ACE ID genotype affects blood creatine kinase response to eccentric exercise

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Yamin C, Amir O, Sagiv M, Attias E, Meckel Y, Eynon N, Sagiv M, Amir RE. ACE ID genotype affects blood creatine kinase response to eccentric exercise. J Appl Physiol 103: 2057–2061, 2007. First published September 20, 2007; doi:10.1152/japplphysiol.00867.2007.—Unaccustomed exercise may cause muscle breakdown with marked increase in serum creatine kinase (CK) activity. The skeletal muscle renin-angiotensin system (RAS) plays an important role in exercise metabolism and tissue injury. A functional insertion (I)/deletion (D) polymorphism in the angiotensin I-converting enzyme (ACE) gene (rs4646994) has been associated with ACE activity. We hypothesized that ACE ID genotype may contribute to the wide variability in individuals’ CK response to a given exercise. Young individuals performed maximal eccentric contractions of the elbow flexor muscles. Pre- and postexercise CK activity was determined. ACE genotype was significantly associated with postexercise CK increase and peak CK activity. Individuals harboring one or more of the I allele had a greater increase and higher peak CK values than individuals with the DD genotype. This response was dose-dependent (mean ± SE U/L: II, 8,882 ± 2,362; ID, 4,454 ± 1,105; DD, 2,937 ± 753, ANOVA, P = 0.02; P = 0.009 for linear trend). Multivariate stepwise regression analysis, which included age, sex, body mass index, and genotype subtypes, revealed that ACE genotype was the most powerful independent determinant of peak CK activity (adjusted odds ratio 1.3, 95% confidence interval 1.03–1.64, P = 0.02). In conclusion, we indicate a positive association of the ACE ID genotype with CK response to strenuous exercise. We suggest that the I allele increases risk for developing muscle damage, whereas the DD genotype may have protective effects. These findings support the role of local RAS in the regulation of exertional muscle injury.

There is growing evidence for a genetic contribution to the phenotypic responses of exertional muscle damage (8, 13).

The renin-angiotensin system (RAS) plays an important role in human body fluid homeostasis and left ventricular remodeling. The angiotensin-converting enzyme (ACE) is a key component in the RAS, generating the vasoconstrictor angiotensin (ANG) II and degrading vasodilator kinins (11). ACE is widely expressed in human tissues, including skeletal muscle, and may play a metabolic role during exercise (20). ANG II has known effects on metabolism (6) and is a recognized growth factor necessary for the hypertrophy of skeletal muscle in response to mechanical load (16). Most of its known physiological and pathophysiological activities are mediated through the ANG II type 1 receptor (AT1R), which is also the only ANG II receptor present in human skeletal muscle (20).

A functional polymorphism of the human ACE gene has been identified in which the presence (insertion: I allele), rather than the absence (deletion: D allele), of a 287-bp Alu repeat element in intron 16 (rs4646994) is associated with lower enzyme activity in both serum and tissue (12, 39), resulting in greater production of ANG II and aldosterone and a decreased half-life of bradykinin (4, 52).

ACE ID polymorphism has been extensively studied in relation to human physical performance. Several reports from European and US Caucasian populations suggested the association of the I and the D alleles with endurance (1, 15, 30–32, 42) and sprint performance (31, 32, 53), respectively. However, some studies in which elite athletes were drawn from diverse sporting disciplines, requiring mixed skills, have failed to demonstrate any association with the ACE genotype (37, 46). Of note, in a different ethnic population of Israeli Caucasians, the ACE DD genotype has been associated with elite endurance athletes (2).

Because there is considerable RAS activity in skeletal muscle that is involved in the regulation of muscle metabolism, vascular tone, and injury responses, we hypothesized that the ACE ID genotype may contribute to the development of exertional rhabdomyolysis and therefore may affect CK response to strenuous exercise. To test our hypotheses, in the present study, we used repetitive eccentric contractions as an exercise model for inducing exertional rhabdomyolysis in healthy young individuals. We investigated the association of ACE ID alleles with CK response to exercise.

MATERIALS AND METHODS

Subjects. Seventy healthy physical education students (42 men and 28 women; aged 22–32 yr) volunteered for the study. Participants

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Table 1. ACE ID allele and genotype frequencies in the study group with subjects’ physical characteristics

<table>
<thead>
<tr>
<th>Variable</th>
<th>Value</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, yr</td>
<td>24±3</td>
<td>0.18</td>
</tr>
<tr>
<td>Height, cm</td>
<td>171±7</td>
<td>0.91</td>
</tr>
<tr>
<td>Weight, kg</td>
<td>67±10</td>
<td>0.98</td>
</tr>
<tr>
<td>LBM, kg</td>
<td>55±11</td>
<td>0.93</td>
</tr>
<tr>
<td>BMI, kg/m²</td>
<td>22.6±1.6</td>
<td>0.96</td>
</tr>
</tbody>
</table>

Values are absolute and relative (in parentheses) frequencies, and means ± SD for continuous variables. ACE, angiotensin-converting enzyme; I, insertion allele; D, deletion allele; ID, homozygotes for the deletion allele; II, homozygotes for the insertion allele; ID, heterozygotes. *χ² = 0.93; degrees of freedom = 2; P = 0.62 for genotype frequencies in men vs. women. 1χ² = 0.01; degrees of freedom = 1; P = 0.91 for allele frequencies in men vs. women.
and lowest in exertional rhabdomyolysis. Conversely, it seems that the type may influence CK response to eccentric contractions with the present study was that individuals with one or more healthy young men and women. The major finding of the skeletal muscle response to strenuous eccentric exercise in since peak CK values were highest in DD genotype having increased risk for developing ACE DD genotype may favorably confer protective effects against exercise-induced muscle injury.

Several potential mechanisms may explain how the ACE genotype influences individuals’ CK response to strenuous exercise. The increased ACE activity associated with the DD genotype may lead to enhanced production of ANG II, which is the predominant biological product of RAS, mediating many of the local effects of ACE on skeletal muscle. ANG II is a necessary factor in mediating vascular smooth muscle growth and capillary density in skeletal muscle (20). ANG II has a direct hypertrophic effect on skeletal muscle, and ATIR-mediated ANG II is crucial for optimal overload-induced skeletal muscle hypertrophy (16). Moreover, ANG II has been shown to regulate oxygen consumption and affect muscle energy expenditure (7), and higher maximal oxygen consumption levels have been associated with the ACE D allele (36, 54), indicating an improved oxidative capacity. Although most previous studies associated the ACE I allele (lower ACE activity, high kinin ligand generation, and increased half-life of bradykinin) with increased skeletal muscle metabolic efficiency and perhaps improved contractile function (5, 18, 43, 44), local RAS activity in skeletal muscle is much more complicated. ACE is not only involved in ANG II production and bradykinin degradation, but it also regulates the levels of ANG (1–7) peptide, which is known to cause vasodilating effects (20). Thus it is possible that the protective effects of the ACE D allele against exercise-induced skeletal muscle damage are mainly mediated through the fine tuning of regulating the levels of ANG II and ANG (1–7).

Another explanation for our findings may rely on the mechanisms underlying the process of muscle damage. In exertional rhabdomyolysis, the initial inciting event (whether mechanical stretch or excitation-contraction uncoupling) is accompanied by the uncontrolled movement of Ca2+ into the sarcoplasm, triggering the next stage in the damage process (34, 50). Bradykinin receptor B2 activation can lead to transient rises in inositol 1,4,5-trisphosphate (35), which is involved in excitation-contraction coupling via increases in cytoplasmic Ca2+ concentration (24). Moreover, data suggest that this process is enhanced by the inhibition of ACE (23). Interestingly, there is evidence that ANG II can affect both sympathetic and neuromuscular transmission (20). Thus it is conceivable that ACE genotype affects CK response via involvement in the regulation of the excitation coupling process.

Heled et al. (17) have recently published a similar study in which no association of ACE genotype with exertional rhabdomyolysis was found. The disagreement between these results and our findings is not uncommon when using population-

![Fig. 1. Creatine kinase (CK) activity in response to the eccentric exercise regimen for the study population. Subjects’ average serum CK activity at baseline and at different points in time postexercise.](http://jap.physiology.org/)

Table 2. Subjects’ phenotypes in relation to ACE genotype

<table>
<thead>
<tr>
<th>Phenotype</th>
<th>ACE I</th>
<th>ACE ID</th>
<th>ACE ID + II</th>
<th>ACE DD</th>
<th>ANOVA P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline CK activity, U/l</td>
<td>147 ± 27</td>
<td>158 ± 15</td>
<td>155 ± 13</td>
<td>161 ± 19</td>
<td>0.920/0.82*</td>
</tr>
<tr>
<td>Peak CK activity, U/l</td>
<td>8,882 ± 2,361</td>
<td>4,454 ± 1,105</td>
<td>5,508 ± 1,040</td>
<td>2,937 ± 753</td>
<td>0.020/0.07*</td>
</tr>
<tr>
<td>Delta CK activity, U/l</td>
<td>8,735 ± 2,352</td>
<td>4,296 ± 1,108</td>
<td>5,353 ± 1,041</td>
<td>2,778 ± 757</td>
<td>0.020/0.07*</td>
</tr>
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</table>

Values are reported as means ± SE. *P value for CK activity in ACE II + ID vs. ACE DD. †P value for linear trend.
association studies and may be attributable to different experimental designs and study cohorts. Data suggest that the effect of ACE genotype on physical performance may depend on the type of exercise (28). Moreover, it is well known that the frequencies of the ACE ID alleles vary considerably among different control populations (3), and the influence of varying genetic background may obscure a true association. To support our findings, we have recently demonstrated in Israeli elite athletes an association of the ACE D allele and DD genotype with endurance performance (2). Of note, our individuals were physically active, but none were well trained or competitive athletes. More importantly, they were not engaged in any resistance training programs and were not highly active. Thus it seems that in the Heled et al. study (17) participants were very active and their fitness level was higher than ours. This is also supported by the relatively lower average increase in CK level of their high responders group compared with our average delta CK levels (1,048 vs. 4,480 U/l). Given that fitness level influences the degree of exercise-induced muscle damage (10) and since the effect of ACE polymorphism depends on individuals’ fitness levels as well (28), the association between ACE genotype and CK response to exercise may become prominent only in sedentary individuals performing a highly intense effort, as in our study.

Finally, it is still possible that ACE ID polymorphism is one of many genetic variants contributing to the observed variance in muscle CK response or that it is in strong allelic association with functional variants in adjacent genes and that these are responsible for the observed associations with ACE genotype (36). Likewise, it has been proposed that the higher ACE activity associated with the ACE DD genotype (12, 39) is perhaps caused by an Alu-associated transcription silencer (47, 48) or by an identified variant of the of the ACE gene that is in linkage disequilibrium with the Alu insertion/deletion polymorphism (21, 38, 49). However, the medical literature is still debating whether this candidate polymorphism is located in the promoter region (38, 49) or in downstream sequences of the ACE gene (21). The inconsistency regarding ACE haplotypes represents some of the difficulties in studying different populations, and the sequencing of coding and noncoding regions of the ACE gene in other populations with different evolutionary histories may reveal alternative polymorphisms. Rieder et al. (38) found some differences in sequence variation between African-Americans and European-Americans. In his analysis, a major genetic subdivision in the deletion haplotypes was evident only in European-Americans, further supporting the notion that some haplotypes that are present in one population may not apply to other populations. Clearly, more work on large sample sizes is needed to confirm our observations and to better clarify the pathways through which ACE ID genotype associates with exertional muscle damage.

In conclusion, our data suggest a positive association between the ACE genotype and CK response to repetitive eccentric contractions and further support the role of local RAS in the regulation of exertional muscle injury.

REFERENCES


