Review Article

Tetrahydrobiopterin Improves Endothelial Function in Cardiovascular Disease: A Systematic Review

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Background. Tetrahydrobiopterin (BH$_4$) is a cofactor of nitric oxide synthase (NOS). Nitric oxide (NO) bioavailability is reduced during the early stage of vascular diseases, such as coronary artery disease, hypercholesterolemia, hypertension, and diabetic vasculopathy, and even throughout the entire progression of atherosclerosis. Methods. A literature search was performed using electronic databases (up to January 31, 2014), including MEDLINE, EMBASE, and Cochrane Central Register of Controlled Trials (CENTRAL), using an established strategy. Results. Fourteen articles were selected with a total of 370 patients. Ten of the fourteen studies showed a significant improvement in the endothelial dysfunction of various cardiovascular disease groups with BH$_4$ supplementation compared with the control groups or placebos. Three studies showed no positive outcome, and one study showed that low-dose BH$_4$ had no effect but that high-dose BH$_4$ did have a significantly different result. Conclusions. This review concludes that supplementation with BH$_4$ and/or augmentation of the endogenous levels of BH$_4$ will be a novel approach to improve the endothelial dysfunction observed in various cardiovascular diseases. BH$_4$ might be considered to be a new therapeutic agent to prevent the initiation and progression of cardiovascular disease.

1. Introduction

Cardiovascular diseases (CVDs), such as coronary artery disease, hypercholesterolemia, diabetes, hypertension, and stroke, remain the largest cause of mortality and morbidity in the world. In 2014, the attributable fractions of adjusted estimated population for the mortality of CVDs are as follows: 40.6% for high blood pressure, 13.7% for smoking, 13.2% for poor diet, 11.9% for insufficient physical activity, and 8.8% for abnormal blood glucose levels [1]. Abnormal endothelial function appeared as an early feature of all CVDs and risk factor syndromes, resulting in the loss of normal homoeostatic pathways that act to inhibit disease processes such as inflammation, thrombosis, and oxidative stress [2, 3].

The endothelium is the largest endocrine organ in the human body and can be involved in the control of vascular tone, platelet reactivity, coagulation, and permeability [4]. Thus, healthy endothelium can protect against excessive/abnormal inflammation and coagulation [5], which are the key processes in CVD development and progression. Furthermore, endothelial function was demonstrated to serve as a predictor of cardiovascular events [6, 7]. Therefore, the evaluation of endothelial function is vital to generate and determine a more effective or final therapeutic strategy for cardiovascular diseases. From a pathophysiologic standpoint, there is an important focus on the prevention and treatment of vascular diseases via the restoration of the normal biosynthesis of nitric oxide (NO) and the reduction of the excessive generation of superoxide anions and reactive oxygen species (ROS).

Tetrahydrobiopterin (BH$_4$) is an essential cofactor for a set of enzymes that are of pivotal metabolic importance, including four aromatic amino acid hydroxylases (AAAH), three nitric oxide synthases (NOS), and alkylglycerol monooxygenase (AGMO). Phenylalanine hydroxylase (PAH) was the first enzyme recognized to depend on BH$_4$ [8]. Phenylketonuria is a genetic disorder characterized by a deficiency of PAH; BH$_4$ may provide good phenylalanine control in the patients who respond to oral administration of BH$_4$. NOS is a critical enzyme mitigated in the production of the messenger molecule NO, which is generated from L-arginine. BH$_4$ is inseparably considered to be a cofactor of NOS enzymes for the progression of NO synthesis [9, 10].
When BH₄ is limited, under the conditions of oxidative stress, BH₄ can be readily oxidized to dihydrobiopterin (BH₄) and eventually converted into biopterin, especially when NOS cofactor activity is not needed. When NOS is uncoupled, ROS rather than NO is produced. NO is used as a soluble gas continuously synthesized from the amino acid L-arginine in endothelial cells via the constitutive calmodulin-dependent enzyme NOS. This substance has a wide variety of biological properties that maintain vascular homeostasis, including the modulation of vascular dilator tone, regulation of local cell growth, and protection of the vessel from the injurious consequences of platelets and cells circulating in the blood. In the early period of different CVDs, the bioavailability of NO is reduced. In humans, endothelial function is altered in different subjects with vascular disease status and correlated with risk factor profiles [2, 11]. Importantly, several prospective studies have identified that supplementation with BH₄ improves endothelial function in patients with coronary artery disease, hypercholesterolemia, hypertension, and diabetic vasculopathy [12–15]. Moreover, there are published clinical studies of BH₄ therapy in the pathogenesis of other vascular diseases, such as pulmonary hypertension [16] and smoking [17, 18], as well as in aging [19–21].

In this regard, supplementation with BH₄ and/or strategies that augment the endogenous levels of BH₄ have been recently identified to be novel approaches that can exert salutary effects on the endothelial dysfunction induced by a variety of vascular diseases. This concept and its therapeutic implications are the focus of considerable investigation, which will likely generate an enlarged spectrum of therapeutically agents available for CVDs.

2. Materials and Methods

A systematic review of the literature concerning BH₄ to improve vascular endothelial function in adult patients was conducted using the recommended guidelines provided by the Cochrane Handbook for the Systematic Reviews of Interventions.

2.1. Search Methods for the Identification of Studies. To select eligible studies, a search was performed of electronic databases, including PUBMED, MEDLINE, and the Cochrane Library, using a search strategy that depended on combinations of the keywords tetrahydrobiopterin/BH₄ and endothelial function or endothelial dysfunction. The last search was updated to January 31, 2014. We deliberately broadened the search to ensure the inclusion of all relevant articles. All the bibliographies of papers retrieved from the search were also screened for additional articles. Only full publications in peer-reviewed journals were selected for potential inclusion in the review.

2.2. Study Selection Criteria. Two reviewers independently assessed titles, abstracts, and/or the full-text papers of the records retrieved from the electronic database searches for possible inclusion according to the predefined selection criteria: (1) type of study, only RCTs were selected for further assessment; (2) participants, only CVD patients older than 18 years were included, regardless of gender; (3) type of intervention, the intervention used any generation of BH₄ alone or combined with other substances, irrespective of the administration approach, and the intervention in the control group was a placebo, alone or combined with other substances; and (4) outcomes, trials focused on the effect of supplementation of BH₄ on endothelial function in patients with CVD.

2.3. Quality Assessment. This study is a “qualitative systematic review” without a meta-analysis. The methodological quality of the RCTs was assessed independently by two reviewers (see Table 1) according to the methods recommended in Section Six of the Cochrane Handbook for Systematic Reviews of Interventions, Version 5.1.0.

3. Results

3.1. Description of Selected Studies. Citations and abstracts were downloaded into Mendeley and Endnote 6 by independent researchers, and any duplicates were deleted. The main search strategy identified 802 publications, and 356 were excluded because of duplication (Figure 1).

A preliminary screening of the titles and abstracts was performed according to the following inclusion criteria: studies related to BH₄ and endothelial function. We excluded reviews, meeting notes, book chapters, animal experiments employing qualitative methods, findings derived from qualitative methods, interviews, and observations or participant observations. Access to the full text of the remaining articles was then sought (see Figure 1).

3.2. Tetrahydrobiopterin in the Treatment of Cardiovascular Disease. In a range of in vivo pharmacological experiments,
Clinical studies have been employed to explore the role of BH₄ on eNOS function in the context of cardiovascular diseases, including coronary artery disease, hypercholesterolemia, hypertension, and diabetic vasculopathy. Based on the resulting experimental evidence, endothelial BH₄ bioavailability has emerged as a rational therapeutic target in vascular disease states (see Table 2).

### 3.3. Coronary Artery Disease

BH₄ was administered acutely or on a short-term basis, delivered via intracoronary/intrarterial infusion [13, 22–25]. In one study, oral BH₄ was used at a low dose (400 mg/d) or high dose (700 mg/d) for 2 to 6 weeks [26]. In another study, BH₄ alone did not influence the vessel area but did prevent vasoconstriction in response to acetylcholine (ACh) (+2 ± 3%, NS, versus baseline) in 15 of the patients with endothelial dysfunction in the trial. Correspondingly, calculated volume flow showed the highest value after coinfusion with Ach and BH₄ [25]. BH₄ significantly improved acetylcholine-induced increases in coronary blood flow (CBF) in patients with diminished flow responses but exerted no effect in those with normal flow responses [22]. However, no difference was observed in the Ach response due to the coinfusion of BH₄ and Ach with respect to the % change in CBF [24]. Settgren et al. found that the endothelium-dependent vasodilatation was significantly less reduced at 15 and 30 min of reperfusion following L-arginine and BH₄ infusion than with saline infusion [25]. BH₄ did not affect the relative changes in the brachial artery diameter from baseline flow-mediated vasodilation (FMD)(%) in type 2 diabetic and coronary heart disease patients [23]. Oral BH₄ treatment for 2 to 6 weeks significantly augmented the BH₄ levels in plasma but had no effect on the vascular redox state or endothelial function [26].

### 3.4. Hypercholesterolemia

The method of administration was mainly infusion via the brachial artery [27–29] or coronary ostium [30]. 22 hypercholesterolemic patients were randomized into groups receiving 4 weeks of oral BH₄ (400 mg twice daily) or placebo [14]. In all studies, BH₄ restored the vascular function in the patients with hypercholesterolemia. BH₄ also restored the endothelial function of coronary arteries in the patients with hypercholesterolemia [28, 30]. BH₄ attenuated the Ach-induced decrease in coronary diameter and restored the Ach-induced increase in coronary blood flow [30]. BH₄ increased exercise-induced hyperemia in all subjects but had no influence on myocardial blood flow (MBF) at rest or during adenosine-induced hyperemia in all subjects. Flow reserve utilization was increased significantly in hypercholesterolemic subjects but remained unchanged in controls [28]. The vasoconstrictor response to L-monomethyl-arginine (L-NMMA) was significantly increased with BH₄ treatment compared with saline infusion (P < 0.05); additionally, the impaired

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**Table 1: Basic characteristics of the included clinical trials.**

<table>
<thead>
<tr>
<th>Study, year</th>
<th>Methods</th>
<th>BH₄-treated Number</th>
<th>Sex (M/F)</th>
<th>Age</th>
<th>Placebo Number</th>
<th>Sex (M/F)</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maier et al., 2000 [13]</td>
<td>Randomized</td>
<td>19</td>
<td>3/16</td>
<td>56 ± 10</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Setoguchi et al., 2001 [22]</td>
<td>Randomized</td>
<td>15</td>
<td>10/5</td>
<td>60 ± 11</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Nyström et al., 2004 [23]</td>
<td>Randomized; single-blind crossover</td>
<td>5</td>
<td>5/0</td>
<td>57 ± 2</td>
<td>5</td>
<td>5/0</td>
<td>57 ± 2</td>
</tr>
<tr>
<td>Worthley et al., 2007 [24]</td>
<td>Randomized controlled</td>
<td>22</td>
<td>4/18</td>
<td>60 ± 9</td>
<td>5</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Settergren et al., 2009 [25]</td>
<td>Randomized; blind, crossover</td>
<td>12</td>
<td>12/0</td>
<td>71 ± 1.5</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cunnington et al., 2012 [26]</td>
<td>Randomized; double-blind; parallel design</td>
<td>30</td>
<td>3/27</td>
<td>*</td>
<td>19</td>
<td>3/16</td>
<td>68 ± 2</td>
</tr>
<tr>
<td>Stroes et al., 1997 [27]</td>
<td>Randomized controlled</td>
<td>13</td>
<td>9/4</td>
<td>32 ± 4</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fukuda et al., 2002 [30]</td>
<td>Randomized controlled</td>
<td>9</td>
<td>7/2</td>
<td>61 ± 9</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wyss et al., 2005 [28]</td>
<td>Randomized controlled</td>
<td>9</td>
<td>7/2</td>
<td>54 ± 8</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Holowatz and Kenney, 2011 [29]</td>
<td>Randomized controlled</td>
<td>9</td>
<td>6/3</td>
<td>53 ± 3</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cosentino et al., 2008 [14]</td>
<td>Randomized; double-blind; parallel design</td>
<td>11</td>
<td>7/4</td>
<td>61 ± 9</td>
<td>10</td>
<td>10/0</td>
<td>54 ± 10</td>
</tr>
<tr>
<td>Higashi et al., 2002 [31]</td>
<td>Randomized controlled</td>
<td>8</td>
<td>6/2</td>
<td>48 ± 11</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Porkert et al., 2008 [12]</td>
<td>Randomized</td>
<td>8</td>
<td>6/2</td>
<td>44 ± 9</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heitzer et al., 2000 [15]</td>
<td>Randomized controlled</td>
<td>23</td>
<td>7/16</td>
<td>52 ± 2</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>12</td>
<td>8/4</td>
<td>50 ± 3</td>
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</tr>
</tbody>
</table>
serotonin-induced vasodilation was restored by this treatment [27]. Localized BH4 alone or in combination with other substances augmented the NO-dependent vasodilatation in hypercholesterolemic patients but showed no effect in normocholesterolemic subjects [29]. BH4 restored endothelium-dependent, NO-mediated vasodilatation but had no effect on endothelium-independent vasodilatation due to sodium nitroprusside [14].

3.5. Hypertension. BH4 (500 μg/min) was infused intrararterially for 5 min. The forearm blood flow (FBF) response to Ach in hypertensive patients increased significantly to the level of normal control subjects [31]. Oral high-dose BH4 (400 mg/d) produced a significant decrease in systolic (P < 0.03) and mean blood pressure (BP) (P < 0.04). The decrease in diastolic BP did not reach statistical significance (P < 0.08). No significant change in BP was observed in subjects given low-dose BH4 (200 mg/d). There was a significant improvement in FMD with 400 mg of BH4 but no significant change with 200 mg of BH4 [12].

3.6. Diabetic Vasculopathy. In diabetes, cardiovascular disease is a common complication. Endothelial dysfunction occurs as the first step in the pathogenesis of diabetes to promote arteriosclerosis. BH4 enhanced vascular response to acetylcholine-induced vasodilatation, whereas endothelium-independent vasodilatation was not affected in diabetes patients [15, 25]. In contrast, Cosentino et al. found that BH4 improved glucose disposal in individuals with type 2 diabetes but without any discernible changes in vasodilatation or macrovascular blood flow [14]. BH4 restored the endothelium-dependent vasodilatation induced by an oral glucose challenge in the forearm of healthy subjects [32].

4. Discussion

Previous research has indicated that maintaining adequate BH4 levels in the endothelium is critical in regulating the balance of NO and superoxide synthesis in CVDs. Numerous studies have examined the effect of BH4 supplementation on endothelial dysfunction in a wide variety of CVDs, including coronary artery disease, hypercholesterolemia, hypertension, and diabetic vasculopathy. The substitution of BH4, an essential cofactor of NOS and a scavenger of oxygen-derived free radicals, is able to restore coronary vasomotion in response to Ach [13, 22, 30]. Supplementation with BH4

<table>
<thead>
<tr>
<th>Study, year</th>
<th>Disease</th>
<th>Outcome</th>
<th>Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maier et al., 2000 [13]</td>
<td>Ischemia reperfusion injury</td>
<td>Prevents endothelial dysfunction</td>
<td>6R-BH4 (Alexis Corp.) intracoronary 10^{-2} M, for 2 min</td>
</tr>
<tr>
<td>Setoguchi et al., 2001 [22]</td>
<td>Coronary artery disease</td>
<td>Improves endothelium-dependent vasodilatation</td>
<td>6R-BH4 (Clinalfa) intracoronary infusion 4 μg/min for 2 min</td>
</tr>
<tr>
<td>Nyström et al., 2004 [23]</td>
<td>Type 2 diabetic and coronary heart disease</td>
<td>Had no effect on endothelial-dependent vasodilatation</td>
<td>6R-BH4 (Schircks) intra-arterial infusion 500 μg/min</td>
</tr>
<tr>
<td>Worthley et al., 2007 [24]</td>
<td>Atherosclerotic disease</td>
<td>Does not improve endothelial function</td>
<td>6R-BH4 (Clinalfa) infusion 250 μg/min and 500 μg/min for 6 min</td>
</tr>
<tr>
<td>Settergren et al., 2009 [25]</td>
<td>Diabetes (type II) and coronary artery disease</td>
<td>Improves endothelial dysfunction</td>
<td>6R-BH4 (Clinalfa) intra-arterial infusion 500 μg/min</td>
</tr>
<tr>
<td>Cunnington et al., 2012 [26]</td>
<td>Coronary artery disease</td>
<td>Has no net effect on vascular redox state or endothelial function</td>
<td>6R-BH4 (Schircks) 400 mg/d or 700 mg/d per oral for 2 to 6 weeks</td>
</tr>
<tr>
<td>Stroes et al., 1997 [27]</td>
<td>Hypercholesterolemia</td>
<td>Restored NO-dependent vasodilatation</td>
<td>6R-BH4 (Alexis Corp.) infusion 500 μg/min</td>
</tr>
<tr>
<td>Fukuda et al., 2002 [30]</td>
<td>Hypercholesterolemia</td>
<td>Improves coronary endothelial function</td>
<td>6R-BH4 (Sigma) intracoronary 1 mg/min for 2 min</td>
</tr>
<tr>
<td>Wyss et al., 2005 [28]</td>
<td>Hypercholesterolemia</td>
<td>Restores flow reserve utilization</td>
<td>6R-BH4 (Schircks) infusion 10 mg kg^{-1} over 30 min</td>
</tr>
<tr>
<td>Holowatz and Kenney, 2011 [29]</td>
<td>Hypercholesterolemia</td>
<td>Augmented NO-dependent vasodilatation</td>
<td>6R-BH4 (Sigma) 10 mM</td>
</tr>
<tr>
<td>Cosentino et al., 2008 [14]</td>
<td>Hypercholesterolemia</td>
<td>Restores NO bioavailability and endothelial function</td>
<td>6R-BH4 (Schircks) 400 mg twice daily orally for 4 weeks</td>
</tr>
<tr>
<td>Higashi et al., 2002 [31]</td>
<td>Hypertension</td>
<td>Augments endothelium-dependent vasodilatation</td>
<td>6R-BH4 (Sigma) infusion 500 μg/min</td>
</tr>
<tr>
<td>Pórkert et al., 2007 [12]</td>
<td>Hypertension</td>
<td>Significant improvement in endothelial function in higher doses</td>
<td>6R-BH4 (Schircks) oral 5/10 mg kg^{-1} day for 8 weeks and 200/400 mg for 4 weeks</td>
</tr>
<tr>
<td>Heitzer et al., 2000 [15]</td>
<td>Diabetes (type II)</td>
<td>Improves endothelium-dependent vasodilatation</td>
<td>6R-BH4 (Schircks) intra-arterial infusion 500 μg/min</td>
</tr>
</tbody>
</table>

Table 2: Effects of BH4 supplementation in human vascular disease.
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augments forearm vessel endothelium-dependent vasodilation by improving endothelial dysfunction [25, 27, 31]. The flow reserve utilization of the coronary microcirculation in hypercholesterolemic subjects is significantly reduced but is nearly restored after BH₄ infusion [28]. BH₄ augmented NO-dependent vasodilation during local heating by increasing the plateau in skin blood flow in hypercholesterolemic humans [29].

These studies involved a limited number of patients in whom BH₄ was administered acutely or on a short-term basis, and BH₄ was typically delivered via intracoronary/intraarterial infusion, which is not representative of a suitable route of administration for chronic disease management. The breadth of preclinical and acute clinical data implicating BH₄ as a key regulator in endothelial function suggests that oral BH₄ therapy may be able to prevent or treat CVDs. Clinical trials investigating oral BH₄ supplementation have shown varied efficacy in numerous disorders with an apparent lack of efficacy in diseases such as hypertension, hypercholesterolemia, and coronary artery disease. Porkert and coworkers showed that oral BH₄ at a daily dose of 400 mg or higher has a significant and sustained antihypertensive effect in subjects with poorly controlled hypertension but that lower dose (200 mg per day) BH₄ has no effect [12]. Twenty-two hypercholesterolemic patients were randomized to receive 4 weeks of either oral BH₄ (400 mg twice daily) or placebo, and age-matched healthy volunteers served as controls. They found that chronic BH₄ treatment led to an eightfold increase in plasma BH₄ levels and restored the impairment in endothelium-dependent relaxation due to ACh in hypercholesterolemic patients but did not affect control subjects. Importantly, they also demonstrated that BH₄ significantly reduced the plasma levels of 8-F2 isoprostane, a marker of oxidative stress, and that the effect of BH₄ treatment on NO bioavailability is independent of any change in LDL cholesterol [14]. In contrast, oral low-dose (400 mg/d) or high-dose (700 mg/d) BH₄ for 2 to 6 weeks in patients with established coronary artery disease significantly elevated plasma BH₄ levels. However, this elevation in plasma BH₄ was tempered by similar rises in plasma BH₄ and biopterin, so that the ratio of reduced biopterins to oxidized ones (BH₂/[BH₂+biopterin]) in plasma remained unchanged after treatment, with neither molecule having an effect on the vascular redox state or endothelial function [26]. In addition, a phase 2 clinical trial sponsored by the US pharmaceutical company BioMarin failed to observe an ameliorative effect of the oral administration of BH₄ in patients with poorly controlled hypertension. There are studies providing preliminary evidence that oral BH₄ could increase artery compliance and decrease arterial stiffness in healthy older men [33] or estrogen-deficient postmenopausal women [34]. 6R-BH₄ was administered starting at a dose of 2.5 mg/kg and increasing to 20 mg/kg over 8 weeks. This treatment produced an improvement in the 6-minute walking distance, with the most significant improvement at a dose of 5 mg/kg, in patients with pulmonary hypertension [16].

The vascular effects following the oral administration of BH₄ appear complex and dose dependent, which may be explained by either the rapid clearance of BH₄ after oral administration and/or an enhanced oxidation to BH₂, which lacks eNOS cofactor activity. Thus, systemic oxidative stress may play a critical role in determining the degree of oxidation of BH₄ to BH₂ and hence the ratio of BH₄/BH₂ and efficacy of the treatment [26]. Recent data from cultured endothelial cells [35, 36] suggest that the intracellular levels of BH₂ and, more specifically, the ratio between reduced and oxidized biopterins are important in regulating eNOS coupling. Considering that BH₄ is easily oxidized to BH₂, strategies should increase the supplementation of BH₄ with antioxidants. On one hand, they can reduce the oxidation of BH₄ to BH₂; on the other hand, they may synergistically decrease oxidative stress and increase nitric oxide. This hypothesis is supported by observations in which the antioxidant vitamin C stimulates eNOS enzymatic activity by increasing the intracellular concentration of BH₄ [33, 37]. Vitamin C likely exerted its beneficial effects in that study through a variety of molecular mechanisms. In its capacity as an antioxidant, it enhances NO bioavailability by quenching O²⁻, thus limiting the inactivation of NO that occurs when O²⁻ and NO combine to produce OONO⁻ [38]. Vitamin C also stabilizes existing BH₄ [39] and increases endothelial BH₄ synthesis [40]. We have demonstrated that plasma biopterin oxidation status is closely linked to the amount of ascorbate in plasma and hence in the diet in vivo [41]. However, studies in larger cohorts of patients would be required to determine whether this dual (BH₄ plus antioxidant) intervention would be efficacious on a chronic basis.

In addition, acute or short-term supplementation with BH₄ via intracoronary/intra-arterial infusion has no beneficial effect on endothelial dysfunction in CVDs [23, 24]. These findings suggest that, in humans, BH₄ does not passively diffuse from the circulating blood into the vascular endothelium. Previous work has indicated that biopterin transport is cell type dependent and that both direct uptake (as BH₄) and conversion to BH₂ followed by recycling via dihydrofolate reductase (DHFR) are possible mechanisms [42]. In fact, in patients with coronary artery atherosclerosis, high plasma levels of BH₄ are associated with low BH₄ levels in the endothelium [43]. To ensure that BH₄ is imported into the endothelium, it must undergo oxidation to BH₂; imported BH₄ is then regenerated back to BH₄ by DHFR. A recent study found that human DHFR has very low affinity for 7,8-BH₂ and that folic acid inhibits 7,8-BH₂ recycling [44]. Thus, we consider that the low activity of endothelial DHFR is an important factor limiting the benefits of BH₄ therapies.

5. Conclusion

In summary, targeting BH₄ remains a rational therapeutic strategy in CADs. However, we found that oral BH₄ treatment in patients with CADs significantly elevates the BH₄ levels in blood but that this effect is significantly limited by the systemic oxidation of exogenous BH₄ to BH₂, which lacks eNOS cofactor activity. More studies should be directed toward interventions that can favorably alter the endogenous BH₄/BH₂ ratio in the human vascular endothelium via a
selective increase in the absolute BH$_4$ levels, the prevention of BH$_4$ oxidation, or an increase in BH$_4$ recycling. In particular, the effect of antioxidant coadministration to prevent the systemic and vascular oxidation of exogenous BH$_4$ warrants further attention. Beneficial effects of acute BH$_4$ supplementation on endothelial function have been reported in many human studies. However, the long-term based clinical trials are deficient. Oral administration can be considered to be representative of a suitable administration route for chronic disease management. Therefore, long-term experiments investigating oral BH$_4$ supplementation are needed.

**Conflict of Interests**

The authors declare that there is no conflict of interests.

**Authors’ Contribution**

Qiongying Wang and Mina Yang contributed equally to this work.

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**References**


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