Research Article
PGC-1α Induction in Pulmonary Arterial Hypertension

Manuel Mata,1, 2 Irene Sarrion,1 Lara Milian,3 Gustavo Juan,3, 4 Mercedes Ramon,4 Dolores Naufal,5 Juan Gil,6 F. Ridocci,4 O. Fabregat-Andrés,4 and Julio Cortijo1, 2, 3

1 Department of Molecular Medicine, Research Foundation of the University General Hospital of Valencia, 46014 Valencia, Spain
2 Centro de Investigación Biomédica en Red (CIBER) de Enfermedades Respiratorias, 46014 Valencia, Spain
3 Department of Pharmacology, University of Valencia, 46010 Valencia, Spain
4 Division of Pneumology, University General Hospital of Valencia, 46014 Valencia, Spain
5 Division of Pneumology, University General Hospital of La Fè, 46026 Valencia, Spain
6 Division of Pneumology, University General Hospital of Alicante, 03010 Alicante, Spain

Correspondence should be addressed to Manuel Mata, mata_manroi@gva.es

Received 4 May 2012; Revised 13 June 2012; Accepted 10 July 2012

Academic Editor: Remi Mounier

Copyright © 2012 Manuel Mata et al. This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Idiopathic Pulmonary arterial hypertension (IPAH) is characterized by the obstructive remodelling of pulmonary arteries, and a progressive elevation in pulmonary arterial pressure (PAP) with subsequent right-sided heart failure and death [1]. There are five categories in which pulmonary hypertension (PH) diseases can be grouped according to specific therapeutic interventions directed at dealing with the cause of (1) PAH, (2) pulmonary hypertension with left heart disease, (3) PH associated with disorders of the respiratory system or hypoxemia, (4) PH caused by thrombotic or embolic diseases, and (5) PH caused by multifactorial mechanisms [2]. Idiopathic PAH (IPAH) is included in group 1 and within patients with a mean pulmonary artery pressure (PAPm) ≥25 mmHg, and a pulmonary capillary wedge pressure (PCWP), left atrial pressure, or left ventricular end-diastolic pressure ≤15 mmHg, and a pulmonary vascular resistance greater than three Wood units [3]. Remodelling of pulmonary arteries leads to an increase of pulmonary vascular resistance (PVR) which produces right ventricular (RV) overload, hypertrophy and dilatation, and eventually RV failure and death [4]. These changes are due to an inadequate adaptation of myocardial contractility [5].

Although physiopathology of IPAH remains under investigation, the role of radical oxygen-mediated events, including myocardial ischemia, seems clear [6]. During the progression of PAH, there is a progressive hypoxia situation originated as a consequence of an increase in the demand of oxygen by hypertrophied cardiomyocytes, as well as a reduction in the capillary density [7, 8]. This hypoxia situation leads to an imbalance in oxidative/antioxidative status with...
The main objective of this study is to analyze the expression levels of PGC-1α in 12 IPAH-diagnosed patients and in 15 healthy volunteers. These levels are correlated with the progression of the disease, with cytochrome c (CYTC) and superoxide dismutase (SOD) mRNA levels and with total antioxidant status (TAS) and glutathione peroxidase (GPX) activity.

2. Materials and Methods

2.1. Patients. In this study 12 IPAH-diagnosed patients were compared with 15 healthy volunteers. Inclusion criteria for the 12 diagnosed patients included an mPAP > 25 mmHg, a PWP less or equal to 15 mmHg and a PVR > 3 Wood units measured by catheterization. Clinical features of patients included in this study are summarized in Table 1. All patients received different combinations of bosentan, treprostinil, nifedipine, and iloprost before sample collection. Healthy volunteers were paired in age with patients (51.34 ± 8.28 and 56.5 ± 3.23 years old, resp.).

All experiments were approved by the local ethics committee and informed consent was obtained. On the one hand 2.5 mL of peripheral blood were collected in PAX gene RNA collection tubes (Qiagen, Valencia, CA, USA) and stored at −80°C until its analysis, as recommended by the manufacturer. On the other hand, 4 mL of peripheral blood was collected in EDTA vacutainers (Becton Dickinson, NJ, USA). Plasma was isolated by centrifugation (15 minutes at 2500 rpm) and stored at −80°C in 50 µL aliquots.

2.2. Determination of PGC-1α, CYTC, and SOD mRNA Expression. Total RNA was extracted from peripheral blood stored in PAX gene collection tubes using the PAXgene blood RNA kit (Quiagen, Valencia, CA, USA), according to manufacturer instructions. RNA concentration was determined by spectrophotometry using the Nanodrop 200 spectrophotometer (Fischer Scientific, Madrid, Spain) at 260 nm. Only extractions with a ratio 260/280 nm > 1.4 were considered in this study. RNA integrity was evaluated by electrophoresis using the Bioanalyzer (Agilent technologies, Santa Clara CA, USA). Only those extractions with an RIN near 10 were used for gene expression studies.

cDNA was synthesized using the TaqMan RT reagents (Applied Biosystems, Foster City, CA, USA) following manufacturer's instructions. Reactions were 1/2 diluted and preamplification was carried out using the TaqMan preamp master mix (Applied Biosystems, Foster City, CA, USA) according to the supplier instructions. Assays on demand against PGC-1α, CYTC, SOD, and GAPDH were purchased from Applied Biosystems and gene expression was carried out in a 7900HT real-time thermocycler (Applied Biosystems, Foster City, CA, USA). The comparative ΔCt method was used to calculate relative expression levels of the genes included [23].

2.3. Determination of Total Antioxidant Status (TAS). TAS was determined in plasma samples using the Total Antioxidant Assay kit (Cayman Chemical Company, Ann Arbor, MI, USA) following the manufacturer’s instructions. This assay relies on the ability of antioxidants in the sample to inhibit the oxidation of ABTS (2,2′-azino-di-[3-ethylbenzthiazoline sulfonate]) to ABTS+ by metmyoglobin. Capacity of antioxidants in the sample to prevent ABTS oxidation is compared with that of Trolox, a water-soluble tocopherol analog. Results are expressed as mM Trolox equivalents.

2.4. Analysis of Glutathione Peroxidase (GPX) Activity. GPX activity was estimated in plasma samples using the GPX assay kit (Cayman Chemical Company, Ann Arbor, MI, USA), according to supplier instructions. Plasma samples were 1/2 diluted in sample buffer (provided with the kit) and the GPX activity was evaluated calculating the change in absorbance at 340 nm (ΔA340 nm/min) as it is described in the user’s manual included in the kit. Results are presented as nmol/min/mL.

2.5. Data Analysis. Data are presented as the mean ± SEM. Statistical analysis of the results was carried out by nonparametric Mann-Whitney test and nonparametric Spearman correlation analysis using the GraphPad software (GraphPad Software Inc., San Diego, CA). Significance was accepted when P < 0.05.
| ID | Age (years) | Sex | PaO₂ (mmHg) | 6MWT (m) | PAP (mmHg) | CI (L/min/m²) | PVR (dyn/sec/cm²) | VR | PGC-1α RE | CYTC RE | SOD RE | TAS (mM) | GPX (nmol/min/mL) | Treatment |
|----|-------------|-----|-------------|----------|------------|---------------|-----------------|----|------------|----------|--------|----------|----------------|-------------|-----------|
| HP1| 45          | F   | 67          | 595      | 48         | 1.3           | 12.4            | No | 2.87       | 2.45     | 4.12    | 0.21     | 70.23          | e + b       |
| HP2| 75          | M   | 62          | 255      | 70         | 1.8           | 11              | No  | 0.34       | 0.42     | 0.24    | 0.05     | 23.76          | a + s + i   |
| HP3| 34          | F   | 85          | 554      | 35         | 2.8           | 6.2             | YES | 67.00      | 38.50    | 7.45    | 0.28     | 119.05         | n           |
| HP4| 58          | F   | 70          | 380      | 48         | 2.2           | 12              | No  | 6.07       | 5.47     | 2.29    | 0.19     | 67.89          | b + t       |
| HP5| 38          | F   | 83          | 450      | 38         | 3.24          | 6.1             | YES | 8.96       | 6.95     | 26.77   | 0.15     | 91.27          | n           |
| HP6| 53          | F   | 68          | 360      | 40         | 2.1           | 8.5             | No  | 3.22       | 2.59     | 4.64    | 0.25     | 85.91          | i + b + s   |
| HP7| 64          | M   | 60          | 240      | 53         | 2.3           | 7.7             | No  | 0.34       | 0.48     | 0.14    | 0.04     | 20.22          | b + s + t   |
| HP8| 66          | M   | 57          | 334      | 50         | 1.8           | 8.6             | No  | 1.41       | 1.01     | 0.13    | 0.11     | 45.42          | s + i + b   |
| HP9| 60          | F   | 58          | 120      | 49         | 1.1           | 18.9            | No  | 0.34       | 0.08     | 0.13    | 0.02     | 24.26          | s + i + b   |
| HP10| 55         | F   | 63          | 320      | 31         | 2.5           | 7.5             | YES | 7.76       | 8.34     | 3.47    | 0.22     | 90.85          | b + s       |
| HP11| 48         | F   | 62          | 534      | 59         | 1.4           | 13.6            | No  | 0.33       | 0.36     | 0.17    | 0.06     | 19.21          | e + s + b   |
| HP12| 72         | F   | 60          | 280      | 65         | 2.2           | 12.5            | No  | 0.22       | 0.21     | 0.50    | 0.01     | 14.34          | i + b       |

**PaO₂**: partial pressure of oxygen in arterial blood, 6MWT: 6-minute walk test, PAP: pulmonary arterial pressure, CI: cardiac index, PVR: pulmonary vascular resistance, VR: vasoreactivity, PGC-1α: peroxisome proliferator-activated receptor gamma coactivator 1-α, RE: relative mRNA expression, CYTC: cytochrome c, SOD: superoxide dismutase, TAS: total antioxidant status, GPX: glutathione peroxidase, e: epoprostenol, s: sildenafil, i: iloprost, b: bosentan, t: treprostinil, and n: nifedipine.
3. Results

3.1. PGC-1α CYTC Are Expressed in PAH Blood Samples. Our first objective in this study was to evaluate if the expression levels of PGC-1α and CYTC mRNA were differentially expressed in blood of PAH-diagnosed patients compared to healthy volunteers. Gene expression analysis was undertaken and results indicated that neither of the genes were expressed in healthy donors, contrary to what happened in PAH patients, in which the expression levels of both genes were clearly detected. In order to obtain comparative data, the average ΔCt of PAH group was calculated and expression levels of each patient were estimated. Results are represented in Table 1.

3.2. Superoxide Dismutase (SOD) Expression Is Reduced in PAH Patients. SOD expression levels were measured in PAH patients. Our results indicate that the expression of this enzyme is lower in PAH patients compared to healthy donors (1.01 ± 0.61- and 3.93 ± 0.89-fold change, resp.) as it is represented in Figure 1(a). Next we calculated the relative expression of this gene in a similar way to PGC-1α and CYTC in order to correlate its expression levels with indicators of progression of the diseases. The results obtained are shown in Table 1.

3.3. Total Antioxidant Status Is Reduced in PAH Patients. Hypoxia is one of the most important factors affecting PAH patients. Due to the relevance of PGC-1α induction in the responsiveness against the oxidant injury, we decided to analyze the TAS in PAH patients included in this study. On one hand, we found that TAS is lower in PAH patients compared to healthy donors (0.13 ± 0.027 and 0.484 ± 0.048 mM, resp.), as it is shown in Figure 1(b). On the other hand, we found a clear correlation of TAS levels and the relative expression levels of PGC-1α as described in point 3.5. TAS levels of PAH patients are summarized in Table 1.

3.4. PAH Patients Activity of Glutathione Peroxidase (GPX) Is Decreased. The activity of GPX enzyme in plasma samples of PAH patients and healthy donors was done. Results obtained are represented in Figure 1(c) and clearly demonstrate that the activity of this enzyme is reduced in PAH patients.

Figure 1: Oxidative status of idiopathic pulmonary hypertension patients (IPAH). Relative expression of SOD (a), TAS (b), and glutathione peroxidase (GPX) activity were evaluated in peripheral blood from 12 IPAH patients and 15 healthy donors. The nonparametric Mann-Whitney test was used to analyze data. Significance was accepted when $P < 0.05$. 

|  | Healthy PAH | PAH | $P < 0.001$ | $P < 0.001$ | $P < 0.001$ |
|----------------|-----------|-----|-------------|-------------|-------------|
| Relative expression of SOD mRNA | $1.01 ± 0.61$ | $3.93 ± 0.89$ | | | |
| Total antioxidant status | $0.13 ± 0.027$ | $0.484 ± 0.048$ | | | |
| GPX activity | $100$ | $200$ | | | |

Table 1: Oxidative status of idiopathic pulmonary hypertension patients (IPAH). Relative expression of SOD (a), TAS (b), and glutathione peroxidase (GPX) activity were evaluated in peripheral blood from 12 IPAH patients and 15 healthy donors. The nonparametric Mann-Whitney test was used to analyze data. Significance was accepted when $P < 0.05$. 

(a) SOD mRNA 

(b) Total antioxidant status 

(c) GPX activity
compared to healthy volunteers (56.034 ± 10.37 and 165.46 ± 11.38 nM/min/mL, resp.). GPX activity is summarized in Table 1.

3.5. Multiple Regression Analysis of Clinical, Molecular, and Biochemical Features of IPAH Patients. Finally, multiple-regression analysis of clinical, molecular, and biochemical data was done using the nonparametric Spearman test. The correlation matrix is shown in Table 2. Concerning PGC-1α, results are summarized in Figure 2. We found a negative correlation between age, PAP, and PVR (Figures 2(a), 2(b), and 2(d)). This correlation was significant for PAP and PVR ($P = 0.0001$ and $P = 0.0426$, resp.) but not for the age ($P = 0.108$). On the contrary, the correlation was positive for CI, PaO2, CYTC and SOD relative expression, TAS, and GPX activity (Figures 2(c), 2(e), 2(f), 2(g), 2(h), and 2(i)). In all cases the change was considered significant. No correlation was found between PGC-1α levels and 6 MWT, which was only significantly correlated with age of the patients.

4. Discussion

In this study we analyzed the expression levels of PGC-1α, CYTC and SOD mRNA as well as TAS and GPX activity in peripheral blood of 12 well-characterized IPAH-diagnosed patients and 15 healthy donors. Our results demonstrate that mRNA of PGC-1α and CYTC can be detected by real time RT-PCR in PAH patients, but not in healthy volunteers. On the other hand, relative expression levels of SOD are decreased in these patients, compared to controls, as well as TAS and GPX activity. Correlation studies carried out indicate that there is a clear correlation between PGC-1α levels and the clinical parameters included in this study, indicating the progression of the disease and the oxidative...
Table 2: Multiple-regression analysis of clinical, molecular, and biochemical features of IPAH patients.

| PGC-1α | 6 MWT | Age | PAP | CI | PVR | CYTC | SOD | TAS | GPX | PaO2 | P values | Correlation coefficients |
|--------|-------|-----|-----|----|-----|------|-----|-----|-----|------|----------|-------------------------|
| 0.13585 | 0.03470 | 0.0041 | 0.04289 | 0.00625 | 0.00012 | 0.00277 | 0.00206 | 0.00010 | 0.00618 | 0.43663 | -0.61973 | -0.87326 | 0.36634 | -0.75354 | 0.92960 | 0.78171 | 0.79579 | 0.95073 | 0.73852 |
| 0.15585 | 0.00451 | 0.07089 | 0.35841 | 0.31914 | 0.03581 | 0.04786 | 0.03317 | 0.01683 | 0.01097 | 0.00625 | 0.55674 | -0.75524 | -0.53846 | -0.12281 | -0.18881 | 0.55245 | 0.46853 | 0.67832 | 0.50350 | 0.69123 |
| 0.00041 | 0.07089 | 0.04786 | 0.00791 | 0.00824 | 0.00000 | 0.00012 | 0.00010 | 0.00010 | 0.00618 | 0.00625 | 0.00451 | 0.07089 | 0.35841 | 0.31914 | 0.03581 | 0.04786 | 0.03317 | 0.01683 | 0.01097 |
| 0.04289 | 0.70377 | 0.35841 | 0.00791 | 0.00000 | 0.00012 | 0.00010 | 0.00010 | 0.00010 | 0.00618 | 0.00625 | 0.00451 | 0.07089 | 0.35841 | 0.31914 | 0.03581 | 0.04786 | 0.03317 | 0.01683 | 0.01097 |
| 0.00625 | 0.55674 | 0.31914 | 0.00791 | 0.00000 | 0.00012 | 0.00010 | 0.00010 | 0.00010 | 0.00618 | 0.00625 | 0.00451 | 0.07089 | 0.35841 | 0.31914 | 0.03581 | 0.04786 | 0.03317 | 0.01683 | 0.01097 |
| 0.00012 | 0.06251 | 0.03581 | 0.00000 | 0.00000 | 0.00012 | 0.00010 | 0.00010 | 0.00010 | 0.00618 | 0.00625 | 0.00451 | 0.07089 | 0.35841 | 0.31914 | 0.03581 | 0.04786 | 0.03317 | 0.01683 | 0.01097 |
| 0.00277 | 0.12445 | 0.04786 | 0.00000 | 0.00000 | 0.00012 | 0.00010 | 0.00010 | 0.00010 | 0.00618 | 0.00625 | 0.00451 | 0.07089 | 0.35841 | 0.31914 | 0.03581 | 0.04786 | 0.03317 | 0.01683 | 0.01097 |
| 0.00020 | 0.01532 | 0.03581 | 0.00000 | 0.00000 | 0.00012 | 0.00010 | 0.00010 | 0.00010 | 0.00618 | 0.00625 | 0.00451 | 0.07089 | 0.35841 | 0.31914 | 0.03581 | 0.04786 | 0.03317 | 0.01683 | 0.01097 |
| 0.00010 | 0.09516 | 0.01683 | 0.00000 | 0.00000 | 0.00012 | 0.00010 | 0.00010 | 0.00010 | 0.00618 | 0.00625 | 0.00451 | 0.07089 | 0.35841 | 0.31914 | 0.03581 | 0.04786 | 0.03317 | 0.01683 | 0.01097 |
| 0.00618 | 0.01279 | 0.01097 | 0.00000 | 0.00000 | 0.00012 | 0.00010 | 0.00010 | 0.00010 | 0.00618 | 0.00625 | 0.00451 | 0.07089 | 0.35841 | 0.31914 | 0.03581 | 0.04786 | 0.03317 | 0.01683 | 0.01097 |

6 MWT: 6-minute walk test, PAP: pulmonary arterial pressure, CI: cardiac index, PVR: pulmonary vascular resistance, CYTC: cytochrome c, SOD: superoxide dismutase, TAS: total antioxidant status, GPX: glutathione peroxidase, PaO2: partial pressure of oxygen in arterial blood, PGC-1α: peroxisome proliferator-activated receptor gamma coactivator 1-α, RE: relative mRNA expression.
status of patients. We found a negative correlation between expression levels of PGC-1α and age, PAP and PVR, as well as a positive correlation with CI, indicating that those patients with higher levels of PGC-1α have an improvement of lung and heart functions. As pointed out in the results section, no correlation was found between 6 MWT and PGC-1α levels. A possible explanation is that this parameter is affected by other factors like the age of the patients [24].

PGC-1α is a transcriptional coactivator which has been shown to activate a broad range of transcription factors and to regulate genes encoding mitochondrial proteins including CYTC under hypoxemia, as it has been shown in animal models [25–27]. Results presented here demonstrate a good correlation between expression levels of PGC-1α and CYTC in circulating blood of IPHA patients, supporting these findings.

IPAH is characterized by a sustained hypoxia situation that leads to cellular damage and contributes to RV failure [9, 10]. TAS determines the response capacity of a biological system to oxidative-mediated events. This status represents the balance between oxidant and antioxidant molecules. We found a significant decrease of TAS in IPAH patients compared to healthy donors. Despite the coherence of the results obtained, under our knowledge, this is the first study demonstrating this decrease in IPAH patients.

One of the most important antioxidant enzymes is SOD and its expression is reduced under chronic hypoxia [28]. These findings are consistent with the decrease of SOD observed in PAH patients compared to healthy volunteers. SOD over expression prevents the development of PH and ameliorates established PH in hypoxia-induced pulmonary hypertension in mice and primary human endothelial cells [29]. We observed a good correlation between PGC-1α and SOD expression levels, which could support the implication of this antioxidant enzyme in the pathogenesis of IPAH.

Another key enzyme controlling oxidative damage is GPX as it has been observed in lung of IPAH patients [30]. Similar to what happens with SOD, we observed a significant decrease of the activity of this enzyme in IPAH patients compared to healthy donors and a positive correlation with the expression levels of PGC-1α, which is coherent with the antioxidant role of this transcriptional coactivator in oxidative enzymopathies [16].

All patients included in this study are being treated with different combinations of drugs including calcium channel blockers, endothelin receptor antagonists, PDE5 inhibitors and synthetic analogues of prostacyclin. Although the effects of the treatment attenuating the oxidant level are well known [31–33], heterogeneity on treatments linked to the limited number of patients included in this study make difficult to reach a conclusion about the effect of medication on altering the antioxidant/oxidant status. However, regardless of the treatment, all patients considered in this study are under mild/moderate hypoxemia. More studies including the novo patients and comparing the situation before and after medication are needed to understand the effects of treatment on hypoxemia status and the relation with mechanisms controlled by PGC-1α.

The principal limitation of this study is the number of patients included, however IPAH is a rare disease with a prevalence of 2-3 per million per year [34]. Data presented here indicate the possible role of PGC-1α in controlling the progression of the disease and the oxidative status of IPAH patients. This study suggests that the monitoring of circulating PGC-1α mRNA levels could be indicative of the progression of the disease, providing valuable information of parameters like the treatment efficacy and the severity of the progression of the disease. Another important aspect is that the monitoring of circulating PGC-1α involves noninvasive procedures without risk for the patient and that it could be carried out in a fast and economical way. For these reasons we proposed PGC-1α as a potential new biomarker of the progression of PAH.

Acknowledgments

This work was supported by Grants PI10/02294 (M. Mata), SAF2008-03113 (J. Cortijo), and CIBERES (CB06/06/0027) from the Ministry of Science and Innovation and the Health Institute “Carlos III” of the Spanish government as well as research Grants from regional government (GV2007/287 and AP073/10, Generalitat Valenciana).

References

[1] S. Rich, D. R. Dantzker, S. M. Ayres et al., “Primary pulmonary hypertension. A national prospective study,” Annals of Internal Medicine, vol. 107, no. 2, pp. 216–223, 1987.
[2] V. V. McLaughlin, S. L. Archer, D. B. Badesch et al., “ACCF/AHA 2009 expert consensus document on pulmonary hypertension: a report of the American College of Cardiology Foundation Task Force on Expert Consensus Documents and the American Heart Association: developed in collaboration with the American College of Chest Physicians, American Thoracic Society, Inc., and the Pulmonary Hypertension Association,” Circulation, vol. 119, no. 16, pp. 2250–2294, 2009.
[3] N. Galié, M. M. Hoeper, M. Humbert et al., “Guidelines for the diagnosis and treatment of pulmonary hypertension,” European Respiratory Journal, vol. 34, no. 6, pp. 1219–1263, 2009.
[4] G. E. D’Alonzo, R. J. Bart, S. M. Ayres et al., “Survival in patients with primary pulmonary hypertension: results from a national prospective registry,” Annals of Internal Medicine, vol. 115, no. 5, pp. 343–349, 1991.
[5] M. R. Bristow, W. Minobe, R. Rasmussen et al., “β-adrenergic neuroeffector abnormalities in the failing human heart are produced by local rather than systemic mechanisms,” Journal of Clinical Investigation, vol. 89, no. 3, pp. 803–815, 1992.
[6] K. T. B. Mouchaers, I. Schalji, A. M. G. Versteilen et al., “Endothelin receptor blockade combined with phos-phodies-terase-5 inhibition increases right ventricular mitochondrial capacity in pulmonary arterial hypertension,” American Journal of Physiology, vol. 297, no. 1, pp. H200–H207, 2009.
[7] A. L. Des Tombe, B. J. Van Beek-Harmsen, M. B. E. Lee-De Groot, and W. J. Van Der Laarse, “Calibrated histochemistry applied to oxygen supply and demand in hypertrophied rat myocardium,” Microscopy Research and Technique, vol. 58, no. 5, pp. 412–420, 2002.
[8] P. Zong, J. D. Tune, and H. F. Downey, “Mechanisms of oxygen demand/supply balance in the right ventricle,” Experimental Biology and Medicine, vol. 230, no. 8, pp. 507–519, 2005.
[9] M. Sano, T. Minamino, H. Toko et al., “p53-induced inhibition of Hif-1 causes cardiac dysfunction during pressure overload,” *Nature*, vol. 446, no. 7134, pp. 444–448, 2007.
[10] N. F. Voelkel, R. A. Quaiife, L. A. Leinwand et al., “Right ventricular function and failure: report of a National Heart, Lung, and Blood Institute working group on cellular and molecular mechanisms of right heart failure,” *Circulation*, vol. 114, no. 17, pp. 1883–1891, 2006.
[11] Y. Hoshikawa, S. Ono, S. Suzuki et al., “Generation of oxidative stress contributes to the development of pulmonary hypertension induced by hypoxia,” *Journal of Applied Physiology*, vol. 90, no. 4, pp. 1299–1306, 2001.
[12] J. Q. Liu, I. N. Zelko, E. M. Erbynn, J. S. K. Sham, and R. J. Folz, “Hydroxyl pulmonary hypertension: role of superoxide and NADPH oxidase (gp91phox),” *American Journal of Physiology*, vol. 290, no. 1, pp. L2–L10, 2006.
[13] S. Lakshminrusimha, J. A. Russell, S. Wedwood et al., “Superoxide dismutase improves oxygenation and reduces oxidation in neonatal pulmonary hypertension,” *American Journal of Respiratory and Critical Care Medicine*, vol. 174, no. 12, pp. 1370–1377, 2006.
[14] M. N. Ahmed, H. B. Suliman, R. J. Folz et al., “Extracellular superoxide dismutase protects lung development in hypoxia-exposed newborn mice,” *American Journal of Respiratory and Critical Care Medicine*, vol. 167, no. 3, pp. 400–405, 2003.
[15] B. Elmedal, M. Y. de Dam, M. J. Mulvany, and U. Simonsen, “The superoxide dismutase mimetic, tempol, blunts right ventricular hypertrophy in chronic hypoxic rats,” *British Journal of Pharmacology*, vol. 141, no. 1, pp. 105–113, 2004.
[16] J. A. Leopold, “Redox pioneer: Professor Joseph Loscalzo,” *Antioxidants & Redox Signaling*, vol. 13, no. 7, pp. 1125–1132, 2010.
[17] Z. Wu, P. Puigserver, U. Andersson et al., “Mechanisms controlling mitochondrial biogenesis and respiration through the thermogenic coactivator PGC-1,” *Cell*, vol. 98, no. 1, pp. 115–124, 1999.
[18] L. Ding, X. Liang, D. Zhu, and Y. Lou, “Peroxisome proliferator-activated receptor-α is involved in cardiomyocyte differentiation of murine embryonic stem cells in vitro,” *Cell Biology International*, vol. 31, no. 9, pp. 1002–1009, 2007.
[19] T. Honda, K. Kaikita, K. Tsujita et al., “Piroglandin A1, a peroxisome proliferator-activated receptor-γ agonist, attenuates myocardial ischemia-reperfusion injury in mice with metabolic disorders,” *Journal of Molecular and Cellular Cardiology*, vol. 44, no. 5, pp. 915–926, 2008.
[20] T. Shiomi, H. Tsutsui, S. Hayashidani et al., “Piroglandin A1, a peroxisome proliferator-activated receptor-γ agonist, attenuates left ventricular remodeling and failure after experimental myocardial infarction,” *Circulation*, vol. 106, no. 24, pp. 3126–3132, 2002.
[21] T. L. Yue, J. Chen, W. Bao et al., “In vivo myocardial protection from ischemia/reperfusion injury by the peroxisome proliferator-activated receptor-γ agonist rosiglitazone,” *Circulation*, vol. 104, no. 21, pp. 2588–2594, 2001.
[22] O. Fabregat-Andrés, A. Tierrez, M. Mata, J. Estornell-Erill, F. Ridocci-Soriano, and M. Monsalve, “Induction of PGC-1α expression can be detected in blood samples of patients with ST-segment elevation acute myocardial infarction,” *PLoS ONE*, vol. 6, no. 11, Article ID e26913, 2011.
[23] M. Mata, B. Sarriá, A. Buenestado, J. Cortijo, M. Cerdá, and E. J. Morcillo, “Phosphodiesterase 4 inhibition decreases MUC5AC expression induced by epidermal growth factor in human airway epithelial cells,” *Thorax*, vol. 60, no. 2, pp. 144–152, 2005.
[24] C. Casanova, B. R. Celli, P. Barria et al., “The 6-min walk distance in healthy subjects: reference standards from seven countries,” *European Respiratory Journal*, vol. 37, no. 1, pp. 150–156, 2011.
[25] J. A. Calvo, T. G. Daniels, X. Wang et al., “Muscle-specific expression of PPARγ coactivator-1α improves exercise performance and increases peak oxygen uptake,” *Journal of Applied Physiology*, vol. 104, no. 5, pp. 1304–1312, 2008.
[26] J. Lin, H. Wu, P. T. Tarr et al., “Transcriptional co-activator PGC-1α drives the formation of slow-twitch muscle fibres,” *Nature*, vol. 418, no. 6899, pp. 797–801, 2002.
[27] L. Leick, J. Fentz, R. S. Bienso et al., “PGC-1α is required for AICAR-induced expression of GLUT4 and mitochondrial proteins in mouse skeletal muscle,” *American Journal of Physiology*, vol. 299, no. 3, pp. E456–E465, 2010.
[28] E. Nozik-Grayck, H. B. Suliman, S. Majka et al., “Lung EC-SOD overexpression attenuates hypoxic induction of Egr-1 and chronic hypoxic pulmonary vascular remodeling,” *American Journal of Physiology*, vol. 295, no. 3, pp. L422–L430, 2008.
[29] M. N. Ahmed, Y. Zhang, C. Codipilly et al., “Extracellular superoxide dismutase overexpression can reverse the course of hypoxia-induced pulmonary hypertension,” *Molecular Medicine*, vol. 18, no. 1, pp. 38–46, 2012.
[30] F. A. Masri, S. A. A. Comhair, I. Dostanic-Larson et al., “Deficiency of lung antioxidants in idiopathic pulmonary arterial hypertension,” *Clinical and Translational Science*, vol. 1, no. 2, pp. 99–106, 2008.
[31] J. Milara, E. Gabarda, G. Juan et al., “Bosentan inhibits cigarette smoke-induced endothelin receptor expression in pulmonary arteries,” *European Respiratory Journal*, vol. 39, no. 4, pp. 927–938, 2012.
[32] J. Milara, J. L. Ortiz, G. Juan et al., “Cigarette smoke exposure up-regulates endothelin receptor B in human pulmonary artery endothelial cells: molecular and functional consequences,” *British Journal of Pharmacology*, vol. 161, no. 7, pp. 1599–1615, 2010.
[33] J. Milara, G. Juan, J. L. Ortiz et al., “Cigarette smoke-induced pulmonary endothelial dysfunction is partially suppressed by sildenafil,” *European Journal of Pharmacological Sciences*, vol. 39, no. 5, pp. 363–372, 2010.
[34] N. Rudaarakanchana, R. C. Trembath, and N. W. Morrell, “New insights into the pathogenesis and treatment of primary pulmonary hypertension,” *Thorax*, vol. 56, no. 11, pp. 888–890, 2001.