Metabolic Flux as a Predictor of Heart Failure Prognosis

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Evidence for an impaired CK system in the human failing heart dates as far back as 1939 with the observation that total creatine levels are reduced by 30%. Since then, numerous animal and human studies have established firmly that a reduction in both creatine and CK enzymatic activity are a hallmark of the failing heart, regardless of pathogenesis. During the 1980s, advances in $^{31}$P MRS enabled noninvasive measurement of high-energy phosphate metabolites in the living human heart for the first time. The Figure shows stylized cardiac $^{31}$P spectra illustrating the typically large PCr peak and 3 smaller peaks representing the phosphate groups of ATP. Absolute concentrations are difficult to obtain and for this reason it is common to report the PCr/ATP ratio as a measure of relative abundance (value $\approx 1.8$ in the normal heart). This ratio is a relatively robust marker of energetic status because it reflects loss of total creatine and the equilibrium constant for the CK reaction favors ATP synthesis by 100-fold, such that ATP levels are maintained near normal in all but the most advanced stages of heart failure. A fall in PCr/ATP, therefore, mostly reflects a fall in PCr levels. Clearly, however, there may be a pseudonormalization of PCr/ATP under circumstances where ATP becomes depleted. A series of studies in the 1990s showed that PCr/ATP was significantly reduced in patients with dilated cardiomyopathy and correlated with traditional measures of heart failure severity such as New York Heart Association class and ejection fraction. Furthermore, patients that responded to medical treatment also showed an improvement in PCr/ATP and in a prospective study, PCr/ATP was shown to be an excellent prognostic indicator of mortality.

The latest report by Bottomley et al is a welcome and logical progression of this approach and builds on earlier studies from the same group to establish $^{31}$P MRS methods to measure CK flux in the human heart. Acquiring these measurements is a major technical challenge, but the basic concept is simple enough (Figure). There are several reasons why flux might be superior to measuring metabolite levels. First, it avoids the problem of PCr/ATP pseudonormalization described above. Second, flux through CK is arguably more sensitive with a wider dynamic range, because it reflects both changes in metabolites and in CK activity. Third, it has been argued that CK is part of a near-equilibrium enzymatic network, where changes in flux may occur in the absence of altered metabolite levels. However, it should be noted that there is a certain ambiguity to what exactly CK flux represents because it is not unidirectional, but rather an average flux for all NMR-visible CK reactions within the volume of interest, and in common with metabolite quantification there is no distinction between different cellular compartments.

Having previously established that CK flux is impaired in patients with heart failure, Bottomley et al report on a prospective nonrandomized study in 58 patients with
nonischemic cardiomyopathy and 17 healthy volunteers. All were confirmed to be free of coronary artery disease and had been clinically stable for ≥2 weeks before a single $^{31}$P MRS examination to obtain a 1-dimensional (1D) data set from the anterior myocardium. Follow-up was for a median 4.7 years (up to 8.2 years) with death and hospitalization as end points. The take-home finding is that CK flux, but not metabolite levels or PCr/ATP, was an independent predictor of all cause and cardiovascular mortality.

Clearly this is a promising initial finding, which needs to be repeated in a larger and more diverse cohort. For example, it is important to know whether reduced CK flux is selective for heart failure. The authors have shown previously that CK flux is reduced in ischemic myocardium commensurate with the extent of infarct transmurality, and have excluded coronary artery disease in this study. What other comorbidities may affect CK flux? The PCr/ATP ratio has been shown to be reduced in hypertension, diabetes mellitus, obesity, valve disease, and inherited heart muscle diseases, such as hypertrophic cardiomyopathy. Although not studied to date, it is likely that CK flux will also be decreased in these conditions. Furthermore, are these findings true for all ages and ethnicities? It is a limitation that this study examines a single time point, when change in flux over time may be an even better prognostic indicator. This would also answer the question of whether CK flux is a marker for therapeutic efficacy; that is, does CK flux increase when New York Heart Association class improves as previously shown for PCr/ATP ratio. For example, if, as has been suggested, reduced CK flux occurs early in disease pathogenesis, then can it be used to predict patients who are about to develop heart failure? This kind of risk stratification is more likely to have a real impact on clinical practice than predicting poor prognosis in patients that are already diagnosed and receiving optimal therapy. A much larger prospective study in a general aging population could address this question. In the meantime, it seems likely that there will be a niche role for CK flux measurements in the assessment of new therapies specifically targeting cardiac energetics and metabolism.

So what do these findings tell us about the pathophysiology of heart failure? The Bottomley study adds to a growing number of clinical studies for several decades that provide correlative evidence that energetic changes are closely related with the development of heart failure. This clearly implies,
but does not prove causality, particularly since the results from mouse models have been much more equivocal. Our laboratory has shown recently that mice completely deficient in creatine and PCR do not develop more severe heart failure and have normal survival after chronic myocardial infarction. We have demonstrated previously similar findings in rats with pharmacological depletion of creatine and in mice with genetic deletion of CK17,18, showing that CK deficiency is unlikely, in itself, to contribute to worsening heart failure. We would therefore argue that the issue of causality has yet to be settled, but perhaps this is a side-show that can await clarification at a later date. The more important issue is not whether CK deficiency is an underlying cause of heart failure, but more pertinently, whether augmenting the CK system (i.e., supraphysiological stimulation) has therapeutic promise. An important proof-of-principle study, also from the Johns Hopkins group, recently demonstrated that the answer to this question is yes. Transgenic mice overexpressing the muscle isoform of CK in the heart maintained CK flux at higher levels in a heart failure model of pressure-overload, and this was associated with higher ejection fraction and improved survival. This opens a whole new and exciting avenue for future study and the ability to make noninvasive measurements of CK flux is likely to play a pivotal role. Clearly, this technology is still in its infancy but we can expect to hear a lot more from metabolic flux imaging in the years to come.

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**References**

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