

JPET #76869

Electrophysiological effects of prucalopride, a novel enterokinetic agent, on isolated atrial myocytes from patients treated with beta-adrenoceptor antagonists

Davide Pau, Antony J Workman, Kathleen A Kane and Andrew C Rankin.

Section of Cardiology, Division of Cardiovascular & Medical Sciences, University of Glasgow, Royal Infirmary (D.P., A.J.W., A.C.R.) and Department of Physiology & Pharmacology, University of Strathclyde, Glasgow, UK (K.A.K.).

JPET #76869

Running title

a) Electrical effects of prucalopride in human atrial myocytes

b) Corresponding author: Dr Davide Pau, Section of Cardiology, Division of Cardiovascular & Medical Sciences, University of Glasgow, Royal Infirmary, 10 Alexandra Parade, Glasgow G31 2ER, UK. Tel: +44 (0)141 211 1231. Fax: +44 (0)141 552 4683. E-mail: d.pau@clinmed.gla.ac.uk

c) Number of text pages: 26

Number of tables: 1

Number of figures: 7

Number of references: 40

Number of words in Abstract: 250

Number of words in Introduction: 496

Number of words in Discussion: 1388

d) Abbreviations: 5-HT₄, 5-hydroxytryptamine type 4; APD, action potential duration; EC₅₀, effective concentration causing 50% of maximal I_{CaL} response; E_{max}, maximal I_{CaL} response to drug; ERP, effective refractory period; I_{CaL}, L-type calcium current.

e) Section assignment: Cardiovascular

JPET #76869

Abstract

Prucalopride is a selective 5-HT₄ receptor agonist developed for the treatment of gastrointestinal disorders. The endogenous agonist 5-HT acting via 5-HT₄ receptors increases the L-type Ca²⁺ current, I_{CaL}, with potentially pro-arrhythmic consequences (Pau et al., 2003). The aims of this study were to investigate the effects of prucalopride on I_{CaL}, action potentials, refractory period and arrhythmic activity in human atrial myocytes, and to compare these with the effects of 5-HT, using the whole-cell perforated patch-clamp technique. Prucalopride (10⁻⁹-10⁻⁴ M) produced a concentration-dependent increase in I_{CaL} amplitude, with a maximum response at 10 μM, from -5.3±0.6 to -10.9±1.5 pA/pF (p<0.05; n=22 cells, 10 patients), without affecting its voltage-dependency. Subsequent application of 10 μM 5-HT further increased I_{CaL} to -17.7±2.8 pA/pF (p<0.05; n=16 cells, 9 patients). The increase in I_{CaL} by prucalopride, 98±15%, was significantly smaller than that by 5-HT, 233±26% (p<0.05). Prucalopride (10 μM) significantly increased the action potential duration at 50% repolarisation (APD₅₀) from 12±2 to 17±3 ms (p<0.05; n=22 cells, 9 patients). Following washout of prucalopride, 5-HT (10 μM) increased APD₅₀, to a greater extent, from 14±3 to 32±7 ms (p<0.05; n=11 cells; 8 patients). The APD₇₅, APD₉₀ and ERP were unaffected by prucalopride or 5-HT. Furthermore, 5-HT induced abnormal depolarisations in 27% of the cells studied, whereas prucalopride induced none (p<0.05). In conclusion, in human atrial cells prucalopride, at concentrations markedly above those used therapeutically, acted as partial agonist on I_{CaL} and APD₅₀, with no effect on late repolarisation or refractory period, and was devoid of arrhythmic activity.

JPET #76869

Introduction

Activation of 5-hydroxytryptamine type 4 receptors (5-HT₄) may have multiple functional roles in the human body, including inotropic effects in the atrium, prokinetic activity in the gastrointestinal tract and involvement in memory and learning processes in the brain (Eglen et al., 1995; Hegde and Eglen, 1996). Moreover, 5-HT₄ receptors have been implicated in various pathological conditions including atrial arrhythmias (Kaumann, 1994), neurodegenerative diseases (Wong et al., 1996) and gastrointestinal motility disorders (Talley, 1992). Consequently, 5-HT₄ receptors have been a target for the development of novel 5-HT₄ agonists (e.g. to treat functional bowel disorders (Talley, 2001) and 5-HT₄ antagonists (e.g. to treat atrial fibrillation, Kaumann, 1994).

In human atrium, 5-HT₄ receptors are the only sub-type present (Kaumann et al., 1990; Blondel et al., 1997) and activation with 5-HT increases the amplitude of the L-type Ca²⁺ current (I_{CaL}) via the cyclic AMP-dependent cascade (Oquadid et al., 1992). Pro-arrhythmic activity of 5-HT has been demonstrated previously in human atrial muscle (Kaumann and Sanders, 1994), and in human atrial myocytes (Pau et al., 2003), probably associated with the increased I_{CaL}. Moreover, it has been postulated that the release of 5-HT from platelets may be involved in the origin and maintenance of atrial fibrillation (Kaumann, 1994). In a pig model of atrial fibrillation, a 5-HT₄ antagonist, RS-100302, has been reported to be antiarrhythmic by prolonging the effective refractory period (Rahme et al., 1999) suggesting that endogenously released 5-HT may shorten the effective refractory period, thereby sustaining re-entry circuits. For these reasons, there has been concern that 5-HT₄ receptor agonists when used as gastrokinetic agents in humans may generate atrial arrhythmias via intracellular Ca²⁺ overload and/or a reduced refractoriness (Tonini et al., 1999; Yusuf et al., 2003).

JPET #76869

Prucalopride, a novel 5-HT₄ receptor agonist with a benzofurancarboxamide structure, is currently under investigation for the treatment of idiopathic chronic constipation (Coremans et al., 2003). It has been demonstrated to be a potent and specific 5-HT₄ receptor agonist in studies on human native and recombinant 5-HT₄ receptor subtypes (Prins et al., 2000; Briejer et al., 2001; Pindon et al., 2002). There has been only one previous study on the effects of prucalopride on cardiac ion currents, specifically the rapid component of the recombinant delayed rectifier K⁺ current (I_{Kr}) encoded by the cloned human ether-a'go-go related gene (HERG) (Potet et al., 2001). This study showed that micromolar concentrations of prucalopride significantly blocked I_{Kr}. Whilst I_{Kr} is present in the human ventricle (Li et al., 1996), in the human atrium it is not clear whether I_{Kr} may play a substantial role in action potential repolarisation (Wang et al., 1994; Lee and Lee, 1998; Bertaso et al., 2002). The electrophysiological effects of prucalopride have not yet been studied in human atrium.

The aims of this study were to assess in human atrial myocytes (1) the electrophysiological effects of prucalopride on I_{CaL}, action potential duration (APD), cellular effective refractory period (ERP) and arrhythmic activity, and (2) to compare the effects of prucalopride with those of the endogenous agonist 5-HT.

JPET #76869

Methods

Tissue and cell isolation

Procedures for obtaining human tissue were approved by the institutional ethics committee of Glasgow Royal Infirmary, and conforms to the Declaration of Helsinki (World Medical Association, 1997). Samples of the right atrial appendage were obtained from consenting patients undergoing cardiac surgery. All patients had received prior therapy with β -adrenoceptor antagonists. Atrial cells were isolated enzymatically using a method described in detail by Workman et al. (2001).

Electrical recording techniques

The whole-cell perforated patch-clamp technique was used to record action potentials and calcium currents, as described in detail by Pau et al. (2003). Briefly, cells were superfused at 37°C with a physiological solution containing (mM): NaCl (130.0), KCl (4.0), CaCl₂ (2.0), MgCl₂ (1.0), glucose (10.0), HEPES (10.0), pH 7.4. To record calcium currents, electrodes were filled with a solution containing (mM): CsCl (30.0), HEPES (5.0), MgCl₂ (1.0), Cs methanesulfonic acid (100.0), NaCl (5.0). To record action potentials, an internal solution containing (mM): KCl (30.0), HEPES (5.0), MgCl₂ (1.0), K methanesulfonic acid (100.0), NaCl (5.0) was used. The series resistance was observed to stabilise between 5-15 min at $9.9 \pm 0.3 \text{ M}\Omega$ (n=96 cells), with a mean cell capacity of $78 \pm 2 \text{ pF}$. Capacitative transients were compensated electronically from the recordings, and the voltage drop across the series resistance was also compensated (68-80%). The software program WinWCP (J. Dempster, University of Strathclyde, UK) was used both to stimulate and record electrical activity. All currents were normalized to the cell's capacity.

JPET #76869

Experimental protocols

Voltage-clamp was used to record I_{CaL} . The voltage-dependency of this current was measured from a holding potential of -40 mV, increasing in steps of 10 mV, up to +40 mV, with pulses of 250 ms duration (0.33 Hz). The time-dependent effect of drugs on peak I_{CaL} was measured with pulses of 250 ms duration, from -40 to +10 mV (0.2 Hz).

Current-clamp was used to record actions potentials and the cellular effective refractory period at the physiological rate of 75 beats per min (bpm) using 5 ms stimulating pulses of 1.2 x threshold strength. The ERP was measured using a standard S_1 - S_2 stimulation protocol and was defined as the longest S_1 - S_2 interval which failed to elicit an S_2 action potential of amplitude >80% of the preceding S_1 action potential. The APD was calculated as the interval between the action potential upstroke and repolarisation to the level of 50% (APD₅₀), 75% (APD₇₅) and 90% (APD₉₀) of the upstroke amplitude. I_{CaL} , action potentials and the ERP were recorded before, and 90 s after, drug additions and again 180 s after removal of drugs.

Drugs

Prucalopride (R093877; Briejer et al., 2001) and the specific 5-HT₄ antagonist GR-113808 (Kaumann, 1993) were donated by Johnson & Johnson Pharmaceutical Research & Development (Beerse, Belgium) and were dissolved in dimethyl sulfoxide (DMSO) with a stock solution of 10 mM and subsequently diluted in physiological solutions. 5-HT (Sigma, St. Louis, Mo., USA) was made up as a 10 mM stock solution in distilled water.

Data analysis and statistics

Clinical characteristics and drug treatments of each patient were obtained from the case notes. Only patients in sinus rhythm at the time of surgery were included. Cells were

JPET #76869

excluded from analysis if either the APD_{50} or peak I_{CaL} decreased irreversibly during the protocol. Concentration-response data for the effect of prucalopride on I_{CaL} were fitted iteratively (Prism 3.0, Graphpad Software, San Diego, CA, USA) using a variable slope sigmoidal concentration-response curve (Hill equation). The curves were fitted to mean I_{CaL} values, obtained at 6 concentrations of prucalopride between 1 nM and 100 μ M. The concentration-response curve for 5-HT was obtained previously in our lab (Pau et al., 2003). Curve fit values were compared using a two-tailed unpaired Student's t-test. Time-dependent inactivation of I_{CaL} was fitted by a bioexponential function using the WCP software programme and was defined by the following equation: $I_{CaL}(t) = A_1 \cdot \exp(-t/\tau_1) + A_2 \cdot \exp(-t/\tau_2) + C$, where A_1, A_2 and τ_1, τ_2 are the amplitudes and decay time constants of the respective exponential components, and C is the steady state amplitude. Data are expressed as mean \pm standard error of the mean (SEM), with n being equal to the number of cells studied. Mean values were compared using two-tailed paired or unpaired Student's t-tests, as appropriate. A Fisher's exact test was used to assess the level of significance of differences in the incidences of arrhythmic activity between drugs. $p < 0.05$ was regarded as statistically significant.

JPET #76869

Results

Patients' clinical characteristics

All patients were undergoing coronary artery bypass graft surgery, were taking β -adrenoceptor antagonists, suffered from angina, and none had severe left ventricular dysfunction (Table 1). Eighty-two percent of the patients were also treated with an angiotensin converting enzyme (ACE) inhibitor and 36% of the patients with a calcium channel blocker. β -adrenoceptor antagonists had been administered for more than 10 days prior to surgery. No patient was administered sotalol (a β -blocker with additional class III anti-arrhythmic activity). Patients received their routine cardiac drugs on the day of surgery. Mean heart rate was 58 ± 2 bpm (n=11).

Effects of prucalopride, 5-HT and GR-113808 on I_{CaL} in human atrial cells

Prucalopride produced a significant increase in the amplitude of I_{CaL} , as shown in Figure 1 by the I_{CaL} current density-voltage relationships. An example of original I_{CaL} recordings is also shown (inset of Figure 1). Prucalopride (10 μ M) increased the mean magnitude of peak I_{CaL} (recorded at +10 mV) from -5.7 ± 0.7 pA/pF to -10.2 ± 1.6 pA/pF ($p < 0.05$, n=10 cells, 7 patients). This increase in peak I_{CaL} occurred without any change in the voltage dependency of the current, and was reversible on washout of prucalopride (-5.7 ± 1.1 pA/pF; n=7 cells, 5 patients).

The time course of change in I_{CaL} by prucalopride and its blockade by the specific 5-HT₄ receptor antagonist, GR-113808, can be seen in Figure 2. Prucalopride at 10 μ M caused a stable increase in I_{CaL} , which was completely antagonised by GR-113808 at 1 μ M (n=5 cells, 3 patients). This increase, from a control value of -5.9 ± 1.2 to -13.1 ± 3.8

JPET #76869

pA/pF, was abolished by GR-113808 to -5.4 ± 1.2 pA/pF ($p < 0.05$). The effect of this antagonist was partially reversible upon its washout (to 6.5 ± 1.1 pA/pF).

Figure 3A shows that the increase in I_{CaL} with prucalopride ($10 \mu\text{M}$) was less than that produced by 5-HT ($10 \mu\text{M}$) in the same cell. This was confirmed by mean data: prucalopride increased I_{CaL} from -5.5 ± 0.8 to -10.5 ± 1.7 pA/pF ($p < 0.05$, $n = 16$ cells, 9 patients). Subsequent superfusion of 5-HT alone, in the same cells, increased I_{CaL} further, to -17.7 ± 2.8 pA/pF ($p < 0.05$). The percentage increase in I_{CaL} produced by 5-HT ($233 \pm 26\%$ compared to control) was significantly greater than that produced by prucalopride ($89 \pm 15\%$; $p < 0.05$) (Figure 3B). The time-dependent inactivation of I_{CaL} was unchanged by the application of prucalopride ($10 \mu\text{M}$) or 5-HT ($10 \mu\text{M}$). The fast (τ_1) and the slow (τ_2) inactivation time constants of basal I_{CaL} were 4.4 ± 0.3 ms and 47.7 ± 8.1 ms, respectively, and were not significantly different in the presence of prucalopride ($\tau_1 = 6.0 \pm 1.8$ ms and $\tau_2 = 41.9 \pm 6.2$ ms) or 5-HT ($\tau_1 = 5.6 \pm 1.8$ ms and $\tau_2 = 40.0 \pm 5.1$ ms). The respective fractions of the fast ($A_1 = 72.5 \pm 1.9\%$) and slow ($A_2 = 27.5 \pm 1.9\%$) components of the I_{CaL} inactivation amplitude remained unchanged by the application of either prucalopride or 5-HT.

The concentration-response relationship of the effect of prucalopride on I_{CaL}

The concentration-response curve of the effect of prucalopride on peak I_{CaL} obtained in atrial cells from patients with prior β -adrenoceptor antagonists treatment, is shown in Figure 4. This figure also shows the superimposed concentration-response curve of the effect of 5-HT on peak I_{CaL} obtained previously in our lab in atrial cells from a similar group of patients (Pau et al., 2003). Prucalopride (from 1 nM to $100 \mu\text{M}$) elicited a concentration-dependent increase in the amplitude of peak I_{CaL} (measured at +10 mV), with a maximum response (E_{max}) equal to an increase of $93 \pm 14\%$ above control ($n = 7-22$ cells, 2-9 patients). This was significantly less than that produced by the maximum

JPET #76869

response of 5-HT ($E_{\max}=299\pm 12\%$ above control; $p<0.05$). However, there were no significant differences between prucalopride and 5-HT for either the log EC_{50} (-6.66 ± 0.44 vs -7.09 ± 0.07 , respectively) or the Hill coefficient, n_H (0.76 ± 0.46 vs 1.46 ± 0.56 , respectively).

Effect of prucalopride and 5-HT on action potentials and the refractory period

Figure 5 shows representative traces of action potentials and measurements of ERP illustrating the effects of 10 μM prucalopride (Figure 5B) or 5-HT (Figure 5C), compared to control conditions (Figure 5A). Prucalopride (10 μM) caused a small but significant prolongation in the APD_{50} from 12 ± 2 to 17 ± 3 ms ($p<0.05$; $n=22$ cells, 9 patients), representing an increase of 6 ± 2 ms ($p<0.05$). This effect was fully reversible upon washout of prucalopride (12 ± 3 ms; $n=13$ cells, 8 patients). There was no significant or reversible effect of prucalopride on the APD_{75} (141 ± 12 vs 146 ± 11 ms), APD_{90} (237 ± 18 vs 236 ± 18 ms) or ERP (224 ± 25 vs 232 ± 28 ms).

In 11 of the 22 cells (from 8 patients) studied with prucalopride, we investigated the effects of 5-HT at 10 μM following 3 min washout of prucalopride at 10 μM . As shown in Figure 6A, the prolongation of the APD_{50} produced by 5-HT, from a control value of 14 ± 3 to 32 ± 7 ms ($p<0.05$), was greater than the prolongation produced by prucalopride (12 ± 2 to 19 ± 5 ms; $p<0.05$), in these cells. The mean duration by which the APD_{50} was increased was also greater with 5-HT (18 ± 5 ms) compared to that with prucalopride (7 ± 3 ms; $p<0.05$). The effect of 5-HT was fully reversible after 3 min washout (15 ± 4 ms; $n=7$ cells, 6 patients). 5-HT did not significantly affect the APD_{75} , APD_{90} or the ERP, consistent with our previous report (Pau et al., 2003). Figure 6B shows that the calcium channel blocker nifedipine at 10 μM prevented the prucalopride and the 5-HT-induced increases in APD_{50} in the 11 (5 patients) and 4 cells (2 patients) studied,

JPET #76869

respectively. This concentration of nifedipine had been shown to markedly reduce I_{CaL} from -4.8 ± 0.8 to -0.2 ± 0.1 pA/pF ($p < 0.05$; $n = 5$ cells, 4 patients).

Effects of prucalopride and 5-HT on arrhythmic activity in human atrial cells

Abnormal depolarisations were not observed in any of the 22 cells to which 10 μ M prucalopride was applied. In contrast, when 10 μ M 5-HT was subsequently applied (to 11 of these), abnormal depolarisations occurred in 3 (27%) of the cells studied ($p < 0.05$). Figure 7 shows an example of abnormal depolarisations caused by 5-HT, but not by prucalopride, and their abolition by GR-113808 at 1 μ M. In another cell, from a different patient, 5-HT induced abnormal depolarisations in the absence, but not in the presence, of nifedipine at 10 μ M (not shown).

JPET #76869

Discussion

This study has demonstrated, for the first time to our knowledge, that prucalopride in human atrial cells, acted as a partial rather than full agonist on the L-type calcium current and action potential early repolarisation via 5-HT₄ receptors. Similarly to 5-HT, prucalopride lacked effects on the late phase of the atrial action potential repolarisation and the effective refractory period. Unlike 5-HT, prucalopride did not induce abnormal depolarisations.

Prucalopride has been shown previously to be a full agonist in several areas of the human body including the gastrointestinal (Prins et al., 2000) and central nervous systems (Robert et al., 2001). Studies using either native or recombinant 5-HT₄ receptors have shown that prucalopride had similar, or even greater, efficacy than the endogenous agonist 5-HT (Prins et al., 2000; Pindon et al., 2002; Lezoualc'h and Robert, 2003). The EC₅₀ value for prucalopride in human atrial cells in the present study was higher than that obtained with human recombinant 5-HT_{4a} and 5-HT_{4b} receptor isoforms (Briejer et al., 2001; Pindon et al., 2002) which indicated a lower potency of the agonist in human atrial cells. In this study we included only patients who had been previously treated with β -adrenoceptors antagonists. Such prior therapy did not affect the mRNA expression of 5-HT₄ receptors and L-type Ca²⁺ channels subunits α_{1c} , α_2/δ_1 , β_{1a} , β_{1b} , β_{1c} in the human atrium (Grammer et al., 2001). However, we have previously shown in human atrial cells that prior β -blockade enhanced the maximal response of I_{CaL} to 5-HT but with no effect on the EC₅₀ or the Hill coefficient of the concentration-response curve for 5-HT (Pau et al., 2003). Hence our finding of lower potency remains relevant to patients who have not been receiving β -adrenoceptors antagonists.

To date, nine 5-HT₄ receptor subtypes (5-HT_{4a-i/hb/n}) have been identified and localised in the human body (Langlois and Fischmeister, 2003; Brattelid et al., 2004), but only

JPET #76869

some of these (5-HT_{4a-c}, 5-HT_{4g}, 5-HT_{4i} and 5-HT_{4n}) have been shown to be present in the human atrium (Bach et al., 2001; Medhurst et al., 2001; Vilaro' et al., 2002; Brattelid et al., 2004). In addition, the pharmacological properties of the 5-HT₄ isoforms have been associated with different receptor levels of expression (Bach et al., 2001; Medhurst et al., 2001; Vilaro' et al., 2002; Brattelid et al., 2004). Thus, it is possible that prucalopride acts as partial agonist with low potency in human atrial cells because of the expression of specific 5-HT₄ isoforms and/or because of the different levels of expression of these isoforms present in the human atrium, compared to other tissues. In addition, 5-HT and prucalopride, acting via 5-HT₄ receptors, may differently affect the signal transduction cascade, including the phosphorylation of different isoforms of the L-type Ca²⁺ channel (Pindon et al., 2002). These questions may be resolved following the development of more selective agonists, antagonists and antibodies acting on specific 5-HT₄ receptor subtypes, or by co-expressing the L-type Ca²⁺ channels with the recombinant 5-HT₄ receptors isoforms in a 5-HT receptor-free cell model.

Prucalopride significantly prolonged the early repolarisation phase of the action potential without affecting the late phase or the refractory period, likely due to the observed increase in I_{CaL}. This was confirmed by the experiments using the calcium channel blocker, nifedipine, which abolished the effects of prucalopride and 5-HT on the action potential. In addition, prucalopride had a less marked action to prolong APD₅₀ than did 5-HT (at maximally effective concentrations) consistent with the partial activity observed on I_{CaL}. However, we cannot exclude effects on other currents of importance during repolarisation in the human atrium, such as the transient outward K⁺ current, I_{TO}, and the ultra-rapid component of the delayed rectifier K⁺ current, I_{Kur}.

The fact that a 5-HT₄ antagonist, RS-100302, prolonged the ERP in an in vivo pig model of atrial fibrillation (Rahme et al., 1999) suggested that 5-HT₄ agonists may shorten the ERP and, therefore, be pro-arrhythmic by reducing the minimum path length

JPET #76869

required for re-entry. However, this is not supported by our experiments in isolated human atrial cells, in which neither prucalopride nor 5-HT abbreviated the late phase of repolarisation or the refractory period. It is noteworthy that in canine atrial cells isolated using the “chunk” method, the repolarising, delayed rectifier K^+ current was recorded in significantly fewer cells than in those isolated by enzyme perfusion (Yue et al., 1996). Also it has been reported that, in the human atrium, this current is limited to only a subpopulation of cells (Wang et al., 1994) or even absent (Lee & Lee, 1998; Bertaso et al., 2002). These two factors may explain the lack of effect of prucalopride and 5-HT to shorten late repolarisation and refractory period in human atrial myocytes. Alternatively, in the pig, the 5-HT₄ antagonist, RS-100302, may have had a direct effect, independently of blocking 5-HT receptors to prolong ERP.

In the present study, we investigated the effects on I_{CaL} of a range of concentrations of prucalopride, from 1 nM to 100 μ M, in order to obtain a full concentration-response relationship of the drug. For comparison, the effective therapeutic range of prucalopride in humans has been found to be between 1 and 10 nM with a mean plasma concentration of around 2 ng/mL (~5 nM) after 4 weeks treatment period, and with a half-life of prucalopride around 24 h (Emmanuel et al., 2002). Therefore, the concentration of 10 μ M used here to investigate the effects of prucalopride on action potentials, refractoriness and arrhythmic activity was 1000-fold higher than its normal therapeutic concentration in humans. Nevertheless, despite using atrial cells from patients with prior treatment with β -adrenoceptor antagonists, which has been shown to increase the incidence of 5-HT induced arrhythmic contractions (Sanders et al., 1995) and abnormal depolarisations (Pau et al., 2003), we have shown that 10 μ M prucalopride, did not induce abnormal depolarisations in any of the atrial cells studied. In contrast, 10 μ M 5-HT, after perfusion with 10 μ M prucalopride, induced abnormal depolarisations in ~27% of the cells studied which is also consistent with our previous

JPET #76869

observations in human atrial myocytes (Pau et al., 2003). It is noteworthy that in the study by Sanders et al. (1995) the partial 5-HT₄ agonist, renzapride, was not reported to produce arrhythmic contractions in human atrial cells, whilst 5-HT produced such contractions in human atrial cells and strips. In the present study, it is likely that prucalopride lacked arrhythmogenic activity because it acts as a partial rather than a full agonist and caused a significantly smaller increase in I_{CaL} and calcium loading than did 5-HT.

There is major concern about the potential for ventricular arrhythmias when using 5-HT₄ receptor agonists as gastrokinetic agents (Tonini et al., 1999; Yusuf et al., 2003). This is related to the ability of several drugs, including the enterokinetic cisapride, to block I_{Kr}, with associated prolongation of the repolarisation phase of the ventricular action potential that underlies the acquired long QT syndrome (Viskin, 1999). The only report of effects of prucalopride on I_{Kr} encoded by cardiac HERG demonstrated that at micromolar concentrations, prucalopride significantly blocked HERG current expressed in a kidney cell line (Potet et al., 2001). However, at therapeutic concentrations, prucalopride had no effect on the QT interval in humans (Krogh et al., 2002; De Schryver et al., 2002), consistent with a lack of effect of prucalopride on human ventricular I_{Kr}. The present findings in human atrial myocytes, of a lack of effect of prucalopride on late repolarisation and refractoriness are also consistent with an absence of effect on atrial delayed rectifier K⁺ current. An additional mechanism by which prucalopride might affect action potential duration would be by influencing the time-course of inactivation of I_{CaL}, as well as its peak density, but we demonstrated here that prucalopride and 5-HT had no effects on I_{CaL} inactivation in human atrial cells.

In conclusion, these data indicate that, in the human atrium, the prucalopride-induced increase in calcium current was associated with prolongation of the early phase of action potential repolarisation, but not late repolarisation, refractoriness or arrhythmic

JPET #76869

activity. Moreover, prucalopride, when compared with 5-HT, behaved as a partial rather than full agonist in enhancing I_{CaL} and APD_{50} in human atrial myocytes. These results further support the hypothesis that the expression of specific 5-HT₄ receptor subtypes in human atrial cells may mediate different functional electrophysiological responses to different agonists, and this needs to be taken into account when using 5-HT₄ agonists in humans.

Acknowledgements

We wish to thank the cardiac surgical staff of Glasgow Royal Infirmary for kindly providing access to human tissues, and Julie Russell for technical support and for maintaining the patient database.

JPET #76869

References

- Bach T, Syversveen T, Kvingedal AM, Krobert KA, Brattelid T, Kaumann AJ, and Levy FO (2001) 5HT_{4a} and 5-HT_{4b} receptors have nearly identical pharmacology and are both expressed in human atrium and ventricle. *Naunyn Schmiedebergs Arch.Pharmacol.* **363**:146-160.
- Bertaso F, Sharpe CC, Hendry BM, and James AF (2002) Expression of voltage-gated K⁺ channels in human atrium. *Basic Res.Cardiol.* **97**:424-433.
- Blondel O, Vandecasteele G, Gastineau M, Leclerc S, Dahmoune Y, Langlois M, and Fischmeister R (1997) Molecular and functional characterization of a 5-HT₄ receptor cloned from human atrium. *FEBS Lett.* **412**:465-474.
- Brattelid T, Kvingedal AM, Krobert KA, Andressen KW, Bach T, Hystad ME, Kaumann AJ, and Levy FO (2004) Cloning, pharmacological characterisation and tissue distribution of a novel 5-HT₄ receptor splice variant, 5-HT_{4i}. *Naunyn Schmiedebergs Arch.Pharmacol.* **369**:616-628.
- Briejer MR, Bosmans JP, Van Daele P, Jurzak M, Heylen L, Leysen JE, Prins NH, and Schuurkes JA (2001) The in vitro pharmacological profile of prucalopride, a novel enterokinetic compound. *Eur.J.Pharmacol.* **423**:71-83.
- Coremans G, Kerstens R, De Pauw M, and Stevens M (2003) Prucalopride is effective in patients with severe chronic constipation in whom laxatives fail to provide adequate relief. Results of a double-blind, placebo-controlled clinical trial. *Digestion* **67**:82-89.

JPET #76869

De Schryver AM, Andriessse GI, Samsom M, Smout AJ, Gooszen HG, and Akkermans LM (2002) The effects of the specific 5HT₄ receptor agonist, prucalopride, on colonic motility in healthy volunteers. *Aliment.Pharmacol.Ther.* **16**:603-612.

Eglen RM, Wong EH, Dumuis A, and Bockaert J (1995) Central 5-HT₄ receptors. *Trends Pharmacol.Sci.* **16**:391-398.

Emmanuel AV, Roy AJ, Nicholls TJ, and Kamm MA (2002) Prucalopride, a systemic enterokinetic, for the treatment of constipation. *Aliment.Pharmacol.Ther.* **16**:1347-1356.

Grammer JB, Zeng X, Bosch RF, and Kuhlkamp V (2001) Atrial L-type Ca²⁺-channel, β-adrenoreceptor, and 5-hydroxytryptamine type 4 receptor mRNAs in human atrial fibrillation. *Basic Res.Cardiol.* **96**:82-90.

Hegde SS and Eglen RM (1996) Peripheral 5-HT₄ receptors. *FASEB J.* **10**:1398-1407.

Kaumann AJ (1993) Blockade of human atrial 5-HT₄ receptors by GR 113808. *Br.J.Pharmacol.* **110**:1172-1174.

Kaumann AJ (1994) Do human atrial 5-HT₄ receptors mediate arrhythmias? *Trends Pharmacol.Sci.* **15**:451-455.

Kaumann AJ and Sanders L (1994) 5-Hydroxytryptamine causes rate-dependent arrhythmias through 5-HT₄ receptors in human atrium: facilitation by chronic β-adrenoceptor blockade. *Naunyn Schmiedebergs Arch.Pharmacol.* **349**:331-337.

Kaumann AJ, Sanders L, Brown AM, Murray KJ, and Brown MJ (1990) A 5-hydroxytryptamine receptor in human atrium. *Br.J.Pharmacol.* **100**:879-885.

JPET #76869

Krogh K, Jensen MB, Gandrup P, Laurberg S, Nilsson J, Kerstens R, and De Pauw M (2002) Efficacy and tolerability of prucalopride in patients with constipation due to spinal cord injury. *Scand.J.Gastroenterol.* **37**:431-436.

Langlois M and Fischmeister R (2003) 5-HT₄ receptor ligands: applications and new prospects. *J.Med.Chem.* **46**:319-344.

Lee KS and Lee EW (1998) Ionic mechanism of ibutilide in human atrium: evidence for a drug-induced Na⁺ current through a nifedipine inhibited inward channel. *J.Pharmacol.Exp.Ther.* **286**:9-22.

Lezoualc'h F and Robert SJ (2003) The serotonin 5-HT₄ receptor and the amyloid precursor protein processing. *Exp.Gerontol.* **38**:159-166.

Li GR, Feng J, Yue L, Carrier M, and Nattel S (1996) Evidence for two components of delayed rectifier K⁺ current in human ventricular myocytes. *Circ.Res.* **78**:689-696.

Medhurst AD, Lezoualc'h F, Fischmeister R, Middlemiss DN, and Sanger GJ (2001) Quantitative mRNA analysis of five C-terminal splice variants of the human 5-HT₄ receptor in the central nervous system by TaqMan real time RT-PCR. *Brain Res.Mol.Brain Res.* **90**:125-134.

Ouadid H, Seguin J, Dumuis A, Bockaert J, and Nargeot J (1992) Serotonin increases calcium current in human atrial myocytes via the newly described 5-hydroxytryptamine₄ receptors. *Mol.Pharmacol.* **41**:346-351.

Pau D, Workman AJ, Kane KA, and Rankin AC (2003) Electrophysiological effects of 5-hydroxytryptamine on isolated human atrial myocytes, and the influence of chronic β -adrenoceptor blockade. *Br.J.Pharmacol.* **140**:1434-1441.

JPET #76869

Pindon A, van Hecke G, van Gompel P, Lesage AS, Leysen JE, and Jurzak M (2002)

Differences in signal transduction of two 5-HT₄ receptor splice variants: compound specificity and dual coupling with G_{αs}- and G_{αi/o}-proteins. *Mol.Pharmacol.* **61**:85-96.

Potet F, Bouyssou T, Escande D, and Baro' I (2001) Gastrointestinal prokinetic drugs have different affinity for the human cardiac human ether-a'-gogo K⁺ channel.

J.Pharmacol.Exp.Ther. **299**:1007-1012.

Prins NH, Shankley NP, Welsh NJ, Briejer MR, Lefebvre RA, Akkermans LM, and Schuurkes JA (2000) An improved in vitro bioassay for the study of 5-HT₄ receptors in the human isolated large intestinal circular muscle. *Br.J.Pharmacol.* **129**:1601-1608.

Rahme MM, Cotter B, Leistad E, Wadhwa MK, Mohabir R, Ford APDW, Eglen RM, and Feld GK (1999) Electrophysiological and antiarrhythmic effects of the atrial selective 5-HT₄ receptor antagonist RS-100302 in experimental atrial flutter and fibrillation. *Circulation* **100**:2010-2017.

Robert SJ, Zugaza JL, Fischmeister R, Gardier AM, and Lezoualc'h F (2001) The human serotonin 5-HT₄ receptor regulates secretion of non-amyloidogenic precursor protein. *J.Biol.Chem.* **276**:44881-44888.

Sanders L, Lynham JA, Bond B, del Monte F, Harding SE, and Kaumann AJ (1995)

Sensitization of human atrial 5-HT₄ receptors by chronic β-blocker treatment.

Circulation **92**:2526-2539.

Talley NJ (1992) Review article: 5-hydroxytryptamine agonists and antagonists in the modulation of gastrointestinal motility and sensation: clinical implications.

Aliment.Pharmacol.Ther. **6**:273-289.

Talley NJ (2001) Serotonergic neuroenteric modulators. *Lancet* **358**:2061-2068.

JPET #76869

Tonini M, De Ponti F, Di Nucci A, and Crema F (1999) Review article: cardiac adverse effects of gastrointestinal prokinetics. *Aliment.Pharmacol.Ther.* **13**:1585-1591.

Vilaro' MT, Domenech T, Palacios JM, and Mengod G (2002) Cloning and characterization of a novel human 5-HT₄ receptor variant that lacks the alternatively spliced carboxy terminal exon. RT-PCR distribution in human brain and periphery of multiple 5-HT₄ receptor variants. *Neuropharmacology* **42**:60-73.

Viskin S (1999) Long QT syndromes and torsade de pointes. *Lancet* **354**:1625-1633.

Wang Z, Fermini B, and Nattel S (1994) Rapid and slow components of delayed rectifier current in human atrial myocytes. *Cardiovasc.Res.* **28**:1540-1546.

Wong EHF, Reynolds GP, Bonhaus DW, Hsu S, and Eglen RM (1996) Characterization of [³H]GR 113808 binding to 5-HT₄ receptors in brain tissues from patients with neurodegenerative disorders. *Behav.Brain Res.* **73**:249-252.

Workman AJ, Kane KA, and Rankin AC (2001) The contribution of ionic currents to changes in refractoriness of human atrial myocytes associated with chronic atrial fibrillation. *Cardiovasc.Res.* **52**:226-235.

World Medical Association (1997) World Medical Association Declaration of Helsinki. Recommendations guiding physicians in biomedical research involving human subjects. *Cardiovasc.Res.* **35**:2-3.

Yue L, Feng J, Li GR, and Nattel S (1996) Transient outward and delayed rectifier currents in canine atrium: properties and role of isolation methods. *Am.J.Physiol* **270**:H2157-H2168.

Yusuf S, Al Saady N, and Camm AJ (2003) 5-hydroxytryptamine and atrial fibrillation: how significant is this piece in the puzzle? *J.Cardiovasc.Electrophysiol.* **14**:209-214.

JPET #76869

Footnotes

a) This work was supported by Johnson & Johnson Pharmaceutical Research and Development.

b) Address correspondence to: Dr Davide Pau, Section of Cardiology, Division of Cardiovascular & Medical Sciences, University of Glasgow, Royal Infirmary, 10 Alexandra Parade, Glasgow G31 2ER, Scotland, UK. E-mail: d.pau@clinmed.gla.ac.uk

JPET #76869

Legends for figures

Figure 1.

Effect of prucalopride on I_{CaL} current-voltage relationship in human atrial myocytes. Current-voltage relationships of I_{CaL} expressed in terms of current density, pA/pF (n=10 cells, from 7 patients). Values are means, with error bars denoting SEM, for control (open circles), prucalopride at 10 μ M (closed circles) and after 3 min washout of prucalopride (open squares, n=7 cells, 5 patients). Asterisks indicate $p < 0.05$ between control and prucalopride values at each voltage step (paired Student's t-test). As an inset, an example of original calcium current (I_{CaL}) traces obtained from a human atrial cell during depolarising voltage clamp pulses (250 ms, 0.33 Hz) from -40 mV to +40 mV, in 10 mV incremental steps, from a holding potential of -40 mV, under control conditions (open circle) and in the presence of prucalopride at 10 μ M (closed circle) is shown.

Figure 2.

Effect of the specific 5-HT₄ antagonist GR-113808 on I_{CaL} stimulated by prucalopride in a human atrial myocyte.

An example of the time course of change in peak I_{CaL} density (pA/pF) plotted at 5 s resolution, in response to 10 μ M prucalopride (open box), followed by the application of GR-113808 at 1 μ M (solid box), and the subsequent washout of the antagonist. Inset traces (a-d) show original currents recorded at the time points labelled.

JPET #76869

Figure 3.

Effect of prucalopride followed by 5-HT on I_{CaL} in human atrial myocytes.

3A. The effect of a range of concentrations (0.1-10 μ M) of prucalopride, followed by a maximal concentration of 5-HT (10 μ M) given cumulatively on I_{CaL} is shown. The effect of washout of 5-HT is also shown. Inset traces (a-d) show original currents recorded at the time points labelled.

3B. Mean data (\pm SEM) for the effect of prucalopride (10 μ M; open bars) and 5-HT (10 μ M; solid bars) on I_{CaL} are shown (n=16 cells, 9 patients). Values are expressed as a percentage increase above control. The asterisk indicates $p < 0.05$ between prucalopride and 5-HT-induced increases in I_{CaL} (paired Student's t-test).

Figure 4.

Concentration-dependent effects of prucalopride and 5-HT on I_{CaL} in human atrial myocytes.

Comparison of the concentration-response relationship for prucalopride (10^{-9} - 10^{-4} ; solid circles; n=7-22 cells, 2 to 9 patients) and 5-HT (10^{-9} - 10^{-5} ; solid squares; n=9-18 cells, 4 to 11 patients; from Pau et al., 2003) on peak I_{CaL} . Values are means \pm SEM. The increase in I_{CaL} is expressed as a percentage of the control value before the addition of prucalopride and 5-HT.

Figure 5.

Effect of prucalopride and 5-HT on action potentials and refractoriness in a single human atrial myocyte.

Representative examples of original action potential recordings before (A), in the presence of 10 μ M prucalopride (B) and, after 3 min washout of prucalopride, 10 μ M 5-HT (C). Cells were paced at 75 bpm. Dotted lines in bold show the level of 50% of the

JPET #76869

action potential amplitude. The cellular effective refractory period (ERP) is indicated by solid bars. The S_2 response used to measure this interval is labelled with an arrow.

Figure 6.

Effect of prucalopride, 5-HT and nifedipine on APD_{50} in human atrial cells.

6A. Mean (\pm SEM) action potential duration (ms) measured at 50% repolarisation (APD_{50} ; n=11 cells, 8 patients), in the absence (open bars) and in the presence of 10 μ M prucalopride (closed bars) or 10 μ M 5-HT (vertical striped bars). Asterisks denotes $p < 0.05$ versus control or drug as indicated by the dotted line (paired Student's t-test).

6B. Mean action potential data for APD_{50} , in the absence (open bars) and in the presence of 10 μ M nifedipine (horizontal striped bars; n=11 cells, 5 patients), 10 μ M nifedipine + 10 μ M prucalopride (closed bars) and 10 μ M nifedipine + 10 μ M 5-HT (vertical striped bars; n=4 cells, 2 patients).

Figure 7.

Effect of prucalopride and 5-HT on arrhythmic activity in human atrial cells.

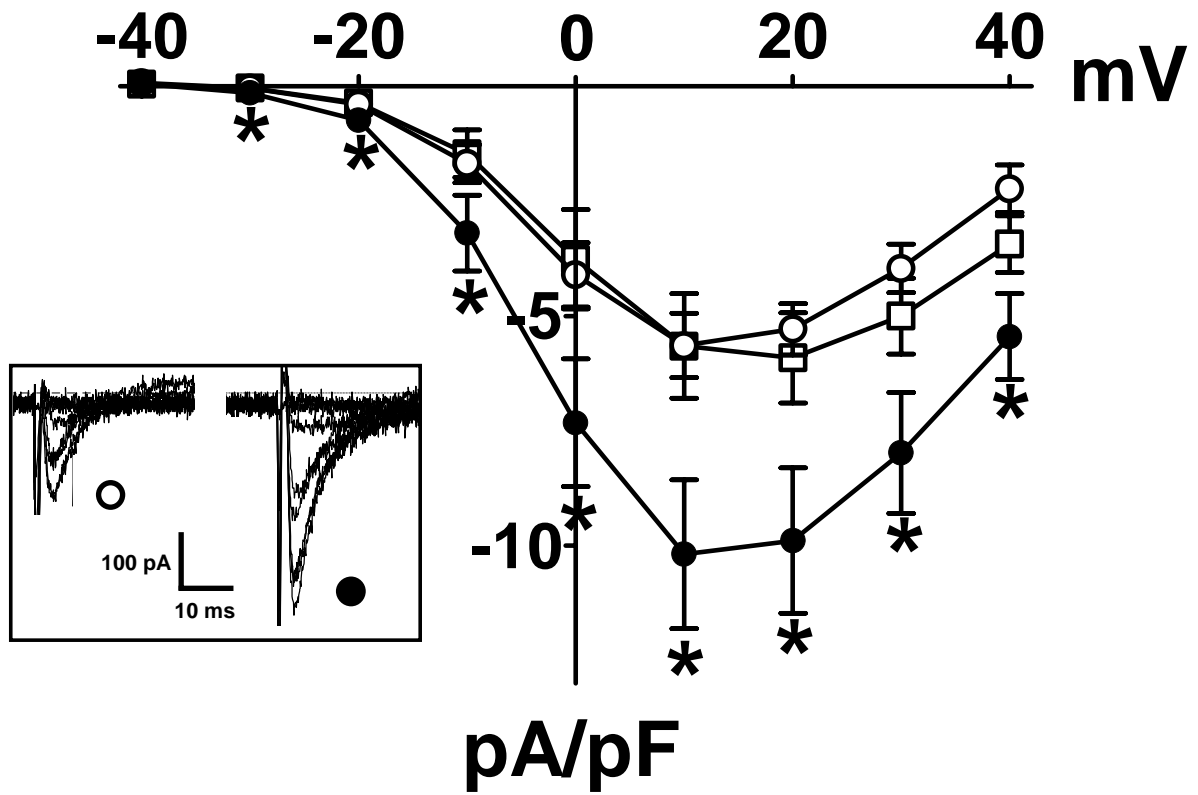
Effect of 5-HT, but not of prucalopride, to promote abnormal depolarisations in a human atrial myocyte and its blockade by the specific 5-HT₄ antagonist GR-113808. An example of original recordings of action potentials obtained from a single human atrial myocyte (paced at 75 bpm), before (A), in the presence of 10 μ M prucalopride (B), 10 μ M 5-HT (C) (following 3 min washout of prucalopride), and then blockade of 5-HT-induced abnormal depolarisations by 1 μ M GR-113808 (D).

Values are numbers of patients (*n* and % of total, respectively) with selected clinical characteristics, except for age (mean±SEM). CABG=coronary artery bypass graft surgery, AVR=aortic valve replacement, ACE=angiotensin converting enzyme, MI=myocardial infarction, LV=left ventricular. All patients were in sinus rhythm on the day of surgery.

	n	%
Patients	11	
Male/female	7/4	64/36
Age	62±3	
Surgery:		
CABG	10	91
CABG+AVR	1	9
Drugs:		
β-adrenoceptor antagonist	11	100
Ca ²⁺ channel blocker	4	36
ACE inhibitor	9	82
Nitrate	6	55
Diuretic	4	36
Lipid lowering	11	100
Symptoms:		
Angina	11	100
Hypertension	4	36
Hyperlipidaemia	10	91
Previous History:		
MI	7	64
Diabetes	2	18
LV Function:		
-normal	6	55
-mild-moderate	5	45
-severe	0	0

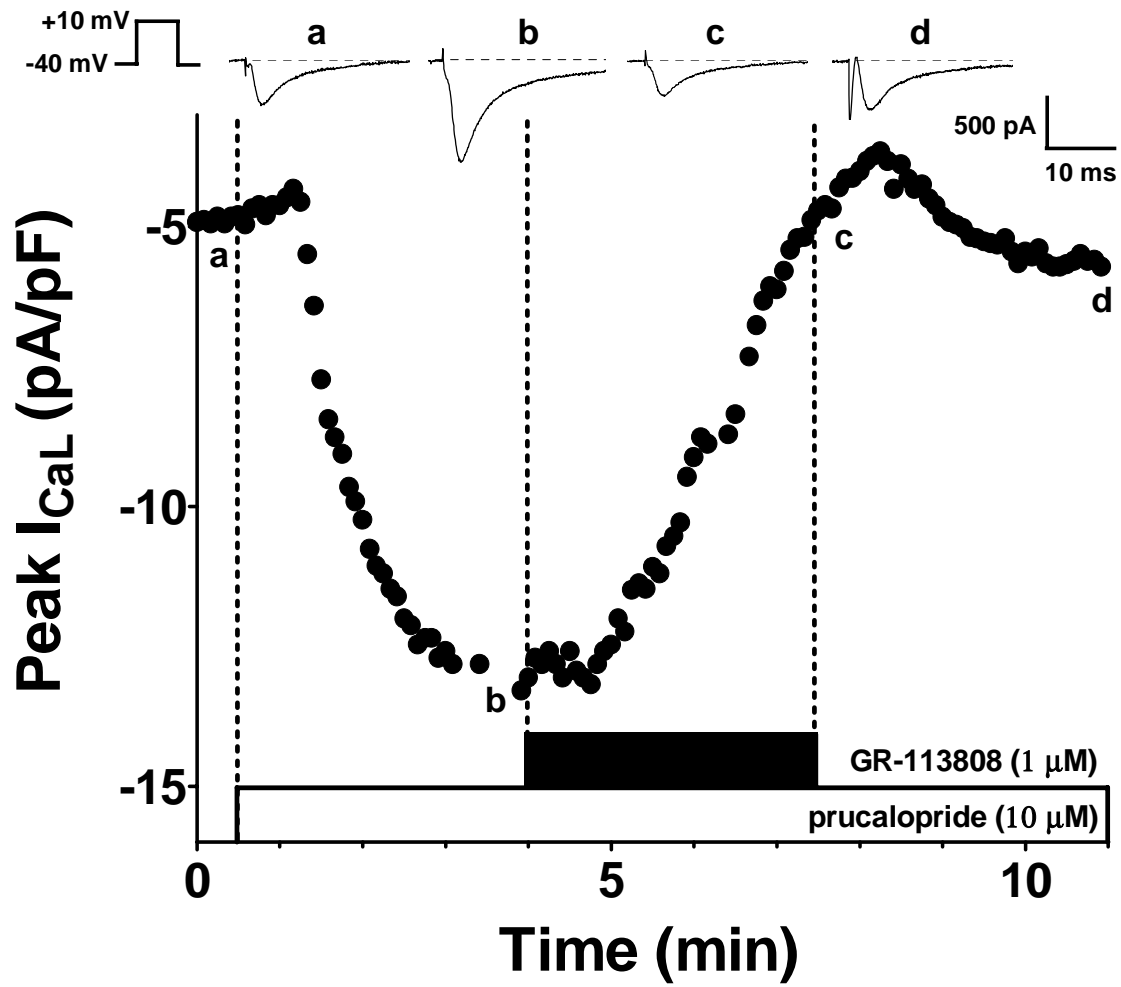
JPET #76869

Figure 1



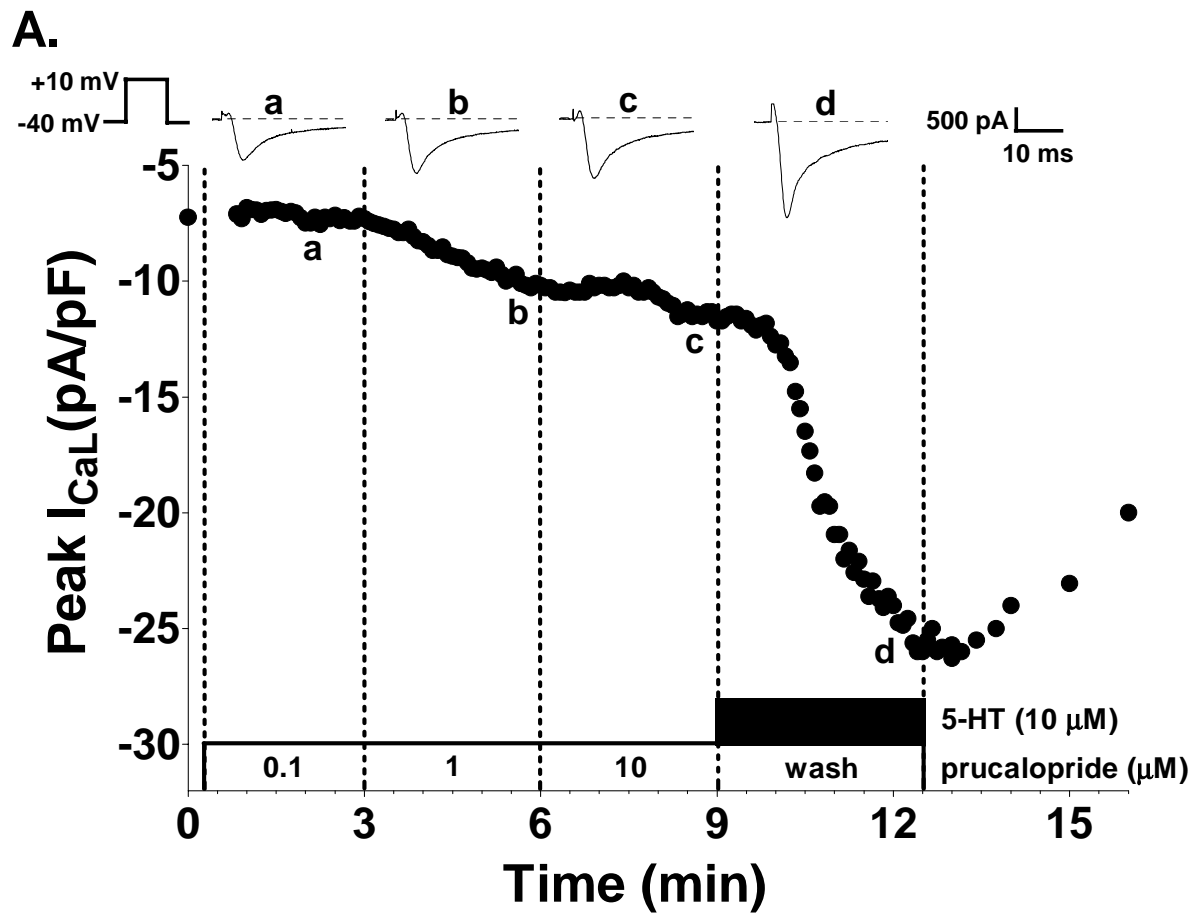
JPET #76869

Figure 2.

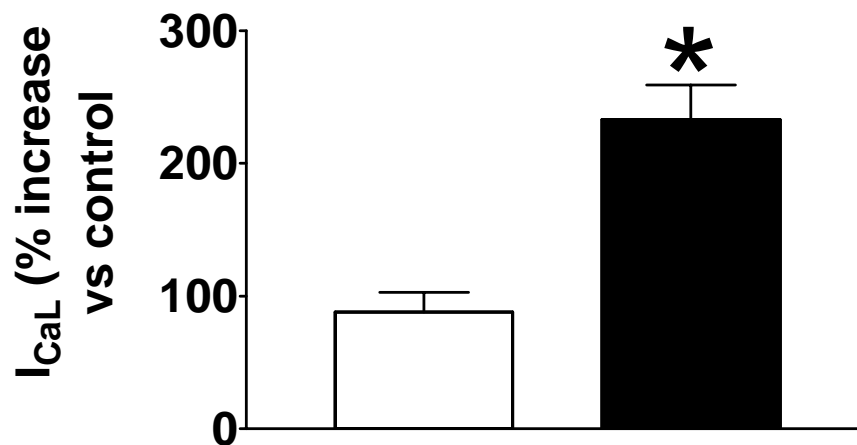


JPET #76869

Figure 3.

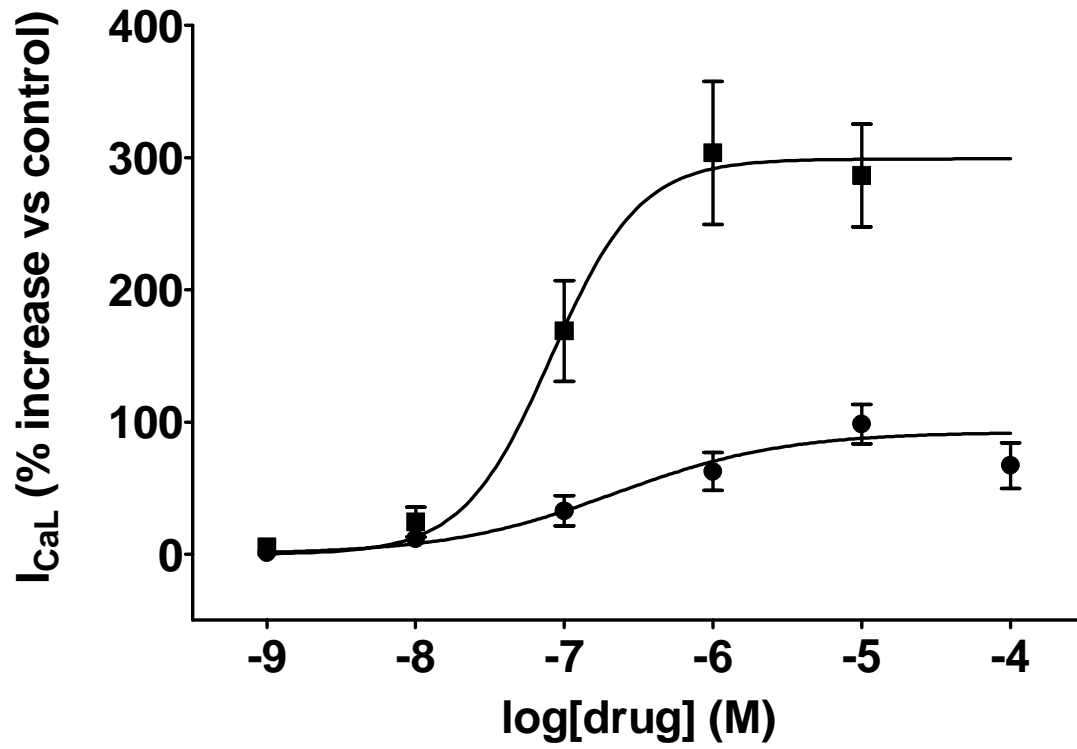


B.



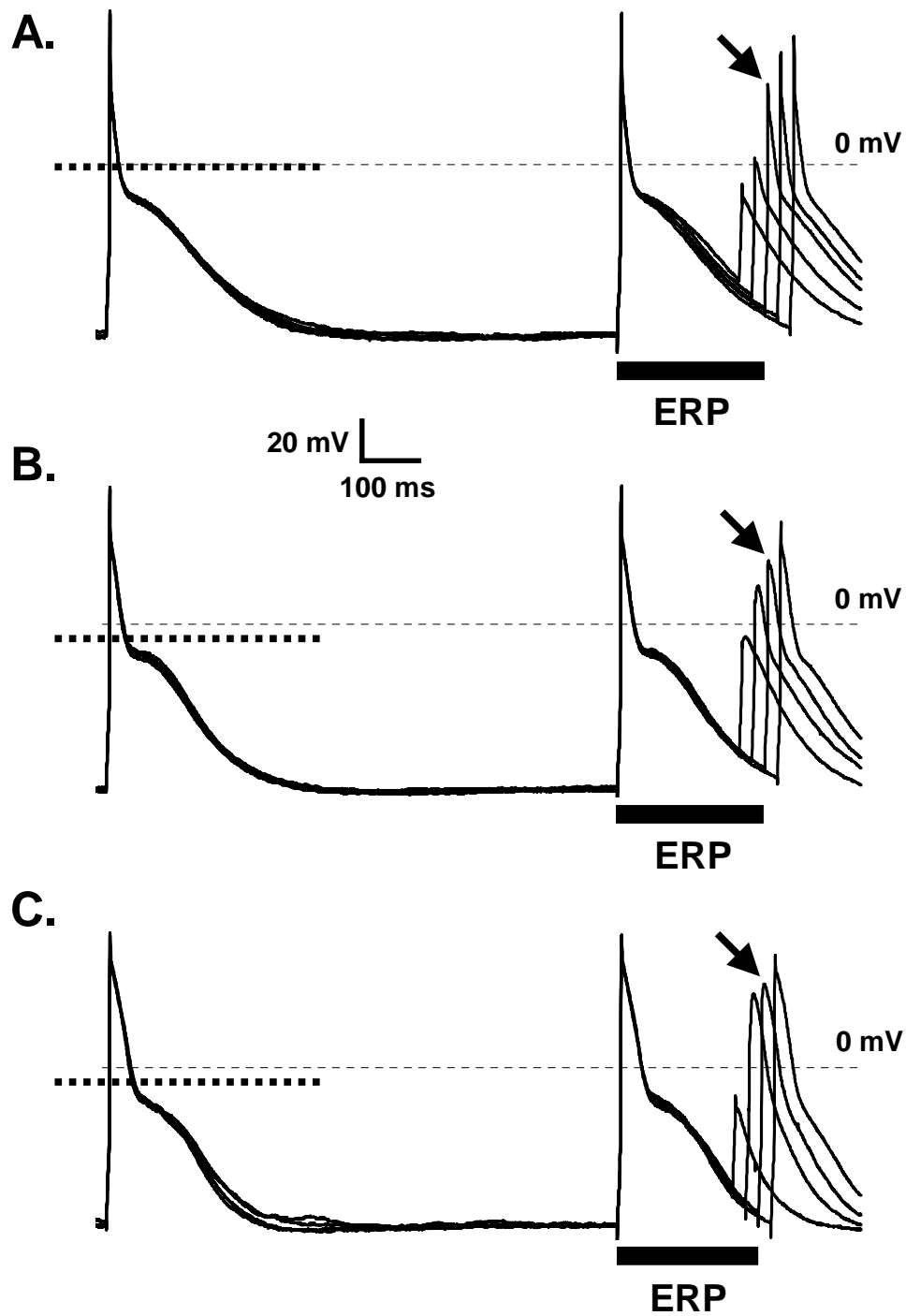
JPET #76869

Figure 4.



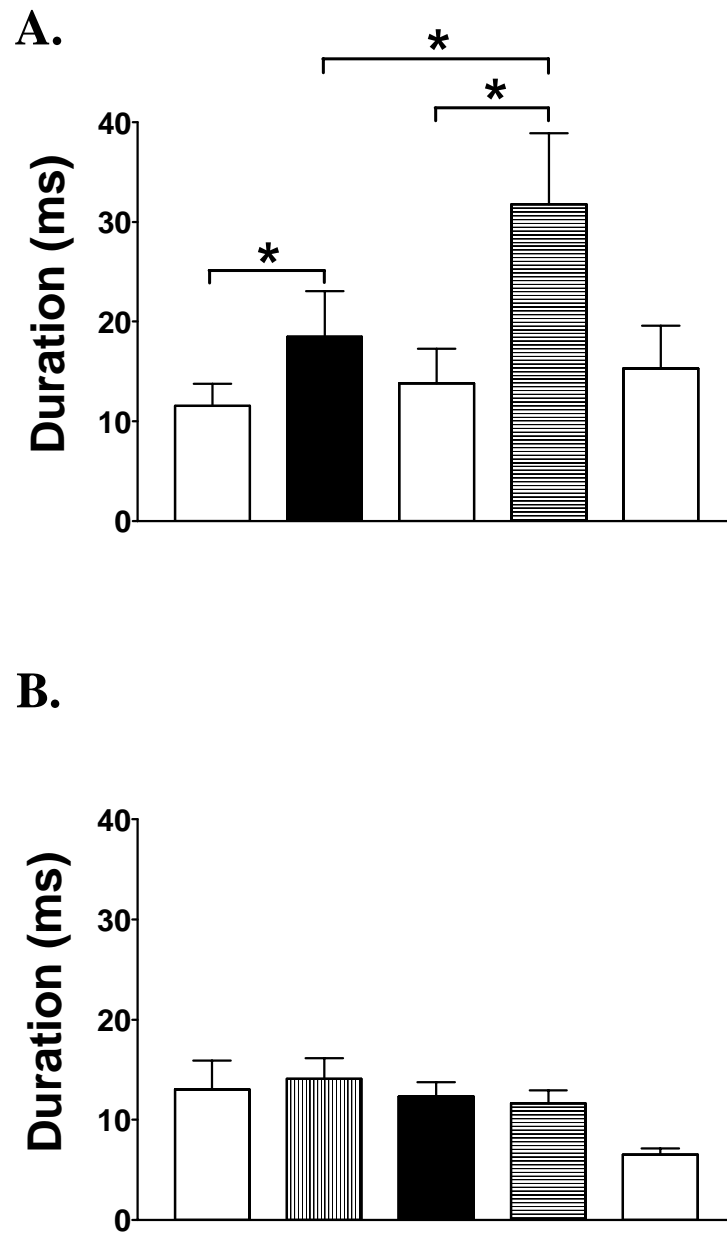
JPET #76869

Figure 5



JPET #76869

Figure 6.



JPET #76869

Figure 7.

