Thromboxane A₂ in Severe Hypertension and Stroke in Stroke-Prone Spontaneously Hypertensive Rats

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Thromboxane A₂ is a prostanoid having potent platelet aggregatory and vasoconstrictor properties. To determine a possible role for thromboxane A₂ in the development of severe hypertension and stroke, we chronically administered the selective thromboxane A₂ synthase inhibitor UK-38,485 (Dazmegrel) to stroke-prone spontaneously hypertensive rats (SHRSP). Serum thromboxane B₂ (the stable hydrolysis product of thromboxane A₂) generation was significantly greater in incubates of whole blood from SHRSP than in those from normotensive control Wistar-Kyoto rats and was inhibited >89% by UK-38,485 administered in vivo. In 10 male SHRSP fed a Japanese-style rat chow and given 1% NaCl in drinking water to accelerate the occurrence of stroke, treatment with 100 mg/kg/day UK-38,485 by gavage starting at 8.6 weeks of age diminished systolic blood pressure elevation at 10 (205 ±2 vs. 220 ±4 mm Hg, p<0.01) and 11 weeks of age (210 ±4 vs. 239 ±7 mm Hg, p<0.01) compared with 10 untreated SHRSP. The ultimate establishment of severe hypertension was not prevented by UK-38,485. Stroke-related mortality was 70% in both UK-38,485-treated and control SHRSP at 14 weeks of age. Histologic examination revealed cerebrovascular lesions consistent with the occurrence of stroke in both control and UK-38,485-treated SHRSP. Our results support a possible role for thromboxane A₂ in the elevation of blood pressure in SHRSP but do not support a possible role for the prevention of stroke by thromboxane A₂ synthase inhibition in these rats. (Stroke 1988; 19:1145-1150)
the onset of stroke in SHRSP.\textsuperscript{15} SHRSP fed Japanese-style rat chow exhibit a higher incidence of stroke than those fed an American diet (88\% vs. 30\% by 9 months of age).\textsuperscript{16} To test our hypothesis that TXA\textsubscript{2} is involved in the development of severe hypertension and stroke, SHRSP fed Japanese-style rat chow and given 1\% NaCl solution to drink were chronically treated with the selective TXA\textsubscript{2} synthase inhibitor UK-38,485.\textsuperscript{17}

\textbf{Materials and Methods}

SHRSP derived from the Okamoto-Aoki strain of SHR and WKY were supplied by Dr. William Watson of the National Institutes of Health and were bred locally. Rats were weaned at 4–5 weeks of age and were fed a standard diet (Purina Lab Chow 5001,Ralston-Purina, St. Louis, Missouri) and allowed water ad libitum. We studied male SHRSP (generations F-56 and F-57) and WKY (generations F-41 and F-42) housed in individual cages.

Concentrations of TXB\textsubscript{2} were determined in incubates of whole blood from SHRSP treated with UK-38,485 (divided between two doses) for 9 days and six 17-week-old SHRSP similarly gavaged with 10 ml/kg/day water. Twelve hours after the last dose, rats were anesthetized with 65 mg/kg i.p. sodium pentobarbital. Blood was removed from the aorta through a midline abdominal incision. Aliquots of whole blood (1 ml) were added to 12\times75 mm borosilicate glass tubes (339-275, Curtin Matheson Scientific Inc., Wayne, New Jersey) and the Bonferroni method for comparison of treatment groups at different times. All other data were analyzed using unpaired t tests. Differences between means having a probability value of $<0.05$ were considered significant. Data are expressed as mean±SEM.

\textbf{Results}

Concentrations of TXB\textsubscript{2} were greater in incubates of whole blood from control SHRSP than from WKY (Figure 1, top). Inhibition of TXB\textsubscript{2} generation in whole blood from SHRSP treated with UK-38,485 was $>89\%$ (Figure 1, bottom).

Figure 2 shows SBP in control and UK-38,485-treated SHRSP. SBP was nearly identical in the two groups before and 5 days after commencing chronic treatment. However, SBP elevation was diminished at 10 (205±2 vs. 220±4 mm Hg, $p<0.01$) and 11 weeks of age (210±4 vs. 239±7 mm Hg, $p<0.01$) in SHRSP treated with UK-38,485. At 12–13 weeks of age, SBP became more variable and no longer differed between groups. In contrast, there was no difference in heart rate between the groups before or after treatment with UK-38,485 or water (data not shown). Body weight was not affected by chronic treatment with UK-38,485 and started to decline at 12–13 weeks of age in both groups. By 14 weeks of age, 70\% of the rats in both groups had died (Figure 3); survival was comparable (the average age at
death was 14.4 ± 0.5 weeks in control SHRSP and 14.3 ± 0.4 weeks in UK-38,485–treated SHRSP).

In four SHRSP high-dose UK-38,485 had no beneficial effect on survival. The age at death of high-dose UK-38,485–treated SHRSP (12.4 ± 0.2 weeks) was significantly less than that of control SHRSP (13.8 ± 0.5 weeks, p < 0.05).

Body, heart, and adrenal gland weight at autopsy were not affected by chronic administration of UK-38,485 (Table 1). Total kidney weight tended to be less in SHRSP receiving UK-38,485; however, this difference was not significant. Lesions were observed on gross examination of the brains of rats from both groups. Histologic examination revealed hemorrhagic and anemic infarcts, rarefaction/edema, parenchymal hematomas, petechial hemorhages, and hyalinosis, necrosis, and thrombosis of small vessels in both control and UK-38,485–treated SHRSP (Table 2). There were no significant differences in the incidence of cerebral lesions between the groups (Fisher’s exact test). Most lesions were in the cerebral cortex. Some rats had multiple lesions, sometimes of different age or type.

Histologic analysis of the brains of high-dose UK-38,485–treated SHRSP also revealed evidence of cerebrovascular lesions (two had infarcts, two had petechial hemorrhages, and all exhibited rarefaction/edema).

Discussion

SHRSP develop severe hypertension, vascular damage, and stroke, which are accelerated by dietary factors and elevated sodium chloride intake. Our study was conducted to evaluate the possible role of TXA2 in the development of severe hypertension and stroke in SHRSP. As previously observed in SHR,5–7 we found higher TXB2 concentrations in serum of incubated whole blood from SHRSP than from WKY controls; formation of TXB2 was inhibited >89% by in vivo administration of 100 mg/kg/day of the TXA2 synthase inhibitor UK-38,485. We maintained our rats on a standard diet as under these conditions platelet counts in SHRSP are the same as in WKY14–20 but otherwise are markedly reduced during accelerated hypertension20; such acceleration may occur when Japanese-style rat chow and saline are fed.

Chronic administration of UK-38,485 delayed the elevation of SBP in SHRSP but did not prevent the occurrence of severe hypertension. In previous studies, UK-38,485 (the TXA2 synthase inhibitor we used) did not alter the elevation of SBP during chronic administration to SHR from 4 to 10 weeks of age.6 In another study, mean arterial blood pressure was unchanged during the initial 12-hour period of UK-38,485 administration and SBP was not lowered until the fourth day of treatment with the TXA2 synthase inhibitor in SHR with established hypertension.3 Other TXA2 synthase inhibitors have been found to delay blood pressure elevation in young SHR.4,5 However, in 18-week-old
SHR with established hypertension, chronic administration of the TXA\(_2\) synthase inhibitor CV-4151 had no effect on blood pressure.\(^4\) In our studies of SHRSP developing severe hypertension, blood pressure was not lowered until after 5 days of UK-38,485 administration; this is consistent with other studies in which thromboxane synthase inhibitors fail to lower blood pressure acutely. Alternatively, the beneficial effect of chronic UK-38,485 treatment on blood pressure in SHRSP may derive from a delay in the progression of vascular injury, such as structural changes in the small arteries and thrombosis.

The mechanism by which UK-38,485 delays blood pressure elevation in SHRSP developing severe hypertension is not known. In addition to blocking the formation of TXA\(_2\), it is possible that the formation of vasodilatory/antiaggregatory prostanoids such as prostacyclin may be increased. Reorientation of endoperoxide metabolism has been demonstrated in vitro with several TXA\(_2\) synthase inhibitors\(^22,23\) and may occur in vivo under conditions of enhanced TXA\(_2\) formation. Interestingly, chronic administration of the cyclooxygenase inhibitor indomethacin, which blocks the formation of prostacyclin in addition to TXA\(_2\) and prostaglandin endoperoxides, did not inhibit the development of severe hypertension and slightly accelerated the development of proteinuria and stroke in SHRSP.\(^24\) Another possibility is that UK-38,485 lowered blood pressure by altering water and electrolyte excretion or fluid intake. Although we did not measure these parameters, it is unlikely that significant alterations in fluid balance occurred as body weight was nearly identical in the two groups throughout the study. UK-38,485 also had no effect on heart rate in SHRSP, suggesting that diminished cardiac output secondary to reduced heart rate is not responsible for the fall in blood pressure. However, we cannot exclude shifts in body fluid compartment sizes or reductions in cardiac contractility (output) as having contributed to the lowered blood pressure in UK-38,485-treated SHRSP. Heart weight at autopsy was similar in control and UK-38,485-treated SHRSP and is consistent with the observation that blood pressure reduction was not sustained; severe hypertension ultimately developed in both groups.

Previous studies have suggested that TXA\(_2\) synthase inhibitors may be of benefit in situations of acute thrombosis.\(^23,25\) Our results indicate that chronic administration of the TXA\(_2\) synthase inhibitor UK-38,485 offers no protection against the emergence of cerebrovascular lesions and stroke-related mortality in SHRSP. The extent of TXA\(_2\) synthase inhibition (89%) we observed was substantial as its determination (made 12 hours after the last 50-mg/kg dose of UK-38,485) represents a mini-

| Table 1. Body and Organ Weights of Stroke-Prone Spontaneously Hypertensive Rats at Autopsy |
|---------------------------------|---------------------------------|------------------|
|                                 | Control (n=10)                  | UK-38,485 (100 mg/kg/day) (n=10) | p        |
| Body (g)                        | 160.3±7.7                       | 157.4±8.5         | >0.8     |
| Heart Absolute (g)              | 0.88±0.04                       | 0.83±0.06         | >0.7     |
| % of body wt                    | 0.56±0.03                       | 0.52±0.02         | >0.2     |
| Total kidney Absolute (g)       | 2.24±0.13                       | 1.91±0.14         | >0.05    |
| % of body wt                    | 1.42±0.09                       | 1.22±0.07         | >0.05    |
| Total adrenal Absolute (mg)     | 50.9±4.7                        | 56.2±4.8          | >0.4     |
| % of body wt                    | 0.032±0.003                     | 0.036±0.003       | >0.3     |

Values are mean±SEM.
Hypertensive Rats

Acute or subacute rarefaction/edema
Fibrinoid necrosis
Lesion

Data are number of brains in which each lesion type was observed.

mum value, with much greater inhibition occurring sooner after dosing. A higher dose of UK-38,485 (200 mg/kg/day) likewise failed to offer protection but rather, tended to promote stroke-related mortality in the few SHRSP studied. Based on our findings, a role for TXA2 as a factor contributing to stroke cannot be excluded as inhibition of TXA2 synthase may have increased levels of its parent compound, prostaglandin H2, which is known to cause contraction of vascular smooth muscle and platelet aggregation by interacting with the TXA2 receptor. Recently, we have found that chronic administration of the angiotensin I converting enzyme inhibitor enalapril prevents stroke-related mortality in salt-loaded SHRSP while only modestly affecting blood pressure. In addition, the calcium channel blocking agent nitrendipine has also been found to prevent stroke in SHRSP without affecting blood pressure. Thus, although TXA2 may contribute to the blood pressure rise in SHRSP, other factors appear to be involved in the evolution of severe hypertension and stroke.

In summary, chronic administration of the TXA2 synthase inhibitor UK-38,485 delayed but did not prevent the development of severe hypertension in SHRSP. UK-38,485 did not prevent stroke-related mortality or diminish the occurrence of brain lesions in SHRSP. Our results support a possible role for TXA2 in the blood pressure elevation of SHRSP but not in the prevention of stroke by TXA2 synthase inhibition.

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References


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