Intravenous Rosuvastatin for Acute Stroke Treatment
An Animal Study

Vincent Prinz, MD; Ulrich Laufs, MD; Karen Gertz, MD; Golo Kronenberg, MD; Mustafa Balkaya, MSc; Christoph Leithner, MD; Ute Lindauer, DVM; Matthias Endres, MD

Background and Purpose—Statins exert rapid cholesterol-independent vasoprotective effects. Here, we tested whether postevent treatment with intravenously (i.v.) administered rosuvastatin improves acute stroke outcome in mice.

Methods—129/SV wild-type mice were subjected to 1-hour filamentous middle cerebral artery occlusion (MCAo), followed by reperfusion, and were postevent treated with i.v. or intraperitoneal (i.p.) rosuvastatin given up to 6 hours after MCAo (dose range 0.02 to 20 mg kg

Results—Rosuvastatin, when administered i.v., significantly reduced lesion size when given up to 4 hours after MCAo and in doses as low as 0.2 mg kg

Conclusions—Rosuvastatin, given intravenously at pharmacologically relevant concentrations, protects from focal brain ischemia up to 4 hours after an event. In our opinion, the development of an intravenous statin formulation is warranted for acute stroke trials with statins in humans. (Stroke. 2008;39:433-438.)

Key Words: cerebral ischemia ■ HMG-CoA reductase inhibitors ■ neuroprotection ■ statins

Statins, inhibitors of HMG-CoA reductase, are widely used cholesterol-lowering drugs and reduce the incidence of myocardial infarctions and stroke. Experimental and clinical evidence suggests that chronic statin treatment may also decrease stroke severity and improve outcome. Statins may also provide stroke-protection when given after ischemia onset. For rapid administration such as for acute stroke treatment, however, we propose the development of an intravenous statin formulation.

Methods

Mice, Treatment, and Measurements of Rosuvastatin Plasma Levels

All experimental procedures conformed to institutional guidelines and were approved by an official committee (G0206/06, LaGeSo, Berlin, Germany). 129/SV wild-type mice (Brr, Berlin, Germany) aged 6 to 8 weeks were used for this study. Rosuvastatin (AstraZeneca) was dissolved in normal saline and administered intravenously (i.v.) or intraperitoneally (i.p.) in a total volume of 150 μL. In a subset of animals, blood was withdrawn for plasma preparation at 1, 3, or 5 hours after rosuvastatin administration and plasma samples were analyzed for rosuvastatin levels by an LC/MS/MS method.

Model of Cerebral Ischemia

Mice were anesthetized by 1.0% (vol/vol) isoflurane in 69% nitrous oxide (N2O) and 30% oxygen (O2) administered via a facemask. Focal cerebral ischemia was induced by 60-minute filamentous middle cerebral artery occlusion (MCAo) and reperfusion as described previously. Rectal temperature was controlled and kept constant at 36.5 ± 0.5°C. Regional cerebral blood flow (rCBF) was measured by means of a flexible probe and laser-Doppler monitoring (Perimed). There was an equivalent drop in rCBF to less than 20% of baseline at filament insertion and an equivalent rise in rCBF at filament withdrawal. In randomly assigned animals, the left femoral artery was cannulated for arterial blood pressure monitoring and blood withdrawal. Arterial blood samples were analyzed for pH, arterial oxygen pressures, and partial pressure of carbon dioxide as described. After 24 hours or 5 days, animals were euthanized by a pentobarbital overdose, and brains were quickly removed from the skull and snap-frozen in isopentane on dry ice for cryostat sectioning. Direct and indirect lesion areas were quantified by computer-assisted volumetry on 20 μm hematoxylin-stained cryostat sections as described.

Western Blot Analysis

Immunoblotting for endothelial nitric oxide synthase (eNOS, BD 610296), phosphorylated eNOS (BD 612706), phosphorylated Akt
Table 1. Rosuvastatin Plasma Levels [ng/mL] in 129/SV Wild-Type Mice at Different Time Points After Single Intravenous Injection

<table>
<thead>
<tr>
<th>Rosuvastatin</th>
<th>1 Hour</th>
<th>3 Hours</th>
<th>5 Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.02 mg kg⁻¹</td>
<td>0.16±0.06</td>
<td>&lt;0.1</td>
<td>0.13±0.06</td>
</tr>
<tr>
<td>0.2 mg kg⁻¹</td>
<td>0.44±0.04</td>
<td>0.28±0.09</td>
<td>0.12±0.02</td>
</tr>
<tr>
<td>2.0 mg kg⁻¹</td>
<td>4.58±1.48</td>
<td>4.01±0.30</td>
<td>4.07±0.81</td>
</tr>
</tbody>
</table>

Mean±SEM; n=4 to 5 animals per group.

Effect of Rosuvastatin Treatment on Cerebral Lesion Size After MCAo
Mice were subjected to 1-hour filamentous MCAo/reperfusion and were postevent treated with i.v. or intraperitoneal (i.p.) rosuvastatin given up to 6 hours after MCAo (dose range 0.02 to 20 mg kg⁻¹ body weight). When administered at 1 hour after ischemia onset, i.v. rosuvastatin provided protection in concentrations of 0.2 and 2.0 mg kg⁻¹ but not 0.02 mg kg⁻¹ (Figure 1A). Similar results were observed when lesion size was calculated with an indirect method to correct for brain swelling: ie, 90.8±10.0 mm³ (vehicle) versus 72.2±6.7 mm³ (2.0 mg kg⁻¹ rosuvastatin, respectively). When given at 6 hours, 0.2 mg kg⁻¹ was ineffective whereas 2.0 mg kg⁻¹ provided significant protection when calculated by the indirect method (P<0.05).

In addition, we compared whether the treatment window was different between the i.p. and i.v. formulations. Therefore, groups of animals received 2.0 or 20 mg kg⁻¹ rosuvastatin given i.p. or 2.0 mg kg⁻¹ given i.v. at 3 hours after MCAo. As demonstrated in Figure 3, high-dose i.p. rosuvastatin did not provide protection at 3 hours as did the low-dose i.v. formulation. Similar results were obtained with the indirect method: 92.8±3.4 mm³ (vehicle) versus 91.4±5.1 mm³ (20.0 mg kg⁻¹ i.p.) versus 72.2±5.2 mm³ (2.0 mg kg⁻¹ i.v.).

Physiological Parameters
We carefully measured physiological parameters after 1 hour in selected mice subjected to MCAo and treated with vehicle versus 2.0 mg kg⁻¹ rosuvastatin. Overall, there were no differences in mean arterial blood pressure, heart rate (not shown), PaO₂, PaCO₂, pH, or rectal temperatures after rosuvastatin administration compared with vehicle-treated animals (Table 2).

Effect of Rosuvastatin Treatment on Functional Deficits and Lesion Size at Day 5
In addition, we tested whether i.v. statin treatment had an effect on functional deficits. Mice were treated with rosuv-
astatin 2 mg kg⁻¹ or vehicle given i.v. at 3 hours after a 1-hour MCAo (n=10 per group), and treatment was continued over 5 days (daily i.p. injections; 2 mg kg⁻¹). Although all animals had a moderate (i.e., grade 2) deficit in the Bederson score directly after reperfusion, rosuvastatin-treated mice had less severe functional deficits on day 5 with a median score of 1.0 (1.0 and 2.0 for 25% and 75% confidence intervals) corresponding to a mild deficit compared with vehicle-treated animals with median scores of 2.0 (1.75 and 2.0 for 25% and 75% confidence intervals) corresponding to a moderate deficit. In addition, rosuvastatin-treated animals had significantly better performance in the pole test (Figure 4A and 4B) and also longer endurance in the wire-hanging test (Figure 4C). Moreover, lesion size at day 5 was also significantly reduced by rosuvastatin treatment (Figure 4D). Infarct sizes measured with the indirect method were 50.6±6.6 mm³ versus 75.1±7.1 mm³ (P<0.05).

**Effects of Rosuvastatin Treatment on Expression of Aortic eNOS, Phospho-eNOS, and Phospho-Akt**

Expression of endothelial nitric oxide synthase (eNOS), phosphorylated, i.e., activated, eNOS (phospho-eNOS) and phosphorylated, i.e., activated, Akt-kinase (phospho-Akt) were quantified by immunoblotting in the aorta at different time points after administration of i.v. rosuvastatin. Significant increases in eNOS and phospho-eNOS were observed with 2.0 mg kg⁻¹ rosuvastatin and of phospho-Akt with 0.2 and 2.0 mg kg⁻¹ rosuvastatin as early as 1 hour after administration (Figure 5). In addition, rosuvastatin i.v. also increased eNOS, phospho-eNOS, and phospho-Akt in cerebral vascular beds: immunoblots from brain tissue lysates revealed a significant (P<0.05) increase of eNOS to 160±17% after 3 hours and 190±21% after 5 hours, phospho-eNOS (to 172±12% after 3 hours and 188±34% after 5 hours), and phospho-Akt (to 169±29% after 3 hour and 192±28% after 5 hour) in mice treated with 2.0 mg kg⁻¹ rosuvastatin i.v. versus vehicle (n=4 animals per group).

**Discussion**

This study has the following major findings: rosuvastatin when given as an intravenous formulation provides protection...
from focal brain ischemia/reperfusion in the mouse when given as late as 4 hour after ischemia in doses as low as 0.2 mg kg\(^{-1}\). The stroke protective effects of i.v. rosuvastatin extended to 5 days after ischemia and were accompanied by functional improvements as determined by a number of functional tests (Bederson score, wire hanging test, pole test). Neuroprotection with i.v. rosuvastatin was achieved with peak plasma concentrations lower than 0.5 ng ml\(^{-1}\) (ie, with the 0.2 mg kg\(^{-1}\) dose), and was associated with increased levels of phosphorylated Akt kinase and phosphorylated eNOS in the vasculature. In contrast, intraperitoneal administration provided protection only when given as early as 1 hour after ischemia onset and at a dose of 20 mg kg\(^{-1}\).

Statins exert pleiotropic effects on the vascular wall that may occur rapidly before any effect on cholesterol levels.\(^1\) We have previously demonstrated that the stroke protective effects of chronic statin treatment are—at least in part—mediated by upregulation of eNOS in the vascular wall.\(^1,3\) In addition to more delayed upregulation of eNOS expression, statins may directly activate eNOS via protein kinase Akt.\(^6\) Activation of phosphatidylinositol 3 (PI3)-kinase mediates the phosphorylation and activation of Akt, and PI3 inhibitors block the effects of statins on Akt.\(^5\) Increased bioavailability of endothelial-derived NO improves endothelium function, increases cerebral blood flow, inhibits platelet aggregation, and exerts antiinflammatory effects, which may all contribute to the protective effects of rosuvastatin.\(^1\) We have previously demonstrated that stroke-protective effects after chronic statin treatment are completely absent in animals deficient in eNOS expression (ie, eNOS knockout mice).\(^3\) It would be interesting to determine whether acute protective effects after intravenous statin treatment are also absent in eNOS knockout mice. Recently, it has also been demonstrated that statins activate AMP-activated protein kinase which may additionally contribute to eNOS activation.\(^6\) In this study, intravenous administration of rosuvastatin conferred increased phosphorylation of Akt-kinase within 60 minutes at doses of 0.2 mg

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**Figure 4.** Functional deficits and lesion size at day 5. Mice were subjected to 1-hour MCAo/reperfusion and treated with rosuvastatin (2.0 mg kg\(^{-1}\)) or vehicle intravenously at 3 hours. On day 5, animals were exposed to functional analysis in the pole test (A and B) and wire-hanging test (C). Thereafter, animals were euthanized and direct ischemic lesion volumes determined on coronal brain cryostat sections by computer-assisted volumetry. n=10 animals per group. Mean±SEM; *P<0.05 vs vehicle.

**Figure 5.** Expression of aortic eNOS, phospho-eNOS, and phospho-Akt after rosuvastatin treatment. Expression of endothelial nitric oxide synthase (eNOS; A), phosphorylated (phospho)-eNOS (B), phosphorylated (phospho)-Akt (C) in aortas of 129/SV wild-type mice standardized to β-actin determined by immunoblotting. Animals were euthanized and aortas quickly snap-frozen at 1, 3, or 5 hours after a single intravenous injection of rosuvastatin (dose range 0.02 to 2.0 mg kg\(^{-1}\)). n=5 animals per group. Mean±SEM; *P<0.05 vs vehicle.
kg⁻¹ and higher. Interestingly, it should be noted that the 0.2 mg kg⁻¹ dose of rosuvastatin provided neuroprotection and increased phospho-Akt but not phospho-eNOS or eNOS. Moreover, the 0.02 mg kg⁻¹ dose, which failed to increase phospho-Akt, also did not confer protection, supporting the concept that Akt activation correlates with acute protection in the stroke model. Importantly, the effects of rosuvastatin on eNOS and Akt-kinase were not limited to peripheral arteries but were also evident in the cerebrovasculature.

Chronic statin treatment provides protection in animal models of stroke particularly when given at high systemic concentrations.⁴,⁵,⁷ Also, postevent treatment may be effective, however only when administered at high doses soon after MCAo.²,⁸–¹⁰ For example, Kilic and coworkers demonstrated that i.p. rosuvastatin was only effective at 20 mg kg⁻¹ and not lower doses and only when administered directly after reperfusion after MCAo.⁸ Moreover, postevent treatment with atorvastatin (administered subcutaneously) exerts neuroprotective effects when administered 4 hours after stroke but only in combination with tissue-type plasminogen activator and not alone.¹⁰ In this study, we demonstrate that the therapeutic window for acute stroke treatment with rosuvastatin can be extended significantly (ie, by at least 3 hours) and the effective dose significantly reduced (ie, by 2 orders of magnitude) with an intravenous formulation.

Statins are ordinarily metabolized extensively in the liver through the first-pass mechanism after oral administration. Data in the rat and human indicate that rosuvastatin is not extensively metabolized and in the main is fecally excreted predominantly as active parent compound.¹¹ What little metabolism there is yields less potent metabolites. Cerebral exposure for rosuvastatin is low because of its hydrophilicity, and any direct protective effects are likely via effects on the cerebral vasculature (see above). It is presently not entirely clear how i.v. administration bypasses this and whether direct effects on the brain are more important for neuroprotection than effects mediated through liver metabolism. Neuroprotection with i.v. rosuvastatin was achieved with very low peak plasma concentrations smaller than 0.5 ng ml⁻¹. Also, there appeared to be a nonlinear relationship of drug levels with increasing doses. This, however, is most likely attributable to the limit of detection. It has been demonstrated that liver-derived mevalonate levels fall dramatically after administration of statins.¹¹ Thus, if peripheral cells, including cerebral vascular endothelial cells, are dependent on circulating mevalonate for production of isoprenoids, this might explain some, if not all, of the pleiotropic effects seen at very low circulating drug concentrations. The liver is a sink for statins, particularly rosuvastatin, which is both an intrinsically potent statin and actively removed by the liver by an active transport mechanism.

In our study, we did not measure plasma levels after i.p. administration; however, these measurements were performed in the Kilic study using the same detection method.⁸ Indeed, rosuvastatin plasma levels after i.p. administration were much higher than after i.v. administration and found to have linear pharmacokinetics: after administration of 0.5, 5, and 20 mg kg⁻¹ plasma drug levels were 263.5, 1559.6, and 2231.8 ng ml⁻¹ at 30 minutes (equating to 0.527, 1.56, and 4.46 μmol/L, respectively). The differences in the plasma drug levels may reflect differences in drug handling after i.v. or i.p. dosing, and the drug may be cleared and concentrated in the liver much more rapidly after i.v. dosing compared with i.p. Therefore, for i.p. dosing there remains a significant plasma drug level, whereas for i.v. the drug is in the effect compartment (ie, liver). This might also fit the hypothesis of hepatic-mediated peripheral effects (see above).

A number of retrospective studies indicate that statin medication before ischemic stroke is associated with a favorable outcome.¹⁰ Recently, a secondary analysis of data from the Stroke Prevention With Aggressive Reduction in Cholesterol Levels (SPARCL) trial showed that patients had a less severe recurrent stroke if they were receiving treatment with 80 mg atorvastatin within the month before the event, compared with those not on treatment.¹² Also, there is preliminary evidence that acute administration of statins in stroke patients may be beneficial: the Markers of Inflammation after Simvastatin in Ischemic Cortical Stroke (MISTICS) trial demonstrated improved neurologic outcome at 90 days in patients treated with simvastatin 40 mg orally within 3 to 12 hours after stroke onset.¹³

In conclusion, we propose the development of an intravenous statin formulation for clinical use. Intravenous formulations of hydrophilic statins such as rosuvastatin that are water soluble are pharmacologically feasible. Indeed, 8 mg rosuvastatin was safely administered intravenously in healthy volunteers, and this dose directly corresponds to the dose used in this study to reduce ischemic brain damage in mice.¹⁴ There is evidence that in patients with acute vascular syndromes or those undergoing cardiovascular surgery discontinuation of statin medication may be associated with impaired vascular function and worse outcome.¹⁵ Therefore, in addition to treatment trials for acute ischemic stroke, intravenous statins could be used in patients previously treated with statins who cannot be treated with statins per os or even via nasogastric tube (eg, unable to swallow, intensive care patients, before major surgery).

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References
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