Action Potentials, Contraction, and Membrane Currents in Guinea Pig Ventricular Preparations Treated with the Antispasmodic Agent Terodiline

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ABSTRACT
Terodiline was widely prescribed for urinary incontinence before reports of adverse cardiac effects that included bradycardia, QT lengthening, and ventricular tachyarrhythmia. The present study on guinea pig papillary muscles and ventricular myocytes was undertaken to gain insight into the cardioactive properties of the drug. Clinically relevant concentrations (10 μM) of terodiline lengthened the action potential duration by up to 12%; higher concentrations shortened the duration in a concentration-dependent manner. The drug depressed maximal upstroke velocity in a use-dependent manner; the IC50 value was near 150 μM at 1 Hz, 60 μM at 3 Hz, 38 μM at 5 Hz, and 3 μM at 1 Hz in muscles depolarized with 14 mM K+. Submicromolar terodiline frequently had a small positive inotropic effect, whereas micromolar concentrations depressed force in a frequency-dependent manner. Voltage-clamp results on myocytes indicate that terodiline inhibits three membrane currents that govern repolarization: 1) E4031-sensitive, rapidly activating K current with an IC50 value near 0.7 μM as previously reported; 2) slowly activating, delayed-rectifier K+ current with an IC50 value of 26 μM; and 3) L-type Ca2+ current with an IC50 value of 12 μM. These findings are correlated with the changes in action potential configuration and developed tension and discussed in relation to the cardio- toxic effects of the drug.

Terodiline, a drug with structural similarities to pencycloline and fendiline, was originally marketed in Sweden in the mid-1960s as a prophylactic agent in angina pectoris. The results of studies on isolated bronchial muscle (Iravani and Melville, 1975) and patients with obstructive pulmonary disease (Castenfors et al., 1975) suggested that terodiline had anticholinergic properties. Anticholinergic activity, as well as Ca2+ antagonism, was documented in subsequent investigations on isolated bladder (Husted et al., 1980). Based on this spectrum of activity, terodiline was investigated for the treatment of urinary incontinence in adults and of nocturnal enuresis in children (Elmer, 1984; Peters, 1984). The outcome of these trials was withdrawal of the drug as an antianginal agent in 1985 and reintroduction in more than 20 countries in 1986 as an effective treatment for urinary incontinence. It quickly became the drug of choice for this condition in Europe (Langtry and McTavish, 1990) but was withdrawn in 1991 after reports of serious cardiac side effects, including bradycardia, atrioventricular block, prolongation of the Q-T interval of the electrocardiogram, and ventricular tachyarrhythmia (torsades de pointes) (Connolly et al., 1991; Stewart et al., 1992). The drug is currently available for clinical investigation and is a prototype structure for the development of newer drugs for the treatment of unstable bladder (Take et al., 1996).

Although the specific electrophysiological mechanism or mechanisms that trigger drug-induced torsades are uncertain (Roden et al., 1996; Woosley, 1996), knowledge of the mechanisms of cardiac action of various torsades-inducing drugs contributes to improved understanding of the arrhythmia. In this regard, there have been investigations into the

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ABBREVIATIONS: V, upstroke velocity; APA, action potential amplitude; APD, action potential duration; APD20, action potential duration at 20% repolarization level; APD90, action potential duration at 90% repolarization level; DMSO, dimethyl sulfoxide; Ica, L-type Ca2+ current; If, delayed-rectifier K+ current; If, inward-rectifying K+ current; If, rapidly activating component of If; Iks, slowly activating component of If; Vmax, maximal upstroke velocity.
alterations of electrophysiological parameters, contraction, and membrane ionic currents caused by class Ia antiarrhythmic quinidine (Nawrath, 1981; Imaizumi and Giles, 1987), class III antiarrhythmic sotalol (Campbell, 1987), the antidepressant imipramine (Valenzuela et al., 1994), antihistamines terfenadine and astemizole (Berul and Morad, 1995; Salata et al., 1995), and the antibiotic erythromycin (Nattel et al., 1990; Daleau et al., 1995).

To our knowledge, there have been two previous studies on the direct effects of terodiline on cardiac cell function. Pressler et al. (1995) found that exposure of canine Purkinje fibers to clinically relevant concentrations (1–10 μM) of terodiline shortened the action potential duration (APD; 50% repolarization) by ~40%. More recently, we determined that the rapidly activating component of delayed-rectifier K+ current (IKr) in guinea pig ventricular myocytes is inhibited by terodiline with IC50 values near 0.7 μM and that slowly activating IKs is inhibited by high concentrations of the drug (Jones et al., 1998). Although the latter actions would have lengthening influences on ventricular action potentials and may therefore be important factors in QT lengthening, it is unclear whether other actions of the drug on ventricular cells might not outweigh the lengthening influences and shorten the action potential as reported for Purkinje fibers. To obtain further information on these and other aspects of terodiline action on ventricular muscle, we recorded action potentials and developed tension in guinea pig papillary muscles treated with 0.1 to 100 μM concentrations of the drug, and we measured Ca2+ and K+ membrane currents in guinea pig ventricular myocytes.

Materials and Methods

**Papillary Muscles.** Papillary muscles were obtained from the right ventricles of adult guinea pig hearts. The guinea pigs (250–350 g) were sacrificed by cervical dislocation, and the hearts were quickly removed and placed in oxygenated (95% O2/5% CO2) Krebs' solution that contained 113.1 mM NaCl, 4.6 mM KCl, 2.45 mM CaCl2, 1.15 mM MgCl2, 21.9 mM NaHCO3, 3.48 mM NaH2PO4, and 10.0 mM glucose (pH 7.4). Muscles were excised and mounted in a Persepol bath (0.25 ml volume) perfused with solution (36 ± 0.2°C) at 4 to 6 ml/min. The mural end of the muscle was fixed by a clamp, and the tendinous end was fixed by a pin or attached to an isometric force transducer (model UC2; Gould Statham, Oxnard, CA). Muscles were adjusted to a length that produced ~75% peak developed tension (resting tension of 50–90 mg).

Muscles were stimulated at 1 Hz with 3-ms-long pulses of 1.2-times threshold strength via a bipolar Ag/AgCl electrode and equilibrated for 60 to 90 min before data collection. When normal Krebs' solution was replaced by Krebs' solution with higher (8–14 mM) than standard (4.6 mM) K+ concentration, there was no compensation for the change in osmolality. Action potentials were recorded with a chart recorder (model RS 3440; Gould, Cleveland, OH) and/or by computer via Axoscope (Axon Instruments, Foster City, CA).

**Ventricular Myocytes.** Single ventricular myocytes were enzymatically isolated as described previously (Ogura et al., 1995). The excised hearts were mounted on a Langendorff column and retrogradely perfused (37°C) through the aorta with Ca2+-free Tyrode's solution containing collagenase (0.08–0.12 mg/ml; Yakult Pharmaceutical Co., Tokyo, Japan) for 10 to 15 min. The cells were dispersed and stored at 22°C in a high-K+, low-Na+ solution supplemented with 50 mM glutamic acid and 20 mM taurine. A few drops of the cell suspension were placed in a 0.3-ml perfusion chamber mounted on an inverted microscope stage. After the cells had settled to the bottom, the chamber was perfused (~2 ml/min) with Tyrode's solution at 36°C. The Tyrode's solution contained 140 mM NaCl, 5.4 mM KCl, 1.8 mM CaCl2, 1 mM MgCl2, 10 mM glucose, and 5 mM HEPES, pH 7.4 with NaOH. In some experiments, this solution was replaced by K+-free Tyrode's or K+-, Ca2+-free Tyrode's that included 0.2 mM Ca2+.

Whole-cell membrane currents were recorded using an EPC-7 amplifier (List Electronic, Darmstadt, Germany). Recording pipettes were fabricated from thick-walled borosilicate glass capillaries (H15/1418 Shuba et al. 90% repolarization levels (APD20 and APD90, respectively) were monitored for 30 min in control and test muscles stimulated at 1 Hz. These parameters were stable in the control muscles and reached quasi-steady state within the observation period when tissues were exposed to terodiline (Fig. 1D).

**Statistics.** Results are expressed as mean ± S.E., and single comparisons were made using Student's t test. Differences were considered to be significant when p < .05.

Results

**Concentration-Dependent Effects of Terodiline on Action Potential Parameters**

**Duration and Amplitude.** The records in Fig. 1, A–C, illustrate the effects of 0.3, 3, and 15 μM terodiline on the configuration of action potentials in guinea pig papillary muscles. The lower concentrations lengthened the action potential, whereas 15 μM lowerd the plateau voltage and slowed phase 3 repolarization.

To quantify the concentration-dependent effects of terodiline, action potential amplitude (APA) and APD at 20 and 90% repolarization levels (APD20 and APD90, respectively) were monitored for 30 min in control and test muscles stimulated at 1 Hz. These parameters were stable in the control muscles and reached quasi-steady state within the observation period when tissues were exposed to terodiline (Fig. 1D). Values at 30 min were expressed as percentages of 0-min values, and the results are shown in Fig. 1E. APD20 was increased by low concentrations of terodiline [peak, 108 ± 2% (n = 14) at 1 μM], slightly reduced by 10 μM, and reduced to 85 ± 1% (n = 11) by 30 μM. The dependence of APD90 on...
drug concentration was similar but shifted to the right; it increased to a peak of \(112 \pm 2\%\) \((n = 19)\) at 3 \(\mu M\) and declined to \(95 \pm 1\%\) \((n = 11)\) at 30 \(\mu M\). APA was unaffected by \(10 \mu M\) terodiline and slightly depressed by higher concentrations.

Control and drug-treated muscles were subsequently stimulated at 3 Hz for 5 min and at 5 Hz for an additional 3 min. In the control muscles, \(\text{APD}_{20}\) declined to \(74 \pm 2\%\) \((3 \text{ Hz})\) and \(57 \pm 2\%\) \((5 \text{ Hz})\) of the 0-min 1-Hz duration, \(\text{APD}_{90}\) declined to \(79 \pm 1\%\) \((3 \text{ Hz})\) and \(62 \pm 2\%\) \((5 \text{ Hz})\), and APA declined by 2 to 4 mV \((\text{Fig. } 2)\). \(\text{APD}_{20}\) and \(\text{APD}_{90}\) also declined when terodiline-treated muscles were driven at 3 and 5 Hz, with the overall outcome that the increases in rate had little effect on the percentage changes induced by the drug \((\text{Fig. } 2A)\). APA in drug-treated tissues was also affected by rate; reductions at high concentrations were up to 35 mV larger at 5 Hz than at 1 Hz, due primarily to reductions in overshoot \((\text{Fig. } 2C)\).

### Maximal Upstroke Velocity

Terodiline reduced maximal upstroke velocity \((V_{\text{max}})\) to \(97 \pm 1\%\) \((3 \mu M)\), \(78 \pm 4\%\) \((30 \mu M)\), and \(57 \pm 6\%\) \((100 \mu M)\) in muscles driven at 1 Hz \((\text{Fig. } 3A)\). Depolarization of the resting membrane was not a factor in the reductions caused by <30 \(\mu M\) drug but may have been at 100 \(\mu M\) \((\text{depolarization of } 2-8 \text{ mV}, n = 6)\). For reference, Pressler et al. \((1995)\) found that \(\geq 25 \mu M\) terodiline caused marked depolarization and inexcitability of canine Purkinje fibers.

Increases in stimulation rate had a marked effect on \(V_{\text{max}}\) in terodiline-treated muscles, with estimated \(IC_{50}\) values declining from 150 \(\mu M\) \((1 \text{ Hz})\) to 60 and 38 \(\mu M\) at 3 and 5 Hz, respectively \((\text{Fig. } 3A)\). Lowering the resting potential by ele-
Effects on Force of Contraction

The cytosolic free Ca²⁺ concentration ([Ca²⁺]c) was calculated with the following equation:

\[ [Ca^{2+}]_c = \frac{F}{F_0} \cdot [Ca^{2+}]_{o} \]

where F is the relative Fluorescence, F₀ is the baseline Fluorescence, and [Ca²⁺]₀ is the extracellular free Ca²⁺ concentration (1.8 mM).

Effects on Membrane Currents

Overview. The records and analysis shown in Fig. 5 provide an overview of the concentration-dependent inhibitory effects of terodiline on membrane currents in guinea pig ventricular myocytes superfused with Tyrode's solution and dialyzed with K⁺ solution. The myocytes were de-polarized for 500 ms from prepulse −40 mV to elicit inward L-type Ca²⁺ current (I_{C₅₀,L}) and outward delayed-rectifier K⁺ current (I_K) and repolarized to −40 mV to elicit outward tail I_K. Exposure to 0.3 µM terodiline for 8 min had little effect on either peak I_{C₅₀,L} or time-dependent I_K at positive potentials, but it reduced tail I_K at −40 mV (Fig. 5A). However, exposures to higher concentrations of the drug (10 and 100 µM) caused reductions in I_{C₅₀,L} and time-dependent I_K as well as further reductions in tail I_K (Fig. 5B–D).

Effects on I_K. Guinea pig ventricular I_K is composed of I_{Kr} (a component that is rapidly activated at potentials up to ~10 mV and specifically inhibited by E4031) and I_{Ks} (a component that is slowly activated at positive potentials) (Sanguinetti and Jurkiewicz, 1990). Figure 6A, a–c, illustrates that tail I_K measured after 500-ms depolarizations can be resolved into tail I_K and tail I_K by the application of 3 µM E4031, that low concentrations of terodiline suppress the E4031-sensitive tail, and that 30 µM terodiline reduces the amplitude of the E4031-insensitive tail by ~50%. A more detailed analysis of terodiline action on tail I_K indicates that the I_{C₅₀} value is near 0.7 µM (Jones et al., 1998).

To quantify the effects of terodiline on I_{Kr}, myocytes were bathed in K⁺-, Ca²⁺-, and Cd²⁺-free solution (conditions that minimize the amplitude of I_{Kr}, relative to I_{Ks}; see Sanguinetti and Jurkiewicz, 1992) and depolarized for 2 s to positive potentials for measurement of time-dependent outward currents. Records from representative myocytes exposed to 5 and 100 µM terodiline indicate that the drug had concentration-dependent inhibitory effects on I_{Kr} elicited by depolarizations up to 80 mV (Fig. 6B, a and b). The effects on current amplitude at 40 mV were used to determine the concentration-response relationship, and the data are well described by a Hill equation with an I_{C₅₀} value of 26 µM and a coefficient of 0.85 (Fig. 6B, c).

Effects on Peak I_{C₅₀,L}. To evaluate the effects of terodiline on peak I_{C₅₀,L}, myocytes that were superfused and dialyzed with K⁺-free solutions (to minimize K⁺ currents) were pulsed at 0.1 Hz with 200-ms steps from −40 to 0 mV, treated with terodiline, and then exposed to 0.4 mM Cd²⁺ to establish the zero-I_{C₅₀,L} background current level. The drug reduced the amplitude of I_{C₅₀,L} in a concentration-dependent manner (Fig. 7, A and B), and this action was sensitive to pulsing rate: in three myocytes, trains of 25 pulses at 3 Hz depressed I_{C₅₀,L} (0.1 Hz) to a much larger extent in the presence of the drug than in its absence (Fig. 6C).

The data obtained from myocytes pulsed at 0.1 Hz are summarized in Fig. 7D. They are well described by the Hill equation with an I_{C₅₀} value of 12 µM and a coefficient of 0.9.
Relation to Action Potential and Contraction. The relevance of the voltage-clamp findings to muscle activity was examined by measuring the effects of 3 μM terodiline on papillary muscles that were pretreated with 5 μM E4031. E4031 slowed repolarization at potentials below ~15 mV (Fig. 7E), and the stable APD₀₉₀ after 15 min was 127 ± 2% of control duration (n = 5). Subsequent exposure to 3 μM terodiline for 30 min lowered the plateau voltage and reduced the lengthened APD₀₉₀ by 9 ± 2% (n = 5). It seems likely that the plateau reduction and APD₀₉₀ shortening were due to inhibition of I_{Ca,L} and that this inhibition was primarily responsible for the accompanying negative inotropy [after 15-min E4031, developed tension was 126 ± 3% of 0-min control (n = 5); after an additional 30-min terodiline, developed tension was 71 ± 6%].

Discussion

APD, Contraction, and Membrane Currents. The findings on APD, contraction, and membrane currents are best correlated by considering them under three terodiline concentration ranges: submicromolar (<1 μM), micromolar (1–5 μM), and high micromolar (≥10 μM). Submicromolar concentrations induced small but significant lengthenings of the action potential that were almost certainly due to partial inhibition of I_{Kr} (IC₅₀ ~ 0.7 μM), and micromolar concentrations induced additional lengthening as expected from more complete inhibition of I_{Kr}. However, the degree of lengthening (e.g., 12% with 3 μM) was smaller than the 27% lengthening in muscles treated with IKr-inhibiting E4031. The most likely explanation for this shortfall is that the lengthening influence related to I_{Kr} inhibition was partially offset by the shortening influence related to reduced peak I_{Ca,L} (IC₅₀ ~ 512 μM). In accord with this interpretation, 3 μM terodiline shortened the APD in muscles pretreated with E4031. High micromolar terodiline depressed V_{max} and the plateau, and this was most likely due to inhibition of Na⁺ current and additional inhibition of I_{Ca,L}. The plateau-abbreviating influence related to these actions is likely to have been at least partially countered by a lengthening influence related to inhibition of I_{Ks} (IC₅₀ ~ 26 μM). Finally, there were indications (lower resting potential; lower outward holding current at ~40 mV) that inhibition of inward-rectifying K⁺ current may have slowed phase 3 repolarization in muscles treated with high concentrations of the drug.

A small positive inotropy was detected in many of the papillary muscles treated with submicromolar terodiline, and it seems likely that this was a consequence of the partial
inhibition of $I_{\text{Kr}}$. Many class III antiarrhythmic agents that inhibit $I_{\text{Kr}}$ induce a small positive inotropy (Wallace et al., 1991), and we found that 5 $\mu$M E4031 augmented force by 26% in accord with findings on rabbit papillary muscles (Cingolani et al., 1991). The link between inhibition of $I_{\text{Kr}}$ and positive inotropy is a lengthening of the action potential that allows a larger influx of $\text{Ca}^{2+}$ (compare with Clark et al., 1996). Although action potential lengthening was more pronounced with micromolar than with submicromolar terodiline, this did not result in a larger positive inotropy. On the contrary, $\geq 1$ $\mu$M terodiline depressed contraction, and this was almost certainly related to the concentration-dependent reduction in $I_{\text{Ca,L}}$ (see Shuba and McDonald, 1994; Grantham and Cannell, 1996). In addition, there may well be a correlation between terodiline-induced abbreviation in time to peak tension (Fig. 4A) and terodiline-induced acceleration of the inactivation of $I_{\text{Ca,L}}$ (Fig. 7A). A further link between $I_{\text{Ca,L}}$ and contraction in drug-treated preparations was that both processes were inhibited by increases in pulsing rate. Kura et al. (1992) suggested that terodiline block of smooth muscle $I_{\text{Ca,L}}$ is rate-dependent.

**Frequency- and Voltage-Dependent Inhibition of $V_{\text{max}}$.** Significant inhibition of $V_{\text{max}}$ occurred with 3 $\mu$M terodiline (reduction to 97 ± 1%) when muscles were driven at 1 Hz and with 1 $\mu$M when they were driven at 5 Hz. Drug-induced inhibition of $V_{\text{max}}$ was also accentuated when muscles driven at 1 Hz were partially depolarized with elevated $K^+$; in the 14 mM $K^+$ trials (resting potential lowered from ~ -89 to ~ -62 mV), the IC50 value for inhibition by terodiline was near 3 $\mu$M (or roughly five times lower than the IC50 value for tetrodotoxin in normally polarized guinea pig ventricular preparations; Baer et al., 1976).

A number of the $V_{\text{max}}$ findings on papillary muscles correlate with those reported by Pressler et al. (1995) in their study on canine cardiac Purkinje fibers. For example, they found that significant (~11%) inhibition required 5 $\mu$M terodiline when the mean resting potential was ~ -90 mV (2.7 mM $K^+$) but only 2 $\mu$M when it was ~ -82 mV (5.4 mM $K^+$) and
that inhibition by 10 μM drug was 25% larger at 2 Hz than at 0.67 Hz. These investigators also recorded a 10% lengthening of the His-ventricle interval in anesthetized dogs when plasma terodiline was ~4 μM and attributed it to slowed conduction related to Na\(^+\) channel block by the drug.

**Adverse Reactions to Terodiline.** The adverse cardiac effects of terodiline include slowing of heart rate, atrioventricular conduction disturbances, QT prolongation, and malignant ventricular tachycardia (torsades de pointes) (Connolly et al., 1991; Stewart et al., 1992). Because both Na\(^+\) and Ca\(^{2+}\) currents are essential for pacemaking and nodal conduction (Munk et al., 1996; Kodama et al., 1997), it seems likely that inhibition of these currents contributes to the bradycardia and atrioventricular block observed in patients receiving terodiline. In addition, action potential lengthening and more positive diastolic potential related to inhibition of delayed-rectifier K\(^+\) current may make important contributions to these disturbances (see Ono and Ito, 1995).

The QT lengthening caused by terodiline has been shown to be dependent on the plasma concentration of the drug (Thomas et al., 1995). The therapeutic concentration is ~1.5 μM, and a concentration of 9.3 μM was measured in one elderly patient (Connolly et al., 1991). Action potentials in guinea pig papillary muscles were lengthened in the presence of 0.1 to 10 μM terodiline, and although this lengthening was moderate (peak 12% at 3 μM), it is in good agreement with the degree of lengthening of the monophasic action potential in dogs (Pressler et al., 1995) and rate-corrected Q-T interval in dogs (Natsukawa et al., 1998) and humans (Stewart et al., 1992; Thomas et al., 1995).
Torsades de pointes is a malignant ventricular arrhythmia associated with a wide variety of drugs administered for their antiarrhythmic properties (e.g., quinidine, sotalol, amiodarone) or for entirely different purposes (e.g., terfenadine, erythromycin, terodiline), with the common outcome that they lengthen the Q-T interval (Roden et al., 1996; Woosley, 1996). The electrophysiological alterations responsible for this arrhythmia are not fully characterized, but it has been postulated that bradycardia, action potential prolongation, and early afterdepolarizations are crucial factors (Jackman et al., 1988; Thomas et al., 1995; Roden et al., 1996). We found no indications of either early or delayed afterdepolarizations in terodiline-treated muscles, most likely because development of these arrhythmogenic events is inhibited when excitatory inward currents are suppressed (compare with Hayashi et al., 1987; January and Shorofsky, 1990; Woosley, 1996). These predicted antiarrhythmic influences of terodiline notwithstanding, concomitant blockade of Na\textsuperscript{+} and K\textsuperscript{+} channels has proarrhythmic potential related to slowed conduction and increased heterogeneity in repolarization time courses (see Follmer and Colatsky, 1990; Sicouri and Antzelevitch, 1993), especially when the block of the Na\textsuperscript{+} channels is use-dependent (Starmer et al., 1991). Unlike guinea pig myocardium, transient outward current contributes to early repolarization in the human myocardium (Beuckelmann et al., 1993), and it is possible that terodiline affects this current in a proarrhythmic manner. Finally, other factors that predispose to acquired ventricular tachy-
arrhythmia (e.g., hypokalemia, myocardial ischemia, antiarrhythmic drugs) may be important in the cardiotoxicity of terodiline (Thomas et al., 1995).

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References


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