Analyses of a novel SCN5A mutation (C1850S): conduction vs. repolarization disorder hypotheses in the Brugada syndrome

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Aims Brugada syndrome (BrS) is characterized by arrhythmias leading to sudden cardiac death. BrS is caused, in part, by mutations in the SCN5A gene, which encodes the sodium channel alpha-subunit Na1.5. Here, we aimed to characterize the biophysical properties and consequences of a novel BrS SCN5A mutation.

Methods and results SCN5A was screened for mutations in a male patient with type-1 BrS pattern ECG. Wild-type (WT) and mutant Na1.5 channels were expressed in HEK293 cells. Sodium currents (I Na) were analysed using the whole-cell patch-clamp technique at 37°C. The electrophysiological effects of the mutation were simulated using the Luo-Rudy model, into which the transient outward current (I to) was incorporated. A new mutation (C1850S) was identified in the Na1.5 C-terminal domain. In HEK293 cells, mutant I Na density was decreased by 62% at −20 mV. Inactivation of mutant I Na was accelerated in a voltage-dependent manner and the steady-state inactivation curve was shifted by 11.6 mV towards negative potentials. No change was observed regarding activation characteristics. Altogether, these biophysical alterations decreased the availability of I Na. In the simulations, the I to density necessary to precipitate repolarization differed minimally between the two genotypes. In contrast, the mutation greatly affected conduction across a structural heterogeneity and precipitated conduction block.

Conclusion Our data confirm that mutations of the C-terminal domain of Na1.5 alter the inactivation of the channel and support the notion that conduction alterations may play a significant role in the pathogenesis of BrS.

KEYWORDS Brugada syndrome; Sodium channel; Genetics; Electrophysiology; Computational analysis

1. Introduction

Brugada syndrome (BrS) is a disorder characterized by ST segment elevation in the right precordial leads V1–V3 on the surface ECG, with atypical right bundle branch block pattern, and an increased risk for sudden cardiac death (SCD).1 The BrS is a primary electrical cardiac disorder, which is inherited as an autosomal dominant trait. Many mutations in SCN5A, encoding the α-subunit of the voltage-gated sodium channel Na1.5, have been identified,2 though only 10 to 30% of clinically affected individuals carry a mutation in this gene.3 Among the ~90 mutations reported thus far,4 only a few of them have been characterized at the molecular and biophysical level using cellular expression systems.1 Most of SCN5A mutations lead to a ‘loss-of-function’ by reducing the sodium current (I Na) available during the phases 0 (upstroke) and 1 (early repolarization) of the cardiac action potential (AP).1 Despite more than 10 years of research in this field, the molecular and cellular mechanisms leading to the BrS are not yet completely understood.5 Interestingly, in some patients, BrS is concealed on the surface ECG and can be unmasked using sodium channel blockers4 or during fever episodes.5

Here, we screened SCN5A in a patient with typical clinical manifestations of BrS. A novel mutation, C1850S, located in the C-terminal domain of Na1.5 was identified.

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When mutant channels were expressed in HEK293 cells, the peak \( I_{Na} \) density was decreased by 62% (at −20 mV) and fast \( I_{Na} \) inactivation was accelerated.

Computer simulations were conducted using the Luo-Rudy (LRd) model to examine the interaction of \( I_{Na} \) and the transient outward current (\( I_{to} \)), proposed to determine early repolarization in the right epicardium. The \( I_{Na} \) density necessary to precipitate repolarization was similar in the right epicardium. The gene sequences. Denaturating high performance liquid chromatography (DHPLC) was performed on DNA-amplification products on at least one temperature condition. Abnormal DHPLC profiles were analysed by sequence reaction in both strands of the exon, using Big Dye termination mix, and analysed by cycle sequencing on an automated laser fluorescent DNA sequencer (ABI prism 3100, Applied Biosystems). The novel mutation C1850S was absent in 200 normal alleles. The investigation conformed with the principles outlined in the Declaration of Helsinki. The index patient gave written informed consent to participate in the study.

2. Methods

2.1 Molecular screening

Genomic DNA was extracted from peripheral lymphocytes, and all coding exons of SCN5A were amplified by polymerase chain reaction, using primers designed in intronic flanking sequences according to the gene sequences. Denaturating high performance liquid chromatography (DHPLC) was performed on DNA-amplification products on at least one temperature condition. Abnormal DHPLC profiles were analysed by sequence reaction in both strands of the exon, using Big Dye termination mix, and analysed by cycle sequencing on an automated laser fluorescent DNA sequencer (ABI prism 3100, Applied Biosystems). The novel mutation C1850S was absent in 200 normal alleles. The investigation conformed with the principles outlined in the Declaration of Helsinki. The index patient gave written informed consent to participate in the study.

2.2 Electrophysiology

SCN5A mutation was engineered into WT cDNA (clone hHTa received from Dr R. Kass) cloned in pcDNA3.1 (Invitrogen), using the QuickChange Kit (Stratagene) and verified by sequencing. For electrophysiology studies, HEK293 cells were transiently transfected with 0.6 µg of WT or mutant Na,1.5 construct cDNAs or 0.3 µg of each. All transfections included 2.0 µg pIREs-hj1-CD8 cDNA encoding hj1 subunit and CD8 antigen as a reporter gene. Cells were transfected using calcium phosphate or Lipofectamine and \( I_{Na} \) were measured after 48 h. Anti-CD8 beads (Dynal) were used to identify transfected cells. Patch-clamp recordings were conducted using an internal solution containing (mmol/L) CsCl 60; CsAspartate 70; EGTA 11; MgCl2 1; CaCl2 1; HEPES 10; and Na2-ATP 5, pH 7.2 with an internal solution containing (mmol/L) CsCl 60; CsAspartate 70; EGTA 11; MgCl2 1; CaCl2 1; HEPES 10; and glucose 5, pH 7.4 with CsOH. Using these solutions, 5 min after rupturing the membrane, we observed no significant alteration of the availability curve and the peak current. Peak currents were measured during an inactivation protocol and \( I_{Na} \) densities (pA/pF) were obtained by dividing the peak \( I_{Na} \) by the cell capacitance obtained from the pClamp function (pClamp suite, v.8, Axon Instruments, CA, USA). For the activation and steady-state inactivation curves, data from individual cells were fitted with Boltzmann relationship, \( y(V_{m}) = 1/[1 + \exp \{(V_{m} - V_{1/2})/\kappa\}] \), in which \( y \) is the normalized current or conductance, \( V_{m} \) is the membrane potential, \( V_{1/2} \) is the voltage at which half of the channels are activated or inactivated, and \( \kappa \) is the slope factor. Recovery from inactivation curves were fitted individually with a mono-exponential relationship. \( I_{Na} \) were measured using a VE-2 amplifier (Alembic Instruments, Montréal, QC) allowing a full compensation of the series resistance, and were analysed using the pClamp software suite. No correction of liquid junction potentials was performed. All measurements were carried out at 37 ± 1°C using a control system (Cell MicroControls) heating the perfusion solution.

2.3 Biochemistry

Western blotting conditions have been described previously. The anti-Nav1.5 affinity purified antibody recognizes residues 493-511 of rat Na,1.5 (ASC-005, Alomone). These residues are identical in the human sequence. The anti-actin antibody was from Sigma.

2.4 Statistics

Data are presented as means ± SEM. The two-tailed Student t-test or the ANOVA test with the Bonferroni correction were used to compare means; \( P < 0.05 \) was considered significant.

2.5 Mathematical modelling of \( I_{Na} \), the action potential, and conduction

The LRd model of the ventricular epicardial cell was used to reconstruct \( I_{Na} \) under voltage clamp conditions as well as the AP of the epicardial myocyte. The model incorporated the updates published by Faber and Rudy as well as the ATP-sensitive \( I_{K_A} \) current as described by Shaw and Rudy. The transient outward \( K \) current \( I_{to} \) was introduced into the model according to the formulation of Dumaine et al. To account for the important heterogeneity of \( I_{Na} \) expression between the left and right ventricles and across the myocardial wall, simulations were run over a broad range of membrane potential, and conduction vs. repolarization disorder in Brugada syndrome

\[ V \sim V_{m} \]

where \( V \) is the voltage at which half of the channels are activated, and \( V_{m} \) is the membrane potential. The rate constants \( h_{Na} \) and \( h_{to} \) were given by the following equations:

\[ h_{Na} = 10^{-6} \exp \left( \frac{V_{m} - E_{Na}}{40} \right) \]

\[ h_{to} = 10^{-6} \exp \left( \frac{V_{m} - E_{to}}{40} \right) \]

where \( E_{Na} \) and \( E_{to} \) are the Nernst potentials of Na and K, respectively. The time constants were given by the following equations:

\[ \tau_{Na} = \frac{1}{h_{Na} - 1} \]

\[ \tau_{to} = \frac{1}{h_{to} - 1} \]

The opening rate constant \( \omega_0 \) of gate h as well as the rates of the m and j gates were not modified. To simulate heterozygote (HZ) cells (or \( I_{Na} \) in cells transfected with equal amounts of WT and mutant cDNA), \( g_{Na} \) was split into two equal components of 8 mS/µF each corresponding to the two SCN5A alleles (\( I_{Na} = I_{Na,WT} + I_{Na,CS} \)).

Further details concerning the modelling approach are provided in the Supplementary material online.
3. Results

3.1 Index case

The index case was a 55-year-old Caucasian male seen at our cardiology clinic (Lausanne, Switzerland) for investigation of a typical type-1 BrS ECG pattern recorded during cystitis with high fever. However, the ECG remained abnormal after fever (Figure 1A). The patient never had syncope or palpitations but his mother died suddenly at age 35. The echocardiography was normal. An electrophysiological study was conducted using two quadripolar leads. Premature ventricular stimulation was performed at cycle length of 600 and 400 ms followed by one and then two premature beats. Ventricular fibrillation was reproducibly inducible at a drive train of 400 ms followed by two premature beats at a coupling interval of 240 and 200 ms, respectively. Sinus rhythm was restored by an external biphasic shock of 120 J. No ajmaline test was performed. An internal cardioverter-defibrillator was implanted.

3.2 Identification and characterization of the SCN5A mutation

A heterozygous G to C substitution at position 5549 of SCN5A resulted in a C1850S mutation in the C-terminal tail of Na+,1.5 (Figure 1B). In HEK293 cells transiently transfected with WT and mutant cDNAs, Western blot analyses showed that the level of protein expression of C1850S mutant channels was comparable with that of WT (Figure 1C). In contrast, using the patch-clamp technique in the whole-cell configuration, at 37°C, C1850S channels generated $I_{\text{Na}}$ with biophysical properties that were clearly different compared with WT currents. First, the peak $I_{\text{Na}}$ density mediated by C1850S channels was reduced by 62 ± 5% at −20 mV (Figure 1D). When cells were co-transfected with equal amounts of WT and mutant cDNAs to mimic the heterozygous status of the patient, $I_{\text{Na}}$ density was intermediate (Figure 1D). Furthermore, as illustrated in Figure 2A, C1850S currents were almost completely inactivated 2 ms after the voltage step (arrows), while WT currents were still substantial. This indicates that C1850S $I_{\text{Na}}$ inactivated faster compared with WT $I_{\text{Na}}$. Figure 2B shows simulated current traces generated by the original $I_{\text{Na}}$ formulation of the LDr model (WT) and by the formulation in which the rate of fast inactivation $\beta_h$ was modified. Acceleration of fast inactivation without modifying other gating kinetics and without modifying $I_{\text{Na}}$ conductance resulted in a reduction of peak $I_{\text{Na}}$ by 63% (at −20 mV) and almost complete inactivation after 2 ms, similar to the experimental findings.

In HEK293 cells, the $V_{1/2}$ of voltage-dependence of steady-state inactivation of C1850S was shifted towards more negative values by 11.6 mV (Table 1 and Figure 3A). No significant alteration in the activation curve $V_{1/2}$ was observed. When HEK293 cells were transfected with equal amount of WT and mutant cDNA, the shift of the steady-state inactivation curve was intermediate (Figure 3A and Table 1). In the $I_{\text{Na}}$ model, the shift of the steady-state inactivation curve towards more negative potentials without alterations in recovery from fast inactivation (discussed later) was simulated by increasing the fast inactivation rate $\beta_h$ in a voltage-dependent manner while leaving $\alpha_h$ unchanged (see Methods).

No change in the kinetics of recovery from fast inactivation was seen (Figure 4A). In the mathematical model of $I_{\text{Na}}$ (Figure 4B), modification of the rate $\beta_h$ did not alter recovery from inactivation.

As illustrated in Figure 2A, fast inactivation is accelerated for the currents mediated by mutant channels compared with WT (arrows in Figure 2A). Individual inactivating current traces were fitted using a mono-exponential function and the resulting time constants ($\tau$) were plotted as a function of the different voltages (Figure 4C). At voltages more negative than 5 mV, the mutant $\tau$ values were significantly shorter compared with WT. In Figure 4D, the same analysis is presented for the model WT and mutant $I_{\text{Na}}$. The voltage-dependent behaviour of the $\tau$ values in the model is comparable with the behaviour observed for the experiments. In transfected HEK293 cells, we also tested the entry into the intermediate inactivated state, but no difference was observed (see Supplementary material online, Figure S1).

### Table 1: Biophysical properties of $I_{\text{Na}}$ recorded in HEK293 cells transfected with wild-type (WT), C1850S, or $1/2$WT and $1/2$C1850S cDNA. For the activation and steady-state inactivation curves (Figure 3A), data points from individual cells were fitted with Boltzmann relationship, and the $V_{1/2}$ and $K$ values of the different conditions are presented; *$P < 0.05$, **$P < 0.01$ vs. WT, Bonferroni correction after ANOVA test.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Steady state $V_{1/2}$ inactivation (mV)</th>
<th>Slope factor: $K$ inactivation (mV)</th>
<th>$V_{1/2}$ activation (mV)</th>
<th>Slope factor: $K$ activation (mV)</th>
<th>Time to half recovery from fast inactivation (ms)</th>
</tr>
</thead>
<tbody>
<tr>
<td>WT</td>
<td>$-78.6 \pm 0.8$ (n = 9)</td>
<td>$6.4 \pm 0.4$ (n = 9)</td>
<td>$-36.9 \pm 1.4$ (n = 7)</td>
<td>$7.0 \pm 0.4$ (n = 7)</td>
<td>$3.4 \pm 0.3$ (n = 13)</td>
</tr>
<tr>
<td>C1850S</td>
<td>$-90.2 \pm 0.5$** (n = 7)</td>
<td>$5.9 \pm 0.4$ (n = 7)</td>
<td>$-35.5 \pm 1.3$ (n = 5)</td>
<td>$7.4 \pm 0.4$ (n = 5)</td>
<td>$3.8 \pm 0.4$ (n = 15)</td>
</tr>
<tr>
<td>$1/2$WT + $1/2$C1850S</td>
<td>$-83.8 \pm 1.8^*$ (n = 9)</td>
<td>$6.9 \pm 0.3$ (n = 9)</td>
<td>$-33.6 \pm 1.3$ (n = 8)</td>
<td>$6.4 \pm 0.6$ (n = 8)</td>
<td>$3.5 \pm 0.6$ (n = 8)</td>
</tr>
</tbody>
</table>

It has been postulated that the clinical manifestations of BrS are related to the propensity of right epicardial tissue to premature repolarization, which can explain ST-segment elevation in the right precordial leads and phase 2 re-excitation by deeper layers of myocardium.6 This susceptibility of the right epicardial AP to lose its dome is explained by the predominance of outward currents over inward currents during phase 1 (notch). During this phase, the balance of transmembrane currents is principally determined by the inactivating $I_{\text{Na}}$, the activating L-type Ca$^{2+}$ current, and the rapidly activating transient outward K$^+$ current, $I_{\text{to}}$. Thus, under conditions of high levels of $I_{\text{Na}}$ as encountered in the right epicardium, the loss of the depolarizing contribution of $I_{\text{Na}}$ caused by its accelerated
inactivation can promote early repolarization. In addition, it was reported that both hyper- and hypokalemia could precipitate the clinical manifestations of BrS.

This background motivated us to investigate the consequences of the C1850S mutation on the epicardial AP as a function of the level of $I_{to}$ expression and of extracellular potassium concentration ($[K^+]_o$). Single cell AP simulations were conducted using the LRd model. For every $[K^+]_o$ tested (2.5 to 12.0 mmol/L in steps of 0.5 mmol/L), we determined the critical value of $g_{to}$ above which the AP loses its dome-shaped plateau and repeated this approach for the WT, HZ, and homozygote C1850S (CS) genotypes.

As shown in Figure 5A, the critical $g_{to}$ was, as expected, the largest for the WT, the smallest for the CS and intermediate for the HZ over the entire range of $[K^+]_o$ tested. Interestingly, there was a biphasic dependence of critical $g_{to}$ on $[K^+]_o$ for all three genotypes with a maximum near $[K^+]_o = 6$ mmol/L. Figure 5B illustrates this loss of the AP dome with increasing levels of $I_{to}$ at a normal $[K^+]_o$ of 4 mmol/L. Increasing $g_{to}$ led first to a loss of the dome in the CS (b), then in the HZ (c) and finally in the WT (d). Thus, accelerated inactivation of $I_{to}$ may lead to premature epicardial repolarization under conditions of elevated $I_{to}$ expression, which, in vivo, can be encountered in the right ventricular epicardium. However, the critical $g_{to}$ values
differed only by a few percent between WT and CS, and the difference between WT and HZ conditions was 1% for all values of $[K^+]_o$.

It is well known that the clinical manifestations of BrS are rate-dependent. Moreover, AP characteristics during pacing at a physiological rate differ from those of an isolated AP elicited in a resting cell. Therefore, to evaluate the behaviour of the model cell paced at a physiological rate, we conducted simulations in which trains of stimuli were applied during 30 s following the initial 1-min period without pacing.

Figure 5C compares APs in the simulated WT, HZ and C1850S mutant cells during 30 s of pacing at a rate of 1 Hz, for $[K^+]_o = 4$ mmol/L and with $g_{to} = 1.315$ mS/mF. This value of $g_{to}$ was inferior to the thresholds at which premature repolarization occurred for the isolated AP (see ‘Methods’).

We then extended the investigation of the critical $g_{to}$ level leading to premature repolarization to the situation of the paced cell. The critical level was defined as the boundary between the complete absence of premature repolarization during the 30-s train and the presence of at least one AP exhibiting premature repolarization. These simulations were conducted at pacing rates of 1 and 2 Hz (Figure 5D and E, respectively). For all three genotypes, the boundaries exhibited a similar shape as in the single AP simulations but were shifted towards smaller values of $g_{to}$. This shift was more prominent at 2 Hz than at 1 Hz. Nevertheless, for both pacing rates and for all values of $[K^+]_o$, the critical $g_{to}$ values differed only by a few percent ($<1\%$ between WT and HZ), similar to the single AP simulations.

3.4 The C1850S mutation causes conduction block in branching tissue

It has recently been proposed that right ventricular fibrosis may contribute to the genesis of conduction disorders...
leading to the characteristic BrS ECG.\textsuperscript{19,20} Fibrous cardiac tissue is characterized by sparsely connected strands and sheets of myocardium intermingled with unexcitable tissue (Figure 6A), and such structures are known to form the substrate of slow conduction or conduction block.\textsuperscript{21}

Therefore, we investigated the consequences of the C1850S mutation on conduction characteristics along a 121-cell strand releasing two branches from its centre (Figure 6A). These simulations were conducted for a single AP. In the simulation presented in Figure 6B, the branches were 20 myocytes long. This branch length was several times the space constant of the strand, which amounted to 533 μm (approximately five cells) at [K\textsuperscript{+}])\textsc{o} = 4 mmol/L (the space constant was not influenced by g\textsc{to} or by the h\textsc{la} genotype). This simulation corresponds to scarce lateral coupling between fibres. The branching strand was characterized by a mismatch between the current generated by the strand before the branch point and the increased load represented by the distal segment of the strand and the two branches.\textsuperscript{22}

Figure 6B shows AP upstrokes, WT and mutant h\textsc{la} currents as well as I\textsc{to} in the vicinity of the branch point for both the WT and the HZ (g\textsc{to} = 0.5 mS/μF, [K\textsuperscript{+}])\textsc{o} = 4 mmol/L). In the WT, the current-to-load mismatch resulted in slow upstrokes and a local conduction delay (0.92 ms). In the HZ, the reduced total I\textsc{Na} shifted the current-to-load balance in favour of the load, which resulted in conduction block.

In Figure 6C, the dependence of the conduction delay and the occurrence of block were investigated as a function of g\textsc{to} in strands releasing branches of different lengths (20, 10, 7, 5, and 2 myocytes).

In the absence of I\textsc{to} (g\textsc{to} = 0), conduction was successful for both genotypes but, irrespective of branch length, the conduction delay for the HZ was always longer than for the WT. For branch lengths of 20, 10, 7, and 5 myocytes, increasing g\textsc{to} led to a progressively increasing conduction delay, until conduction block occurred. The prolongation of the conduction delay was much more prominent for the HZ and the level of g\textsc{to} at which block occurred was considerably lower. While, for both genotypes, the g\textsc{to} level at which block occurred was almost the same for branch lengths of 20 and 10 myocytes, this g\textsc{to} level was larger for shorter branches. Only when branches were much shorter (two
cells) than the space constant, conduction did not fail and the conduction delay remained small for both the WT and the HZ.

Thus, successful conduction in the branched HZ strand is strongly dependent on $I_{\text{to}}$ and branch length. This contrasts with the minimal dependence of the velocity of continuous conduction on $I_{\text{to}}$ as illustrated in Figure 6D, increasing $g_{\text{to}}$ from 0 to 4 mS/mF slowed conduction by a few percent only.

When the local conduction delay across the branch point was longer than $1$ ms, it provided enough time for $I_{\text{to}}$ to activate in the cells immediately before the branch point. The activated $I_{\text{to}}$ then acted to diminish the amount of current available to depolarize the cells beyond the branch point to threshold. When $g_{\text{to}}$ was increased, it therefore resulted in a prolongation of the conduction delay and precipitated block. In the presence of mutant $I_{\text{Na}}$ characterized by accelerated inactivation, the marked diminution of $I_{\text{Na}}$ after 1–2 mS/F (Figure 2) further exacerbated these alterations of conduction.

In Figure 6E, the $(g_{\text{to}}, [K^+]_o)$ parameter space was explored to identify the combinations of $g_{\text{to}}$ and $[K^+]_o$ leading to conduction block in the HZ but not in the WT (light grey area). In this series of simulations, branches were 20 myocytes long. $[K^+]_o$ was varied from 2.5 to 12.0 mmol/L in steps of 0.5 mmol/L, and, for each tested $[K^+]_o$, the critical value of $g_{\text{to}}$ at which conduction block occurred was assessed with a precision of 0.005 mS/mF. Conduction block in the HZ but not in the WT was obtained in a wide region in the parameter space, delimited by bell-shaped boundaries. Furthermore, for all $[K^+]_o$, there was a several fold difference between WT and HZ regarding the critical levels of $g_{\text{to}}$ at which block occurred. A qualitatively similar difference was observed for branches 10, 7, and 5 myocytes long (data not shown). These findings therefore suggest that in discontinuous cardiac tissue, mutations of $I_{\text{Na}}$ exhibiting biophysical characteristics similar to those of the C1850S mutant result in cardiac excitation that is definitely more prone to slow conduction and conduction block, the key ingredients of re-entrant arrhythmogenesis.21

### 4. Discussion

In this study, we investigated the biophysical characteristics of a novel SCN5A BrS mutation, C1850S, at physiological temperature. In addition, we performed AP and conduction simulations using the LRd model to investigate the
mechanisms underlying the arrhythmogenic alterations of repolarization and conduction. C1850S channels generated smaller peak $I_{Na}$, and many of the Nav1.5 steady-state and time-dependent inactivation properties were altered. These alterations significantly reduce $I_{Na}$ during the early phases of the AP. The simulations suggest that at the heterozygous state, the mutation can depress conduction in myocardium exhibiting sites of current-to-load mismatch, as exemplified in our study by a myocyte strand releasing branches.

Figure 6 Conduction in a discontinuous structure is more prone to block in the presence of the C1850S mutation. (A) Schematic of discontinuous cardiac tissue (top) and its representation using the Luo-Rudy model as a strand releasing two branches (bottom). Gray areas represent inexcitable clefts (e.g., connective tissue in fibrosis) between scarcely connected parallel fibres of cardiac myocytes. (B) Simulated action potentials ($V_m$), WT and mutant $I_{Na}$, as well as $I_{to}$ for the wild-type (WT) and heterozygote (HZ) genotypes. Branches were 20 myocytes long in this simulation. Data are shown for the 10 cells proximal and distal to the branch point. The bold traces correspond to the cell at the branch point. $g_{to} = 0.5$ mS/μF and $[K^+]_o = 4$ mmol/L. (C) Conduction delay across the branch point for $[K^+]_o = 4$ mmol/L, as a function of $g_{to}$ for the WT and HZ genotypes. These simulations were conducted with branches 20, 10, 7, 5, and 2 myocytes long (labels). Round symbols denote the occurrence of conduction block. (D) Conduction velocity in unbranched WT and HZ strands as a function of $g_{to}$ ($[K^+]_o = 4$ mmol/L). (E) Boundaries between successful conduction and conduction block in the ($[K^+]_o$, $g_{to}$) parameter space for the WT and HZ genotypes (branch length: 20 cells). Combinations of $[K^+]_o$ and $g_{to}$ above the corresponding curves lead to conduction block (white area: successful conduction for both genotypes; light grey area: successful conduction for the WT genotype but block for the HZ genotype; dark grey area: conduction block for both genotypes). The dot corresponds to the simulation represented in B.
4.1 Heterogeneity of the biophysical properties of Brugada syndrome Na\(_{\text{1.5}}\) channels

Thus far, the cardiac arrhythmias database\(^2\) of the European Society of Cardiology lists more than 90 SCN5A BrS mutations. Among them, five are located in the intracellular C-terminus of Na\(_{\text{1.5}}\) (Figure 1B). Functional characterization has been performed for only 23 mutations (three of them are in the C-terminus).\(^{23}\) The vast majority of these mutations reduce the \(I_{\text{Na}}\) mediated by Na\(_{\text{1.5}}\). However, the molecular mechanisms underlying this reduction are very heterogeneous,\(^{23}\) and most of the mutant channels have a unique pattern of alterations. One can divide these mutations causing loss of function of Na\(_{\text{1.5}}\) (Figure 1B) into two categories. (1) A reduction in steady-state availability due to a prominent prolongation of the branching-induced local conduction delay. (2) Changes in biophysical properties.\(^{23}\) The mutation found in this BrS patient replaces Cys-1850 by a Ser located in a highly conserved part of the C-terminus form a highly structured domain comprising six \(\alpha\)-helices.\(^{24}\) Without more knowledge about the detailed role of this domain, one cannot but speculate about the consequences of this mutation. The biophysical alterations induced by C1850S are mainly related to the \(I_{\text{Na}}\) fast inactivation process. The negative shift of the steady-state availability curve and faster onset of fast inactivation are both consistent with a ‘stabilization’ of inactivated states (fast and slow/intermediate) of mutant channels. Altogether, these findings suggest that Ser-1850, by enhancing the inactivation process, contributes to a ‘loss-of-function’ of mutant channels. Our simulations suggest that acceleration of inactivation alone (determined by the rate \(\beta_n\)) can underlie both the acceleration of inactivation and the shift of steady-state inactivation (by rendering inactivated states more stable) without influencing the activation process.

4.2 Action potential and conduction alterations in the Brugada syndrome

The molecular, cellular, and arrhythmogenic mechanisms underlying the ECG alterations seen in BrS are still a matter of debate.\(^1\) According to the ‘repolarization disorder hypothesis’, re-entrant arrhythmias are caused by a heterogeneous loss of the AP epicardial dome leading to epicardial dispersion of refractoriness, which forms the substrate for reentry. According to the ‘conduction disorder hypothesis’, the typical ECG signs can be explained by slow conduction and activation delays in the right ventricle (in particular in the right ventricular outflow tract).

Our computational results support the conduction disorder hypothesis. On the one hand, loss of the dome was more prone to occur in the presence of mutant \(h_{\text{Na}}\) in single cells. However, the level of \(I_{\text{Na}}\) at which abrupt repolarization occurred was only minimally smaller (1%) for the HZ compared with the WT. On the other hand, in discontinuous tissue, conduction delays and block were markedly potentiated by the presence of mutant \(h_{\text{Na}}\). Interestingly, the levels of \(I_{\text{Na}}\) conductance at which these manifestations occurred were strikingly different from those necessary to result in premature repolarization. Increasing \(g_{\text{Na}}\) to 1.3 mS/\(\mu\)F or more was necessary to result in a loss of the dome in the HZ cell. However, in the branched HZ tissue, a prominent prolongation of the branching-induced local conduction delay and conduction block were already observed at \(g_{\text{Na}}\) levels <0.6 mS/\(\mu\)F for branches consisting of five myocytes or more. In the original formulation of right ventricular \(I_{\text{Na}}\) by Dumaine \textit{et al.},\(^{12}\) a value of 1.1 mS/\(\mu\)F was used. In human right ventricular tissue,\(^{17}\) maximal peak \(I_{\text{Na}}\) was measured to be 9.8 pA/pF (at +60 mV at 36 °C), which translates, assuming a reversal potential of −90 mV and a maximal channel open probability of 0.25, to −0.23 mS/\(\mu\)F. Our study thus suggests that \(I_{\text{Na}}\)-mediated premature repolarization would require a considerable increase in \(I_{\text{Na}}\) density, while conduction alterations in discontinuous tissue could occur at \(I_{\text{Na}}\) levels comparable with those measured previously. In view of the recent findings indicating that structural abnormalities may be involved in the pathogenesis of BrS,\(^{19,20}\) we therefore propose the ‘conduction disorder in discontinuous tissue hypothesis’ as a further mechanism that should deserve a particular attention.

4.3 Role of \(I_{\text{Na}}\) in discontinuous conduction

It has been shown\(^{21}\) that the L-type calcium current (\(I_{\text{Ca,L}}\)) greatly contributes to the success of conduction when conduction is characterized by local conduction delays that extend beyond \(I_{\text{Na}}\) inactivation. In such situations, suppression of \(I_{\text{Ca,L}}\) can precipitate conduction block. Because the time to peak of \(I_{\text{Ca,L}}\) and \(I_{\text{Na}}\) is very similar, our study indicates that \(I_{\text{Na}}\) modulates discontinuous conduction via an analogous mechanism with an opposed polarity. Thus, an increased \(I_{\text{Na}}\) density may precipitate block across a discontinuous structure, while blocking \(I_{\text{Na}}\) may result in a recovery from conduction block. Moreover, our ‘conduction disorder in discontinuous tissue’ concept is in line with the recent finding that a BrS ECG pattern can also be caused by mutations causing loss of function of \(I_{\text{Ca,L}}\).\(^{25}\)

4.4 Effects of extracellular \([K^{+}]\)

Previous work has shown that both hypo- and hyperkalemia can exacerbate the ECG phenotype of BrS.\(^{15,16}\) In our simulations, we observed a biphasic dependence on \([K^{+}]\), of the level of \(g_{\text{Na}}\) leading to conduction block in the branching strand (Figure 6E). This biphasic dependence is reminiscent of the well-known biphasic dependence of conduction velocity (CV) on \([K^{+}]\), which was investigated computationally in detail by Shaw and Rudy.\(^{26}\) As shown in their work, when the resting membrane is hyperpolarized by a decrease of \([K^{+}]\), CV decreases because the charge necessary to bring the membrane to threshold increases. However, during elevation of \([K^{+}]\), CV initially increases (supernormal conduction) until \(K^{+}\)-induced membrane depolarization results in an increasing fraction of inactivated \(h_{\text{Na}}\), leading then to conduction slowing. In the setting of a current-to-load mismatch, as exemplified by tissue branching, this consideration regarding the charge necessary to reach threshold (load) vs. the available \(h_{\text{Na}}\) also explains the biphasic behaviour of conduction block in the branching strand. Thus, our results are in agreement with the notion that changes in \([K^{+}]\); in both directions may exacerbate the clinical manifestations of carriers of mutations leading to a loss of \(I_{\text{Na}}\) function. Moreover, it could be hypothesized that, among other factors, variations in plasma \([K^{+}]\) may play a role in the transient nature of the BrS ECGs.
4.5 Study limitations
The clinical manifestations of BrS are rate-dependent.18 Because of the computational cost of the LRd model, we did not investigate the rate-dependence of conduction characteristics in the branching strands and left the rate-dependent aspects of BrS during long term pacing of single cells out of our study. The simulations of conduction therefore suffer from the limitation that a single stimulus was applied instead of continuous pacing until intracellular ion concentrations have reached their true steady state. As shown in this study, the AP phenotype and conduction block in discontinuous tissue critically depend on the balance between inward and outward currents during early repolarization. Furthermore, the rate-dependence of the AP and of conduction is governed by very intricate dynamic interactions between repolarization, recovery of I_{Na} from inactivation and intracellular Na\(^+\) and Ca\(^{2+}\) overload at rapid pacing rates.10,27 Pacing at different rates or during different periods of time will therefore affect the availability of I_{Na}, I_{Ca,L}, and I_{Ca} during the early phases of the AP and thus the quantitative outcome of the simulations in comparison to an isolated stimulus.

Because numerous membrane transporters relevant to Na\(^+\) and K\(^+\) homeostasis are not incorporated into the LRd model (e.g. the Na\(^+\)/glucose symport and the Na\(^+\)/H\(^+\) exchanger), it cannot be absolutely guaranteed that the intracellular ion concentrations in the model exactly match those in the human heart in vivo. One can nevertheless speculate that at a given heart rate, [Na\(^+\)]\(_i\), might be lower in the presence of the mutation because less Na\(^+\) enters the cell during the AP upstroke. This would increase the driving force for I_{Na}. While this increase might partially compensate for the I_{Na} loss due to the mutation, it appears however unlikely that the extent of this increase would suffice to fully offset the loss of I_{Na} that we observed experimentally.

In addition, since the patient also showed a BrS ECG at normal temperature, we did not test for effects of higher temperature on the biophysical characteristics of mutant cells.

4.6 Conclusions
In conclusion, these results confirm that mutations of the C-terminal domain of Na\(_v\)1.5 significantly alter the inactivation properties of the channel, and support the notion that conduction alterations in discontinuous tissue may be involved in the pathogenesis of BrS. Finally, the computational analyses allowed us to formulate clinically-relevant hypotheses regarding the cellular basis of arrhythmogenesis in the context of BrS, which deserve further investigations.

Supplementary material
Supplementary material is available at Cardiovascular Research online.

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