprotective effect of T₃ may be due to its stimulation of glucose oxidation secondary to an increase in PDH₄ activity, and therefore a reduction in the production of H⁺ by coupling glycolysis with glucose oxidation.

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