Circulating endothelin-1 concentrations in patients with chronic hypoxia

C Ferri, C Bellini, C De Angelis, L De Siati, A Perrone, G Properzi, A Santucci

Abstract

Aims—To evaluate the behaviour of plasma endothelin-1 in patients with chronic hypoxia.

Methods—Fifteen male patients (mean age 52.1 ± 3.1 years) with mild chronic obstructive pulmonary disease (COPD) were studied. Twelve healthy men (mean age 48.3 ± 5.4 years) served as controls. Both patients and controls underwent standard pulmonary function tests, echocardiographic evaluation, and arterial blood gas evaluation. Blood samples for endothelin-1 assay were taken from a previously incannulated antecubital vein after 60 minutes of rest in the supine position. Endothelin-1 was measured by radioimmunoassay after extraction from plasma.

Results—Patients with chronic hypoxia had lower PaO2 values (66.1 ± 6.2 mmHg) than controls (83.8 ± 2.7 mmHg) but PaCO2 values were similar (38.1 ± 2.5 v 36.7 ± 3.1 mmHg, respectively). Arterial pulmonary pressure, therefore, was higher in patients (18.1 ± 3.7 mmHg) than in controls (10.4 ± 2.7 mmHg) as were circulating endothelin-1 concentrations (1.22 ± 0.36 v 0.57 ± 0.1 pg/ml). Furthermore, plasma endothelin-1 concentrations were negatively correlated with PaO2 and directly correlated with pulmonary pressure levels. No significant correlations were found in controls.

Conclusions—These results show a clear relation between chronic hypoxia and circulating endothelin-1 concentrations. Therefore, chronic hypoxia may be regarded as an important stimulus for endothelin-1 release and as one of the main contributors to increased vasoconstriction in the vascular pulmonary bed which often accompanies lung disease.

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Keywords: Endothelin-1, hypoxia, respiratory disease, pulmonary hypertension.

Endothelin-1 is a recently discovered peptide composed of 21 amino acids and released by endothelial cells. Human endothelin-1 is derived from preproendothelin-1, a 212 amino acid peptide, via a 38 amino acid intermediate known as big endothelin-1. The expression of preproendothelin-1 messenger RNA (mRNA) is stimulated by vasopressor hormones such as epinephrine, angiotensin II and arginine vasopressin, substances generated from activated/aggregating platelets such as transforming growth factor β, coagulation products such as thrombin, cytokines such as interleukin-1, and shear stress. Furthermore, substances such as nitric oxide, prostacyclin, atrial natriuretic peptide, and an unknown vascular smooth muscle cell derived inhibitory factor act as inhibitors of endothelin-1 production or secretion, or both. Because of its vasoconstrictive and mitogenic properties, endothelin-1 affects cardiovascular, pulmonary and renal function, and may be involved in the development of several diseases, such as atherosclerosis, myocardial infarction, renal disease, and systemic and pulmonary hypertension.

With regard to the possible interactions between endothelin-1 and pulmonary functions, hypoxia stimulates the release of endothelin-1 from rat resistance vessels. In cultured cells derived from human umbilical cord veins Kourembanas et al demonstrated that hypoxia induced upregulation of endothelin-1 gene transcription results in a four- to eightfold increase in endothelin-1 secretion. Moreover, a recent interesting study conducted in healthy men indicated that hypobalic hypoxia induced by trekking from 1200 m to 5000 m over eight days caused an increase in circulating endothelin-1 concentrations which was inversely correlated with oxygen saturation. Several other factors could have influenced the behaviour of plasma endothelin-1 in these subjects, including the haemodynamic and hormonal changes which usually occur following altitude acclimatisation. Moreover, oxygen tension in the blood was indirectly evaluated as saturated haemoglobin, by percutaneous oxymetry, the measurement of which is strongly affected by cutaneous vasoconstriction caused by total body cooling. However, the report by Giussani et al clearly suggests that hypoxia may affect plasma endothelin-1 concentrations. In this context, several studies reported a close correlation between circulating endothelin-1 and arterial pulmonary pressure.

Therefore, we postulated that a pathological condition associated with chronic hypoxia could be used to evaluate the influence of blood oxygen concentrations on plasma endothelin-1 concentrations, and to verify whether or not the behaviour of this peptide is related to both PaO2 and pulmonary pressure levels. To test this hypothesis, we studied male patients with chronic obstructive pulmonary disease (COPD), but without clinical, ultrasound, or biochemical evidence of atherosclerosis, metabolic abnormalities of lipid or carbohydrate metabolism, or renal function abnormalities.
Methods
The study was approved by the Ethics Committee of the Andrea Cesalpino Foundation. All the participants gave their informed consent on entry. As several factors related to the menstrual cycle and/or menopause influence the behaviour of several hormones which regulate endothelial function, we decided to study male patients only.

Twenty five white men (mean age 53·9 ± 3·8 years) with mild COPD were initially enrolled in the study. The diagnosis of COPD was based on a past history of chronic bronchitis and evidence of air flow abnormalities on standard pulmonary function tests (forced expiratory volume in one second (FEV₁) < 80% predicted values, FEV₁/vital capacity < 80% normal values). All were outpatients aged between 40 and 60 years; had not been taking cardiac glycosides, diuretics, steroids, or theophylline in the three months before the study; did not smoke or drink; and had a body mass index between 19 and 25 kg/m²; supine systolic and diastolic blood pressures below 140 and 90 mmHg, respectively; a serum creatinine concentration <100 μmol/l; a serum sodium concentration >135 mmol/l; microalbuminuria <20 μg/minute; absence of proteinuria; normal glucose metabolism (that is, fasting glucose concentrations <6·0 mmol/l and a normal plasma glucose and insulin response to the oral glucose tolerance test (75 g)); serum cholesterol concentrations between 3·7 and 5·1 mmol/l; and serum triglyceride concentrations between 1·1 and 1·6 mmol/l. Clinical and echo-Doppler evaluation of the neck and limb vessels excluded the presence of atherosclerotic lesions. Moreover, none of the patients had cardiac, hepatic or adrenal disease, or had significant peripheral oedema as assessed by clinical, ultrasound and laboratory tests. In particular, absence of cor pulmonale and left ventricular dysfunction was documented on clinical examination and by electrocardiography and echocardiography. Both patients and controls underwent echocardiographic examination permitting evaluation of the main morphological and functional parameters, such as pulmonary pressure, left ventricular ejection fraction and ventricular kinesia. In particular, two patients with a left ventricular ejection fraction lower than 50% and five patients in whom it was technically impossible to obtain a reliable echo-Doppler evaluation of pulmonary arterial pressure were excluded from the study.

The remaining cohort (18 patients, mean age 51·7 ± 4·5 years) underwent standard pulmonary function tests and analysis of arterial blood gas values. All patients had a PaCO₂ <40 mmHg, whereas PaO₂ values ranged from 55 to 75 mmHg. Twelve healthy men (mean age 48·3 ± 5·4 years) served as controls. Entry criteria were identical with those for the patients.

After recruitment, to establish standard conditions, both patients and controls were placed on a normocaloric diet (about 1 g/kg protein, 2 g/kg carbohydrates, 0·7 g/kg fat) for two weeks with fixed sodium and potassium intake (120 mmol sodium and 60 mmol potassium daily). Sodium was given as sodium chloride. Compliance with restrictions on sodium intake was assessed by measuring 24 hour urinary sodium and chloride excretion on the last three consecutive days of each week. Patients and controls with Na⁺ urinary excretion <80 or >130 mmol/24 hours were excluded. During this phase, three further patients were excluded from the study (all of them had a urinary sodium excretion >140 mmol/24 hours). The remaining cohort of 15 patients (mean age 52·1 ± 3·1 years) and 12 normal subjects constituted the study population. Patients were advised to stop using oral and/or inhaled bronchodilators for the 12 hours before the study. Participants came to the outpatient department at 0800 hours and assumed the supine position in an air conditioned room (22–24°C). An antecubital vein was cannulated with a teflon catheter (Viggo-Spectramed, Helsingborg, Sweden) which was kept pervious by saline (0·9% NaCl at a rate of 10 ml/hour). After 60 minutes of rest, during which blood pressure and heart rate were constantly recorded at 10 minute intervals by an automatic sphygmomanometer (Nippon Colin, Komaki, Japan), venous blood samples for determination of osmolality and plasma endothelin-1, serum electrolyte and creatinine concentrations were taken from the pervious prepared antecubital vein. This particular procedure was chosen to avoid the influence of venepuncture and blood stasis on the release of endothelin-1 from venous endothelial cells. Immediately after venous blood sampling, arterial blood samples for evaluation of blood gas levels were drawn from a brachial artery. For correlations between circulating endothelin-1 and urinary Na⁺, K⁺ and creatinine excretion, the last 24 hour collection of each patient was used.

Biochemical tests
Blood samples for the plasma endothelin-1 assay were collected into pre-chilled tubes (Becton Dickinson Vacutainer Systems, New Jersey, NJ, USA) containing EDTA-K₃ (15% of total added blood volume, NaCl 300 KIU/ml blood) and promptly centrifuged at 1600 × g at 0–4°C for 15 minutes. Plasma was pipetted into polypropylene tubes and stored at −80°C until assayed (mean five days, range one to 10 days). Plasma endothelin-1 was concentrated by extraction through C18 Sep-Pak cartridges (Millipore Corporation, Marlborough, Massachusetts, USA). Sep-Pak columns were activated with 0·1% trifluoroacetic acid buffer, loaded with 2 ml plasma and then washed with 0·1% trifluoroacetic acid buffer. The retained material was eluted with 3 ml of a buffer containing acetonitril (60%) in 0·1% trifluoroacetic acid, and dried in a vacuum by a centrifugal evaporator system (Gyrovap, Howe & Co., London UK). A commercial radioimmunoassay kit (Peninsula Laboratories, Belmont, CA, USA) was used to measure endothelin-1 concentrations in the reconstituted pellet. Cross-reactivity of the system for endothelin-1 is 100%, but is less than 7% for both endothelin-2 and endothelin-3 according
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to the manufacturer. Intra- and interassay coefficients of variation in our laboratory were <10%. Recovery was 80%. Serum and urinary electrolytes were measured by standard laboratory methods using a flame photometer (Biotechnica Instruments, Rome, Italy). Plasma osmolality was determined as freezing point depression by an osmometer (Fiske 2400 Multi-sample Osmometer, Fiske Associates, Needham Heights, Massachusetts, USA).

**BLOOD GAS EXCHANGE EVALUATIONS**

Arterial blood was collected in heparinised syringes from a brachial artery. Gas evaluations were performed by a standard laboratory blood gas analyser (ABL 510 Radiometer, Copenhagen, Denmark).

**BLOOD PRESSURE AND ECHOcardiographic EVALUATIONS**

Systemic arterial blood pressure and heart rate were measured at 10 minute intervals using an automatic sphygmomanometer (Nippon Colin). Mean blood pressure (MBP; mmHg) was evaluated using the formula:

\[ MBP = DBP + \frac{1}{3} (SBP - DBP) \]

where DBP is the diastolic and SBP the systolic blood pressure.

Echocardiographic studies were performed using commercially available equipment with left parasternal and apical approaches. Both patients and controls underwent a complete M mode and B mode evaluation. Functioning of all cardiac valves was also investigated by colour Doppler. Conventionally, blood flow directed towards the transducer was codified in red and that directed away from the transducer in blue; a green colour (variance) represented turbulent flow. Tricuspid regurgitation was carefully detected: the transducer was manipulated to obtain the best visualisation of valvular insufficiency by colour-flow Doppler mapping and a continuous wave Doppler cursor was positioned parallel to the flow. If the angle of intersection between the Doppler cursor and tricuspid regurgitant flow was >20°, attempts to detect tricuspid insufficiency were repeated from the subcostal transducer position. In some cases the subjects were asked to take a deep breath and to remain in inspiratory apnea: in this way, it was usually possible to obtain an optimal representation of tricuspid regurgitant flow and to place the Doppler cursor in position parallel to it. The same manoeuvres were then repeated using the non-imaging, high-sensitivity Pedoff transducer. In our experience, the latter transducer provides an opportunity to detect more defined Doppler envelopes and higher velocities than with combined imaging and the continuous wave Doppler probe. The maximum velocity of the signal tracing observed on at least two consecutive cardiac cycles was used to calculate the pressure gradient. Optimal signals were assumed to be orientated parallel to the direction of regurgitation and thus a flow angle correction for velocity was not used. The transtricuspid systolic pressure gradient (TSPG; mmHg) was calculated on the basis of the modified Bernoulli equation:

\[ TSPG = 4V^2 \]

where V represents the peak systolic velocity of the right ventricle to right atrium signal.

**STATISTICAL ANALYSIS**

All data are presented as means ± SD. Data were recorded using a personal computer (Olivetti, Ivrea, Italy) and a database program (IBM Assistant, IBM Corporation, Armonk, New York, USA). Statistical analysis was performed using statistical software for biomedical science (Primery of Biostatistics, McGraw-Hill, New York, NY, USA). Baseline comparison among groups was performed using the Student’s t test and analysis of variance; linear regression and correlation were used to evaluate correlation between two variables; p<0.05 was considered significant.

**Results**

**Patients**

The general characteristics of the patients with COPD are given in table 1. As shown, the main biochemical parameters confirmed normal glucose and lipid metabolism and there was no evidence of abnormal renal function or of electrolyte disorders. Regarding respiratory parameters (table 2), patients with COPD were

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**Table 1** General characteristics (mean ± SD) of the study population

<table>
<thead>
<tr>
<th>Variable</th>
<th>Patients (n=15)</th>
<th>Controls (n=12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>52±1-3</td>
<td>48±3±5</td>
</tr>
<tr>
<td>Disease duration (years)</td>
<td>4-2±0-2</td>
<td>2.5±0.3</td>
</tr>
<tr>
<td>Body mass index (kg/m²)</td>
<td>25±3-1</td>
<td>25±3-1</td>
</tr>
<tr>
<td>DBP (mmHg)</td>
<td>80±1-2</td>
<td>78±1-2</td>
</tr>
<tr>
<td>MBP (mmHg)</td>
<td>95±3-0</td>
<td>95±3-0</td>
</tr>
<tr>
<td>Heart rate (beats/minute)</td>
<td>75±1-1</td>
<td>71-1±0</td>
</tr>
<tr>
<td>Serum creatinine (mmol/l)</td>
<td>81-0.1±0</td>
<td>80±9±3</td>
</tr>
<tr>
<td>Creatinine clearance (ml/s)</td>
<td>1.6±0-9</td>
<td>1.7±0-3</td>
</tr>
<tr>
<td>Blood urea (mmol/l)</td>
<td>10.9±1-2</td>
<td>11.3±1-0</td>
</tr>
<tr>
<td>Serum Na⁺ (mmol/l)</td>
<td>138±4-3</td>
<td>139±1-3</td>
</tr>
<tr>
<td>Serum K⁺ (mmol/l)</td>
<td>4.2±0-4</td>
<td>4.5±0-2</td>
</tr>
<tr>
<td>Plasma fasting glucose (mmol/l)</td>
<td>5.1±0-6</td>
<td>5.2±0-3</td>
</tr>
<tr>
<td>Plasma fasting insulin (μmol/l)</td>
<td>94±8-5</td>
<td>78±6-9</td>
</tr>
<tr>
<td>Plasma osmolality (mmol/kg)</td>
<td>286±3-2</td>
<td>285±8-2</td>
</tr>
<tr>
<td>Plasma cholesterol (mmol/l)</td>
<td>4.4±1-0</td>
<td>4.2±1-3</td>
</tr>
<tr>
<td>Plasma triglycerides (mmol/l)</td>
<td>1.5±0-1</td>
<td>1.3±0-2</td>
</tr>
</tbody>
</table>

SBP, systolic blood pressure; DBP, diastolic blood pressure.

**Table 2** Respiratory and cardiac parameters of the study population

<table>
<thead>
<tr>
<th>Variable</th>
<th>Patients (n=15)</th>
<th>Controls (n=12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forced vital capacity (litre)</td>
<td>2.8±0-5</td>
<td>3.7±2-4</td>
</tr>
<tr>
<td>FEV₁ (F0.75 second)</td>
<td>1.9±0-2</td>
<td>3.1±0-5</td>
</tr>
<tr>
<td>FEV₁/forced vital capacity (%)</td>
<td>67±3-4</td>
<td>84±1±3</td>
</tr>
<tr>
<td>PaCO₂ (mmHg)</td>
<td>66±1-2</td>
<td>83±5±2</td>
</tr>
<tr>
<td>PaO₂ (mmHg)</td>
<td>38±1-25</td>
<td>36±7-3</td>
</tr>
<tr>
<td>Arterial pH</td>
<td>7.37±0-01</td>
<td>7.38±0-001</td>
</tr>
<tr>
<td>Serum bicarbonates (mmol/l)</td>
<td>25±1-2</td>
<td>24.3±1-8</td>
</tr>
<tr>
<td>Respiratory rate (breaths/minute)</td>
<td>16±1-5</td>
<td>14±0-3</td>
</tr>
<tr>
<td>Haematocrit (%)</td>
<td>46±1-5</td>
<td>45±9±1</td>
</tr>
<tr>
<td>Haemoglobin (g/l)</td>
<td>131±1-3</td>
<td>145.2±15-1</td>
</tr>
<tr>
<td>Oxygen saturation (% saturated haemoglobin)</td>
<td>88±5-4</td>
<td>91.3±5-3</td>
</tr>
<tr>
<td>Pulmonary pressure (mmHg)</td>
<td>18±1-3</td>
<td>10-4±2-7</td>
</tr>
<tr>
<td>Left ventricular ejection fraction (%)</td>
<td>65±6-8</td>
<td>74.8±7-8</td>
</tr>
</tbody>
</table>

FEV₁, forced expiratory volume in one second.

**p<0.01 vs patients with COPD; ***p<0.001 vs patients with COPD; †p<0.0005 vs patients with COPD.**
was 88.5 ± 4.4% saturated haemoglobin. Echocardiographic evaluation did not show any segmental or global alterations in cardiac kinesis. Arterial pulmonary pressure was at the higher end of the normal range (18.1 ± 3.7 mmHg), the normal value at our echocardiography unit, as evaluated in 384 aged matched healthy subjects, being 10.8 ± 3.1 mmHg (range 8–24 mmHg). The left ventricular ejection fraction was slightly reduced (65.6 ± 8.9%), although it was greater than 50% in all patients. The mean circulating endothelin-1 concentration was 1.22 ± 0.36 pg/ml (fig 1A). A negative correlation was found between plasma endothelin-1 concentrations and PaO2 (r = -0.614; p<0.02) (fig 2A). However, plasma endothelin-1 concentrations directly correlated with the degree of arterial pulmonary pressure (r = -0.571; p<0.03) (fig 2B). It was also interesting to note that pulmonary pressure negatively correlated with PaO2 values (r = -0.073; p<0.003). No other correlations were found. In particular, circulating endothelin-1 concentrations did not correlate with blood pressure, plasma glucose, or fasting insulin and lipid concentrations.

**CONTROLS**

The controls had normal values for glucose and lipid metabolism, and renal function (table 1). Cardiac and respiratory parameters (table 2) were also normal. In particular, the controls had normal arterial gas values (PaO2 = 83.8 ± 2.7 mmHg; PaCO2 = 36.7 ± 3.1 mmHg) and oxygen saturation (91.3 ± 3.8% saturated haemoglobin). Plasma endothelin-1 concentrations were 0.57 ± 0.10 pg/ml (fig 1) and did not correlate with PaO2. Arterial pulmonary pressure was 10.4 ± 2.7 mmHg and did not correlate with either circulating endothelin-1 concentrations or PaO2. Plasma endothelin-1 concentrations also did not correlate with the other parameters evaluated, such as plasma glucose and insulin concentrations.

**COMPARISON BETWEEN GROUPS**

When intergroup comparisons were performed, some significant differences were noted. Cir-
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culating endothelin-1 concentrations were signi-
ificantly higher in patients with COPD than
in controls (p<0.001) (fig 1), with very little
overlap between the two groups. Indeed, in
patients with COPD plasma endothelin-1 con-
centrations ranged from 0.54 to 2.10 pg/ml,
whereas in controls these ranged from 0.42 to
0.72 pg/ml (fig 1). As a consequence, only two
patients had plasma endothelin-1 con-
centrations within the normal range, whereas
the remaining 13 had endothelin-1 con-
centrations two- to fourfold higher than those
in controls.

As expected, both FEV₁ and FEV₁/FVC ratio
were lower in the patients than controls (p<0.001 and p<0.005, respectively) (table 2),
as was PaO₂ (p<0.0005). Systolic, diastolic, and
mean blood pressure values were similar in both
groups (table 1); however, mean arterial pul-
monary pressure was significantly higher in
patients than in controls (p<0.0001), but re-
mained within the normal range in both groups.
The left ventricular ejection fraction, however,
was higher in controls (p<0.01) (table 2).

Discussion

Endothelins are potent vasoconstrictors and
mitogens for both vascular smooth muscle
cells and fibroblasts. Increased secretion of
endothelin-1 from the vascular endothelium has
frequently been implicated in systemic
hypertension, atherosclerosis, myocardial in-
farction, renal disease, and pulmonary hy-
pertension.

Hypoxia causes both systemic and pul-
monary arteries to constrict, but the mech-
anism involved has not been elucidated as yet.
However, based on their location, endothelial
cells of the vascular pulmonary bed are thought
to play a key role. In keeping with this
hypothesis, changes in blood oxygen tension
induce endothelial cells to release a number of
different vasoactive agents including
endothelin-1, platelet derived growth
factor, nitric oxide and other unknown sub-
stances, which can modify the contractile and
proliferative rate of the underlying smooth
muscle cells.

All of the above data were obtained in acute
conditions, and the aim of this study was to
verify how long term low PaO₂ values could
affect circulating endothelin-1 concentrations.
Thus, we selected a group of patients with mild
COPD and to exclude confounding factors
caused by advanced disease, the patients
chosen were highly selected. Disease duration
was less than five years in all cases and clinical
and biochemical tests allowed us to exclude
patients with signs of cor pulmonale, peripheral
oedema, electrolyte disorders, or acid/base al-
terations. All patients were hypoxic but had
normal PaCO₂ values. Furthermore, the study
was conducted on lean normotensive subjects
with no clinical or echo-Doppler signs of
atherosclerosis, with normal blood pressure val-
ues, and normal carbohydrate and lipid meta-
bolism.

Our results demonstrate that circulating end-
dothenin-1 concentrations were significantly in-
creased in hypoxemic patients compared with
healthy subjects (p<0.001). Moreover, end-
dothenin-1 concentrations were negatively cor-
related with PaO₂ and directly correlated with
arterial pulmonary pressure. The latter was
higher (p<0.001) in hypoxemic patients than
in the control subjects, being directly correlated
with PaO₂ in the former only.

Our results concur with previous findings in
the rat, of increased synthesis of endothelin-1
in response to hypoxia. The intracellular path-
way by which hypoxia modulates endothelin-1
synthesis in vascular endothelial cells is not
known, but previous findings in cultured
human endothelial cells suggested that oxygen
may act at the nuclear level by increasing
preproendothelin-1 gene expression and con-
sequently preproendothelin-1 mRNA produc-
tion. Action at the post-transcriptional level
is unlikely as endothelin-1 release requires de
novo protein synthesis.

Our study extends the data reported by Giu-
sani et al showing that chronic hypoxia is a
major determinant of circulating endothelin-1
concentrations in patients with respiratory fail-
ure, and suggesting that it may be an important
regulator of the vascular tone in the pulmonary
circulation.

In this regard, hypoxia is already regarded as
a possible pathogenic factor in the de-
velopment of pulmonary hypertension, but
the possible role of hypoxia mediated en-
dothenin-1 release has never been investigated.
However, Adnot et al recently have demon-
strated that endothelin-1 induces greater
pulmonary vasoconstriction in rats with chronic
hypoxia compared with control rats. Moreover,
Giaid et al reported elevated endothelin-1
gene expression in vascular endothelial cells
derived from the lungs of patients with both
primary and secondary forms of pulmonary
hypertension. In keeping with these data, we
showed that pulmonary pressure values were
significantly correlated with plasma endothelin-1
concentrations, suggesting that the peptide may
act as a potent vasoconstrictor for the lung
vascular bed, at least in conditions associated
with a significant increase in its circulating
concentrations. In agreement with this in-
terpretation, De Nucci et al have already
demonstrated the high avidity of the pulmonary
vasculature for circulating endothelin-1, and
both endothelial and vascular smooth muscle
cells receptors have been demonstrated in the
lung. In contrast to this hypothesis, Deleuze et
al showed that endothelin-1 induced dose
dependent vasoconstriction in the pulmonary cir-
culation of calves breathing in hypoxic con-
ditions. In particular, low doses of endothelin-1
induced a mild decrease in the pulmonary ary
pressure, whereas high doses caused pulmonary and systemic vaso-
constriction. Thus, the action of endothelin-1
may differ in pulmonary and systemic cir-
culations, refuting the suggested pathogenic
role for endothelin-1 in the development of
pulmonary hypertension. Nevertheless, the
data from Deleuze et al may simply reflect
the different pressures in the two vascular
beds—the pulmonary circulation is a low pres-
Therefore, endothelin-1 could not constrict pulmonary vessels in vivo because of the presence of highly stimulated endothelin-B receptors on the luminal endothelial surface, and the consequent endothelin-B receptor mediated release of prostacyclin and nitric oxide. Endothelin-1 does not readily penetrate the external endothelial cell membrane and therefore circulating endothelin-1 could not bind to endothelin-A receptors, which mediate vasoconstriction and are expressed by vascular smooth muscle cells lying beneath the endothelium. Therefore, it could be hypothesized that hypoxia might alter vascular reactivity to various agents, acting either in a paracrine or an autocrine manner and interacting at the vascular level. Locally, the prevalence of constrictor agents and/or a decrease in vasodilator concentrations could lead to the development of pulmonary hypertension. In this context, the increase in circulating endothelin-1 concentrations could reflect an increase in the intracellular production of endothelin-1 and its subsequent release. According to this hypothesis, about 80% of newly generated endothelin-1 is secreted through the basolateral membrane, and only 20% is released into the blood. Perhaps, therefore, circulating endothelin-1 should be regarded as a marker for pulmonary hypertension rather than as a cause of lung disease.

In conclusion, the present study demonstrates for the first time that circulating endothelin-1 concentrations are increased in patients with chronic hypoxia. In spite of the increase in plasma endothelin-1 concentrations patients did not have concomitant systemic hypertension, renal damage, or cardiovascular disease. Thus, it is likely that endothelin-1, in conjunction with other endothelium derived vasoactive factors—for example, prostaglandin I_2 and endothelium derived relaxing factor, acts in an autocrine/paracrine manner rather than in an endocrine one. The direct correlation between plasma endothelin-1 concentrations and pulmonary pressure values suggests that endothelin-1 may exert its vasoconstrictive action in the pulmonary vascular bed. Alternatively, it is possible that circulating endothelin-1 may have not a significant effect on the vascular tone in lung arteries, and may be a marker rather than a determinant of pulmonary disease associated with vasoconstriction.

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