Heart failure (HF) remains the most common cause of death and disability, and a major economic burden, in industrialized nations. Physiological, pharmacological, and clinical studies have demonstrated that activation of the renin–angiotensin system is a key mediator of HF progression. Angiotensin-converting enzyme 2 (ACE2), a homolog of ACE, is a monocarboxypeptidase that converts angiotensin II into angiotensin 1–7 (Ang 1–7) which, by virtue of its actions on the Mas receptor, opposes the molecular and cellular effects of angiotensin II. ACE2 is widely expressed in cardiomyocytes, cardiofibroblasts, and coronary endothelial cells. Recent preclinical translational studies confirmed a critical counter-regulatory role of ACE2/Ang 1–7 axis on the activated renin–angiotensin system that results in HF with preserved ejection fraction. Although loss of ACE2 enhances susceptibility to HF, increasing ACE2 level prevents and reverses the HF phenotype. ACE2 and Ang 1–7 have emerged as a key protective pathway against HF with reduced and preserved ejection fraction. Recombinant human ACE2 has been tested in phase I and II clinical trials without adverse effects while lowering and increasing plasma angiotensin II and Ang 1–7 levels, respectively. This review discusses the transcriptional and post-transcriptional regulation of ACE2 and the role of the ACE2/Ang 1–7 axis in cardiac physiology and in the pathophysiology of HF. The pharmacological and therapeutic potential of enhancing ACE2/Ang 1–7 action as a novel therapy for HF is highlighted. (Circ Res. 2016;118:1313-1326. DOI: 10.1161/CIRCRESAHA.116.307708.)

Key Words: angiotensin II ■ angiotensin 1–7 ■ angiotensin-converting enzyme 2 ■ heart failure ■ renin-angiotensin system

The renin–angiotensin system (RAS) is a peptidergic system that functions in the homeostatic control of the cardiovascular and renal systems and in regulating extracellular fluid volume. Inhibition of the RAS plays a central role in alleviating the increased morbidity and mortality of patients with heart failure (HF).1,2 The RAS consists of a series of enzymatic reactions that result in generation of angiotensin II (Ang II). In the first step, renin (an aspartyl proteinase secreted by kidney into the circulation) cleaves hepatic peptide angiotensinogen to produce Ang I in the blood. Ang I is then hydrolyzed by angiotensin-converting enzyme (ACE) in the second step, producing the octapeptide Ang II. This biologically active peptide acts on Ang II type 1 and type 2 receptors (AT1R and AT2R; Figure 1A). Ang II promotes vasoconstriction, inflammation, salt and water reabsorption, and oxidative stress via the activation of AT1R.3 These detrimental effects of Ang II/AT1R have encouraged the quest for a counter-regulatory axis of the activated RAS. RAS was initially thought to function as a systemic entity not localized to any specific tissue. However, this notion of systemic RAS was challenged by observations that many tissues are capable of synthesizing the key components of RAS, including heart, kidney, vasculature, pancreas, retina, and others. The local RAS could produce peptides at
the tissue level that show autocrine effects (on the cells where they are being produced), paracrine effects (on neighboring cells), or endocrine effects (on a distant organ or tissue; via systemic circulation).3,14

Our conception of the RAS family has seen substantial changes with the identification of ACE2, a homolog of ACE. ACE2 is a monocoxyopeptidase that degrades Ang I into a nonapeptide, Ang 1–9 and Ang II into a heptapeptide, Ang 1–7 (Figure 1A). The discovery of ACE2, Ang 1–9, and Ang 1–7 unravels a distinct enzymatic pathway for degradation of Ang I and Ang II as endogenous negative regulation of RAS activation. Moreover, ACE2 has been identified as an important RAS regulator capable of mitigating the deleterious actions mediated by Ang II and AT1R. This is of particular importance in pathological conditions where the RAS is activated. Ang 1–7 is a biologically active peptide exerting a wide array of actions, many of which are opposite to those attributed to Ang II.15–18 In 2003, an endogenous orphan receptor, Mas (MasR), was identified as Ang 1–7 receptor. A779, an MasR antagonist, has been shown to block the majority of Ang 1–7 effects.17,19–22 Ang 1–9 has also shown beneficial biological effects via AT1R that result in cardioprotection.23–26 Thus, although ACE/Ang II/AT1R is a well-established axis of the RAS, the ACE2/Ang 1–7/MasR and ACE2/Ang 1–9/AT1R axes have emerged as physiological antagonists that counter-regulate the activate RAS.30,31 Taken together, the cardioprotective effects of ACE2 can be attributed to (1) degradation of Ang I to Ang 1–9, limiting the availability of substrate for ACE action, (2) degradation of Ang II, limiting its detrimental effects, and (3) generation of Ang 1–7, exerting its cardioprotective effects. Several lines of evidence suggest that ACE2 activity balances 2 different arms. Decreased ACE2 activity results in activation of the Ang II/AT1R axis, contributing to increased progression of heart disease. Increased ACE2 activity leads to activation of ACE2/Ang 1–9 and ACE2/Ang 1–7 axes, leading to protection against heart disease (Figure 1B). In this review, we highlight the role of ACE2/Ang 1–7 in counter-regulation of Ang II actions, different approaches to manipulating ACE2/Ang 1–7 levels, and the potential of enhancing ACE2 action as a therapy for HF.

ACE2: Discovery, Biochemistry, and Regulation

Discovery of ACE2 and Its Differences From ACE

ACE2 or ACE homolog was discovered as a zinc metalloproteinase by 2 different groups in 2000. ACE2 was initially identified from human HF and lymphoma cDNA libraries32,33 and was later shown to serve as a receptor for the severe acute respiratory syndrome coronavirus.34 It was found to possess an apparent signal peptide, a transmembrane domain, and a single metalloproteinase active site containing an HEXXH zinc-binding domain.32,33 ACE2 is a type I transmembrane protein with an extracellular N-terminal domain containing the catalytic site and an intracellular C-terminal tail. Similar to ACE, the catalytic site of ACE2 is exposed (an ectoenzyme) to circulating vasoactive peptides.35 Expression of a soluble truncated form of ACE2 in Chinese hamster ovary cells produced a glycoprotein of 120 kDa that was able to cleave Ang I and II but not bradykinin. Other critical residues typical of the ACE family are conserved in ACE2. Tipnis et al33 discovered that the ACE2 gene contains 18 exons, with several having considerable size similar to the first 17 exons of human ACE. The metalloproteinase catalytic domains of ACE2 and ACE are 42% identical according to the findings of Donoghue et al.35 In spite of such similarity though, unlike ACE, ACE2 does not convert Ang I to Ang II. In fact, ACE2 activity is inhibited by EDTA but is unaffected by ACE inhibitors (ACEi), such as captopril and lisinopril.32,33 Further research revealed a major difference in enzymatic actions of ACE and ACE2. ACE acts a dipeptidyl carboxypeptidase (removing a dipeptide from the C terminus of substrate), whereas ACE2 acts as a monocoxyopeptidase (removing a single amino acid) that degrades Ang I to generate the nonapeptide Ang 1–9 and Ang II to generate the heptapeptide Ang 1–7.32,33 Later studies focused on ACE2 purification and characterization of its catalytic activity, showing a pH optimum of 6.5 and enhancement of ACE2 activity by monovalent anions, including Cl− and F−, but not Br−. This is consistent with the activity of ACE.38 However, ACE2 was later shown to possess one Cl− binding site compared with 2 Cl− sites in ACE.39 Of 126 biological peptides tested with ACE2 using liquid chromatography–mass spectrometry, ACE2 hydrolyzed 3 peptides with high efficiency: Ang II, apelin-13, and dynorphin A 1 to 13. ACE2 also showed a preference for cleaving C-terminal amino acids with peptides ending in Pro-X, where X is a hydrophobic amino acid.38,40 This cleavage preference of ACE2 was supported by a key experiment in which a dipeptide, Pro-Phe, completely inhibited ACE2 activity at 180 μmol/L with Ang II as the substrate.41 In a search for the active site residues of ACE2, site-directed mutagenesis revealed that Arg273 is critical for substrate binding and its replacement causes complete loss of enzyme activity.39

The difference in ACE and ACE2 enzymatic activity became more evident on the discovery that human ACE2 catalytic efficiency is 400-fold higher with Ang II as a substrate than with Ang I.38,42 To further unravel the biological role and importance of ACE2, several ACE2 inhibitors were designed and synthesized via substrate-based43 and structure-based44 pharmacophore design and virtual screening. MLN-4760, a potent and selective inhibitor developed with substrate-based
design, has been a key tool for in vivo and in vitro studies. In the past 15 years, distinct roles of ACE2 have been discovered ranging from catalytic activities with various substrates, functional severe acute respiratory syndrome coronavirus receptor, and an amino acid transporter. ACE2 was initially thought to be expressed only in heart, kidney, and testes, but was eventually found to be widely expressed in various organ systems including the cardiovascular system, kidneys, lungs, and brain, in which it exerts important actions to maintain cardiovascular homeostasis.

**Proteolytic Processing, Transcriptional, and Post-Transcriptional Regulation of ACE2**

Various molecules are shed from cell surfaces by the action of a disintegrin and metalloproteinase (ADAM) 17, also known as tumor necrosis factor-α-converting enzyme. ADAM17-mediated proteolysis of ACE2 releases an enzymatically active ectodomain from the cell surface, generating a soluble, active form of the enzyme. Lambert et al confirmed the ectodomain shedding of heterologously expressed ACE2 in HEK293 cells and endogenously expressed ACE2 in Huh7 cells. Small interfering RNA against ADAM17 reduced the shedding of ACE2 and ADAM17 overexpression increased it, providing direct evidence of ADAM17-mediated ectodomain shedding of ACE2. Lambert et al later discovered that calmodulin, a ubiquitous calcium-binding protein, associates with ACE2 and prevents its shedding, an action inhibited by calmodulin inhibitors. However, increased ACE2 shedding mediated by calmodulin inhibitors was only partially blocked by metalloproteinase inhibitor, suggesting the involvement of alternate proteolytic pathways not yet identified.

The initial observation of ACE2 shedding was further confirmed and shown to be a constitutive and regulated phenomenon in various cell types, including Chinese hamster ovary cells, fibroblasts, 3T3-L1 adipocytes, neurons, cardiomyocytes, and proximal tubular cells. In particular, we identified a positive feedback mechanism in the RAS whereby Ang II facilitates the loss of ACE2 in heart failure.

**Figure 1.** Enzymatic cascade of the renin–angiotensin system (RAS), key receptor systems, and the biological effects mediated by angiotensin II (Ang II) and Ang 1–7. **A.** The RAS cascade showing the angiotensin peptide metabolic pathway. Angiotensinogen, as the starting substrate, is cleaved by renin to Ang I. Ang I is cleaved by angiotensin-converting enzyme (ACE) to Ang II, which is cleaved by ACE2 to Ang 1–7. Ang II acts on AT1 and AT2 receptors. Ang 1–7 acts on Mas receptors and counterbalances the Ang II type 1 receptor (AT1) actions. **B.** Decreased ACE2 shifts the balance in the RAS to the Ang II/AT1 axis, resulting in disease progression. Increased ACE2 (by rhACE2, gene delivery, or ACE2 activators) shifts the balance to the Ang 1–7/Mas axis, leading to protection from disease. APA indicates aminopeptidase A; PCP, prolyl carboxypeptidase; and rhACE2, recombinant human ACE2.
its negative regulator, ACE2. Ang II action on \(AT_R\) leads to phosphorylation (mediated by p38 mitogen-activated protein kinase) and activation of ADAM17, resulting in increased ACE2 shedding (Figure 2).\(^{53,65}\) Shedding of membrane-bound ACE2 is likely responsible for the loss of myocardial ACE2\(^{66,67}\) and elevation in plasma ACE2 activity in HF that correlates with worsened prognosis.\(^{68,69}\) The biological and clinical significance of ACE2 ectodomain shedding is yet to be fully characterized. The inhibition of ectodomain shedding of ACE2 by manipulating the enzyme activity of ADAM17 could have therapeutic potential in HF.

A reporter system using the 3'-untranslated region of an ACE2 transcript was used to determine the functionality of putative microRNA-binding sites identified in vitro. In a luciferase reporter assay containing ACE2 3'-untranslated region, miR-421 strikingly decreased ACE2 protein levels, whereas loss of miR-421 reversed these effects, implying that miR-421 modulates ACE2 expression via post-translational repression rather than degradation of mRNA transcripts. This identified miR-421 as a potential regulator of ACE2 and was the first demonstration of post-transcriptional regulation of ACE2.\(^{70}\) ACE2 mRNA expression is also regulated by sirtuin 1 (SIRT1). Energy stress by hypoxia and adenosine monophosphate kinase activation by 5-amino-4-imidazolecarboxamide riboside increase the cellular ratio of Nicotinamide adenine dinucleotide–oxidized form (NAD+) to nicotinamide adenine dinucleotide–reduced form (NADH) and increase ACE2 expression.\(^{71}\) SIRT1, in the presence of a possible but unknown cofactor, binds to the promoter region of ACE2 and this binding is promoted by 5-amino-4-imidazolecarboxamide riboside. 5-Amino-4-imidazolecarboxamide riboside-induced ACE2 expression is inhibited by an inhibitor of SIRT1, providing strong evidence for the SIRT1-mediated transcriptional regulation of ACE2 under conditions of energy stress (Figure 2).\(^{71}\) Similarly, apelin also increases ACE2 promoter activity in vitro and upregulates ACE2 expression in failing hearts in vivo (Figure 2).\(^{72}\) Therapeutically, agents that increase ACE2 expression (SIRT1 activators and apelin) or inhibitors of negative regulators of ACE2 (tumor necrosis factor-\(\alpha\)–converting enzyme or miR-421) could be utilized to enhance ACE2 activity and counteract cardiovascular diseases, including HF.

**Role of ACE2/Ang 1–7 in HF**

HF is a growing epidemic with high morbidity and mortality at an international scale. Acute and chronic HF are characterized by activation of several signaling pathways associated with pathological hypertrophy and maladaptive ventricular remodeling. HF is caused by damage to or loss of cardiomyocytes and contributes to diminished systolic performance and diastolic dysfunction in the failing heart.\(^{73,74}\) HF involves changes in cardiac structure, myocardial composition, myocyte deformation, and multiple biochemical and molecular alterations, collectively referred to as adverse myocardial remodeling. Despite improvements in medical and surgical therapies, cardiac diseases remain the leading cause of death in North America, with ischemic and hypertensive heart disease as the leading cause of HF.\(^{75–77}\)

Diabetes mellitus and obesity are major causes of morbidity and mortality in all parts of the world, including North America.\(^{78}\) Diabetes mellitus is characterized by insulin insufficiency that is frequently associated with severe cardiovascular complications and increased risk for hypertension, HF; and

![Figure 2. Transcriptional, post-transcriptional, and post-translational regulation of angiotensin-converting enzyme 2 (ACE2).](http://circres.ahajournals.org/)

ACE2 expression is transcriptionally regulated by energy stress and activation of adenosine monophosphate kinase (AMPK) via sirtuin 1 (SIRT1), which binds to the promoter region and facilitates ACE2 mRNA expression. Similarly, apelin binds to the promoter region of ACE2 and enhances its expression. ACE2 mRNA is subject to post-transcriptional regulation by miR-421, which regulates protein expression. Angiotensin II (Ang II), the main effector peptide of the renin–angiotensin system, is produced by ACE and chymase in the heart and other tissues. ACE2, a monooxygenase, degrades Ang II into a heptapeptide, Ang 1–7. Ang II, via its action on Ang II type 1 receptor (AT\(_R\)), promotes nicotinamide adenine dinucleotide phosphate oxidase 2 (Nox2)–dependent reactive oxygen species (ROS) formation. This leads to phosphorylation and activation of p38 mitogen-activated protein kinase (MAPK) and ultimately results in TACE phosphorylation (Thr735) and activation. Activated tumor necrosis factor-\(\alpha\)–converting enzyme (TACE) proteolytically cleaves ACE2 and releases the active ACE2 ectodomain. AICAR indicates 5-amino-4-imidazolecarboxamide riboside; MasR, Mas receptor; and PKC, protein kinase C.
myocardial infarction (MI). Obesity itself is an independent risk factor for development of HF with preserved ejection fraction (HF-pEF), independent of other comorbid conditions. The rising global tide of obesity and diabetes mellitus will likely contribute further to the increasing prevalence of systolic and diastolic HF. Although the mechanisms underlying the intertwined relationship among diabetes mellitus, obesity, hypertension, and cardiovascular events remain to be fully defined, major culprits that have been implicated are cardiovascular inflammation, oxidative stress, mitochondrial dysfunction, and insulin resistance, all closely linked with abnormalities in the RAS.

Neurohormonal changes such as activation of the RAS and increased Ang II levels play a pivotal role in adverse myocardial remodeling and progression to HF. Indeed, pharmacological antagonism of the RAS using ACEi or AT1R blockers is a cornerstone of current medical therapy for human HF, including diabetic cardiomyopathy. Although these pharmacotherapies for HF provide benefits, patients with HF continue to be plagued by clinical deterioration, high morbidity and mortality. Irrespective of the capacity of ACEi to inhibit ACE action, Ang II levels can remain elevated in optimally treated patients with HF. About 50% of the patients using ongoing ACEi therapy exhibit elevated levels of Ang II, the result of activation of mast cell chymase. Therefore, there is an urgent need to identify alternative strategies to minimize the detrimental effects of Ang II and treat HF.

ACE2, by virtue of its action on Ang I and Ang II, is nature’s endogenous ACEi at the cellular level (Figure 3). Ang–9, the product of ACE2 degradation of Ang I, has recently shown promising antihypertrophic, antiinflammatory, and antihypertensive effects. These beneficial effects result in cardioprotection against hypertension and MI. Adenoviral delivery of Ang 1–9 in H9c2 cardiomyocytes has shown antihypertrophic effects comparable with adenoviral Ang 1–7 delivery. Moreover, RhoA/Rho kinase inhibition has shown potent antihypertensive effects that were mediated via the upregulation of vascular and plasma ACE2 and increased plasma Ang 1–9 levels, without an increase in Ang 1–7 levels. This suggests a potential role for Ang 1–9 in the antihypertensive effects of RhoA/Rho-kinase inhibition.

Both Ang I and Ang II can function as the preferred substrate for ACE2. Studies using recombinant human ACE2 (rhACE2) and ACE2 purified from sheep tissues showed Ang II as a preferred substrate for ACE2. In sheep, conversion from Ang I to Ang 1–9 was not detected while the proximal tubules contained robust ACE2 activity that converted Ang II to Ang 1–7. In contrast, changes in ACE2 correlated with plasma Ang 1–9 levels in rats. In a recent study, Ye et al demonstrated that rhACE2 generated Ang 1–7 and Ang 1–9, whereas recombinant murine ACE2 generated predominantly Ang 1–7. In addition, the therapeutically beneficial effects of rhACE2 are highly dependent on Ang 1–7 action in rodents and in human studies, rhACE2 clearly lowered plasma Ang II levels resulting in increased plasma Ang 1–7 levels. However, it remains possible that the contribution of Ang 1–9 in ACE2’s beneficial effects may be underestimated and requires further investigation with a clear emphasis on human studies.

Ang 1–7 activates MasR and exert various effects, the majority of which antagonize Ang II’s effects. These effects include (1) activation of the phosphatidylinositol 3-kinase–Akt–endothelial nitric oxide synthase pathway, (2) inhibition of protein kinase C–p38 mitogen-activated protein kinase pathways, and (3) inhibition of collagen expression to limit cardiac fibrosis (Figure 3). To understand the relative contributions of inhibiting the Ang II/AT1R axis and activating the Ang 1–7/MasR axis to cardioprotective effects, we studied the effects of irbesartan and Ang 1–7 supplementation in pressure-overload–induced HF in ACE2 knockout mice. We found functional redundancy in the antifibrotic and antihypertrophic effects and suppression of pathological signaling. The cardioprotective effects of irbesartan and Ang 1–7 were equivalent, suggesting similar significance of both axes.

Role of ACE2/Ang 1–7 in Hypertension

Activated RAS and Ang II are established key mediators of hypertension; therefore, ACE2 is hypothesized to be a potential modulator of blood pressure and its deficiency leads to hypertension. In a preclinical model of hypertension, ACE2 gene maps to a defined quantitative trait locus on the X-chromosome previously identified as a quantitative locus for blood pressure. Recent studies suggest an association between ACE2 activity and blood pressure levels. Serum ACE2 activity was higher in patients with hypertension compared with healthy individuals. In hypertensive patients with type 1 diabetes mellitus, serum ACE2 activity was positively correlated with systolic blood pressure in both males and females. These studies suggest that elevated ACE2 may be a compensatory response to the hypertension. Indeed, the antihypertensive role of ACE2 has also been established in various preclinical models of hypertension. Lentiviral overexpression of ACE2 results in increased expression of antihypertensive components of RAS (Ang 1–7, MasR, and AT1R), attenuating the elevated blood pressure. Similarly, rhACE2 pretreatment alleviated hypertension induced by acute Ang II infusion and was associated with decreased plasma Ang II and increased plasma Ang 1–7 levels. Cyclohexatin-encapsulated Ang 1–7, AVE0091, and GEN856S (MasR agonists) have shown blood pressure–lowering effects in hypertensive animals. The antihypertensive effects of ACE2/Ang 1–7 generated interest in potential cardioprotective effects against hypertensive heart diseases, a group of disorders that includes HF, ischemic heart disease, hypertensive heart disease, and left ventricular hypertrophy.

Role of ACE2/Ang 1–7 in HF With Reduced Ejection Fraction

ACE2 plays a critical role in the control of cardiac physiology, and altered ACE2 expression or activity is linked to the progression of heart disease (Figure 1B). In heart, ACE2 is expressed in various cells including the cardiomyocytes, cardiac fibroblasts, and coronary endothelial cells, where it negates Ang II actions and also activates Ang 1–7/MasR signaling (Figure 3). ACE2 expression is highly affected by pathological disease conditions, suggesting its role in counterregulating the development of cardiac diseases. In the human
population, genetic variations in the ACE2 gene correlate with susceptibility to cardiovascular disease. Single-nucleotide polymorphisms of ACE2 are associated with variation in septal wall thickness, ventricular hypertrophy, and coronary artery disease.

The first report on the role of ACE2 as an essential regulator of cardiac function came soon after its discovery. In that study, ACE2 knockout mice showed reduced systolic function. The decrease in systolic function was both sex and time dependent, with more severe abnormalities in male than in female mice, and a more pronounced phenotype in older animals. ACE2 knockout mice also showed increased Ang II levels, which were rescued with genetic ablation of ACE. Consistently, we found age-dependent dilated cardiomyopathy in ACE2 knockout mice. This resulted in reduced systolic function along with increased cardiac inflammation and oxidative stress. Myocardial ACE2 protein levels were decreased in pressure-overload–induced HF, suggesting an inverse relationship between myocardial ACE2 protein levels and disease progression. In addition, loss of ACE2 resulted in worsened pathological remodeling in response to pressure-overload–induced biomechanical stress. This was associated with systolic dysfunction and ventricular dilation. Both were deemed because of activation of the myocardial NADPH oxidase system, superoxide production, and matrix metalloproteinase activation, which was attributed to increased local Ang II levels (Figure 3; Table). Post-MI remodeling and coronary artery disease is one of the most common causes of HF. MI increased ACE2 mRNA expression in humans, mice, and rats, whereas loss of ACE2 or inhibition of ACE2 by...
C16, resulted in worsening of MI-induced cardiac dysfunction, increased infarct size, matrix metalloproteinase activation, cardiac extracellular matrix disruption, and inflammation (Table).123,124 Lentiviral125,126 or adenoviral127 overexpression of ACE2 ameliorated MI-induced cardiac remodeling. In addition, lentiviral infection of cultured fibroblasts decreased the acute hypoxic exposure–induced production of collagen.128 Importantly, Ang 1–7 treatment has shown noticeable cardioprotective effects in preclinical models of nonischemic and ischemic cardiomyopathy.15,21,126,129 Ang 1–7 suppressed cardiomyocyte growth in vitro and inhibited MI–induced ventricular hypertrophy in vivo. Ang 1–7 also decreased myocardial levels of proinflammatory cytokines (tumor necrosis factor-α and interleukin-6), leading to alleviation of cardiac inflammation.21,126 These results confirm the important contribution of Ang 1–7 in the cardioprotective effects of ACE2 (Figure 4).

**Role of ACE2/Ang 1–7 in HF-pEF**

HF-pEF, also termed diastolic HF, is often associated with a normal or smaller heart size and diastolic filling abnormalities.

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ACE2KO indicates angiotensin-converting enzyme 2 knockout; Ang II, angiotensin II; CTGF, connective tissue growth factor; DIZE, diminazene aceturate; ERK1/2, extracellular signal–regulated kinase 1/2; FKN, fractalkine; HF-rEF, heart failure with reduced ejection fraction; HF-pEF, heart failure with preserved ejection fraction; LAD, left anterior descending; LV, left ventricle; MI, myocardial infarction; rhACE2, recombinant human ACE2; ROS, reactive oxygen species; and SHR, spontaneously hypertensive rats.
It accounts for ≥30% of all patients with HF, with a similar mortality rate to patients with HF with reduced ejection fraction. Ang II–induced diastolic dysfunction is a clinically relevant, widely accepted preclinical model of HF-pEF. We and others found that loss of ACE2 resulted in worsened cardiac dysfunction, cardiac hypertrophy, and fibrosis, leading to greater diastolic dysfunction in response to Ang II (Table). Importantly, treatment with rhACE2 decreased plasma and myocardial Ang II levels and increased plasma Ang 1–7 levels, providing definitive evidence for a key role of ACE2 in the metabolism of Ang II. Furthermore, rhACE2 attenuated pathological changes mediated by Ang II, reducing myocardial hypertrophy and fibrosis and correcting diastolic dysfunction. However, treatment with rhACE2 did not affect baseline plasma Ang II, Ang 1–7, or blood pressure in wild-type mice. This suggests that substrate availability is a limiting factor in ACE2 enzymatic activity. The pursuit of molecular mechanisms for these actions identified rhACE2’s capacity to inhibit the Ang II effects on transforming growth factor-β1 activation and collagen production. Loss of ACE2 also resulted in increased production of reactive oxygen species via nicotinamide adenine dinucleotide phosphate oxidase 2 activation, which is also supressible by rhACE2. Lentiviral overexpression of ACE2 protects the heart against myocardial injuries induced by Ang II in rats, confirming the role of ACE2 in counteracting HF-pEF. We assessed the contribution of Ang 1–7/MasR activation to the favorable effects shown by rhACE2 in the Ang II–induced murine HF model; inhibition of Ang 1–7/MasR signaling resulted in loss of rhACE2-mediated cardioprotective effects. However, this observation does not rule out the potential contribution of Ang 1–9 to the protective effects of rhACE2. An appropriate preclinical study is required to assess the relative contributions of Ang 1–9 and Ang 1–7. ACE2 is an endogenous regulator of activated RAS-induced HF-pEF and enhancing ACE2 has a marked beneficial effect.

Role of ACE2/Ang 1–7 in Diabetes Mellitus and Obesity-Associated Cardiomyopathy

Diabetes mellitus and obesity are major causes of morbidity and mortality in all parts of the world, including Canada. Studies of the ACE2/Ang 1–7 axis in diabetes mellitus and obesity-associated cardiac dysfunction have shed light on the critical role of this pathway in counter-regulation of the Ang II/Ang II interaction and mortality in patients with HF. Ang II levels can remain elevated in optimally treated patients with HF; ≥50% of patients using ongoing ACEi therapy exhibit elevated levels of Ang II. The generation of plasma Ang II by non–ACE-related enzymes such as chymase suggests that enhancing ACE2 action may indeed have a unique therapeutic role in diabetes mellitus. The role of ACE2 in diabetic cardiovascular complications has been studied in various preclinical models of diabetes mellitus. Tools such as ACE2 knockout mice, adeno viral ACE2 gene transfer, and rhACE2 activators and inhibitors, Ang 1–7 supplementation, Ang 1–7/MasR receptor blockade have been utilized to assess the role of ACE2/Ang 1–7 in diabetic cardiovascular complications.

We studied the role of ACE2 in preventing progression of type 1 diabetic cardiovascular complications using a clinically relevant animal model of diabetes mellitus, the Akita mouse. Akita type 1 diabetic hearts show diastolic dysfunction associated with reduced levels of the cardiac SERCA2a and increased myocardial lipotoxicity. Loss of ACE2 in these hearts, in Akita/ACE2 knockout double mutants, resulted in systolic dysfunction. Akita/ACE2 knockout hearts exhibited increased nicotinamide adenine dinucleotide phosphate oxidase activity, reactive oxygen species production, and protein kinase C and matrix metalloproteinase activation, leading to increased degradation of the cardiac extracellular matrix. This study demonstrated a key role for ACE2 as a negative regulator of activated RAS in diabetic cardiomyopathy. Further studies have validated our findings for this essential role of ACE2 in diabetic cardiomyopathy.

Obesity is characterized by excessive fat accumulation in adipose tissues throughout the body and is the most common nutritional disorder in industrialized countries. Obesity is associated with increased morbidity and mortality and is a risk factor for development of HF-pEF, independent of other comorbid conditions. We studied the role of ACE2 in obesity induced by high-fat diet and associated cardiac dysfunction. Loss of ACE2 was associated with worsened obesity-associated HF-pEF because of increased epicardial adipose tissue inflammation, myocardial lipotoxicity, and cardiac metabolic abnormalities (Table). These findings coupled with the protective effects of ACE2/Ang 1–7 in the vasculature support a key role of adipose tissue inflammation and microvascular dysfunction in the pathogenesis of HF-pEF. Importantly, Ang 1–7 prevented these changes and rescued HF-pEF in ACE2 knockout mice, validating its critical role in ACE2-mediated cardioprotection (Figure 4). As such, enhancing the ACE2/Ang 1–7 pathways represents a potential therapy for HF-pEF, which currently lacks effective therapies.

Therapeutic Approaches and Potential of Enhancing ACE2/Ang 1–7 in HF

Irrespective of the capacity of ACEi to inhibit ACE action, Ang II levels can remain elevated in optimally treated patients with HF; ≥50% of patients using ongoing ACEi therapy exhibit elevated levels of Ang II. The generation of plasma and tissue Ang II by non–ACE-related enzymes such as chymase suggests that enhancing ACE2 action may indeed have a unique therapeutic role. In fact, ACEi and AT-R blocker have been shown to upregulate the expression of ACE2 or prevent the loss of ACE2, ADAM17-mediated ACE2 shedding represents a mechanism by which Ang II induces a positive feedback mechanism in the tissue-localized RAS, leading to its dysregulation. This results in the neurohormonal imbalance that is typical of HF. Inhibiting tumor necrosis factor-α-converting enzyme–mediated shedding of ACE2 from the surface of cardiac cells, leading to retention of ACE2 enzymatic activity within the cardiac microenvironment, might have therapeutic potential. ACE2 is post-transcriptionally regulated by miR-421, inhibition of which may result in...
increased ACE2 expression. Because ACE2 is also subject to transcriptional regulation by SIRT1 and apelin, SIRT1 activators or apelin may have therapeutic benefits by enhancing the actions of ACE2.

A well-studied tool to enhance ACE2 action is rhACE2. A randomized, double-blinded, placebo-controlled study administered intravenous rhACE2 to healthy human subjects and found that the rhACE2 was well tolerated. Despite marked changes in angiotensin system peptide concentrations, hypotension was absent, suggesting the presence of effective compensatory mechanisms in healthy volunteers.106 rhACE2 is primarily responsible for the conversion of Ang II into Ang 1–7 but can also convert Ang 1–10 into Ang 1–9.154 In healthy human volunteers treated with rhACE2, Ang II levels were reduced but Ang 1–7 levels were increased or remained unchanged.104,106 Importantly, in a recently completed phase II trial in patients with acute lung injury, rhACE2 resulted in sustained reduction in plasma Ang II levels and elevation in Ang 1–7 levels.108 We propose that assessment of plasma RAS peptide levels can allow the tailoring of rhACE2 therapy for human HF. rhACE2 provided beneficial effects against Ang II–induced HF-pEF and pressure-overload–induced HF with reduced ejection fraction in murine models of HF (Table).67

Thus, using rhACE2 as a therapy is a viable option, and the advancement of rhACE2 in clinical trials provides the translational impact of rhACE2 findings in murine models.109,109 Several ACE2 activators and Ang 1–7/MasR agonists have been developed. In addition, novel approaches, including oral ACE2 and Ang 1–7 biencapsulated in plant cells, have been designed and used in preclinical studies, showing promising cardioprotective effects.131,155,158 Finally, gene therapy of ACE2/Ang 1–7.

Figure 4. Central role of the angiotensin-converting enzyme 2 (ACE2)/Ang 1–7 axis in heart failure: nonischemic cardiomyopathy, myocardial infarction (MI), diabetic cardiomyopathy, and obesity-associated cardiac dysfunction. Angiotensin II (Ang II)/Ang II type 1 receptor is critically involved in the disease progression leading to nonischemic, ischemic, and diabetic cardiomyopathy and to obesity-associated cardiac dysfunction. By converting Ang II to Ang 1–7, ACE2 shifts the balance to the cardioprotective ACE2/Ang 1–7/Mas receptor axis. EAT indicates epicardial adipose tissue; eNOS, endothelial nitric oxide synthase; MAPK, mitogen-activated protein kinase; MMP, matrix metalloproteinase; PKC, protein kinase C; and ROS, reactive oxygen species.

Conclusions

ACE2 has emerged as the dominant mechanism for negative regulation of the RAS, by metabolizing Ang II into the beneficial peptide Ang 1–7. This important biochemical and physiological property is being harnessed as potential therapy for HF. Since the discovery of ACE2 in 2000, tremendous progress has been made in elucidating its biochemical actions and its key role in heart disease and HF. ACE2 is widely expressed and regulates the fundamental cellular biology of cardiomyocytes, cardiofibroblasts, and coronary endothelial cells in both HF with reduced ejection fraction and HF-pEF models. Ang 1–7 has also emerged in HF models as a physiologically active peptide with protective effects. Enhancing Ang 1–7 action may also provide marked therapeutic effects in HF. Clinical and experimental studies clearly support a physiological and pathophysiological role for ACE2/Ang 1–7 in HF, and studies indicate that increasing/activating ACE2/Ang 1–7 results in beneficial effects to prevent heart disease and HF. Further experimental studies are required that combine rhACE2/ACE2 activators with RAS blockers (such as ACEi or AT1R blockers) to determine if this combined approach offers additional benefits.

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Disclosures

None.

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