Sympathetic Nerve Terminals in the Tunica Media of Human Superficial Temporal and Middle Cerebral Arteries: Wet Histofluorescence

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SUMMARY In specimens from the superficial temporal artery (STA) and middle cerebral artery (MCA), obtained during STA-MCA anastomosis, green fluorescent varicose fibers of sympathetic nerves were clearly visible with both formaldehyde-glutaraldehyde and sucrose-potassium phosphate-glyoxylic acid wet-histofluorescent techniques. These fibers were fairly thick, were densely packed and had a meshwork-like arrangement. Fluorescent terminals were seen both in the adventitia and in the outer muscular layer of the media in both STA and MCA specimens. They were more often observed in patients with prominent atherosclerosis in these vessels. The present study suggests the possible role of sympathetic nerve terminals in the development of vasospasm and occlusive lesions in cerebral vessels. It may also help to explain the marked constriction and transient occlusion following a STA-MCA bypass procedure.

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SUPERFICIAL TEMPORAL ARTERY (STA) — middle cerebral artery (MCA) anastomosis plays a potentially important role in the surgical treatment of ischemic cerebrovascular diseases. STA-MCA anastomosis is not a technically hazardous operation. However, when these vessels are not handled gently during the operation, marked spasm and transient postoperative occlusion are often seen angiographically within the first few days after the bypass procedure.1-4 Allen et al. reported in vitro contractile activity of vasoactive agents on human STA and MCA, and postulated that either the sympathetic nerves or serotonin could be the cause of arterial spasm in these segments.5 However, there have been no histochemical demonstrations of sympathetic nerve terminals in human STA and MCA. We present sympathetic nerve terminals in STA and MCA using wet-histochemical fluorescent techniques and discuss the possible role of these terminals in the development of vasospasm and arterial lesions.

Materials and Methods

The formaldehyde-glutaraldehyde (FaGlu) and sucrose-potassium phosphate-glyoxylic acid (SPG) wet-histofluorescent methods are useful because of their simplicity and constant visualization of catecholamine fiber arrangements. fluorescent terminals were seen in the adventitia of the vascular wall in both STA and MCA specimens. These terminals, within the media, were seen alongside elastic fibers (fig. 2). Most of them were observed in the collagen and elastic tissue of the innermost layer of the adventitia. They were fairly thick in diameter, had a high density of fluorescence and appeared in a meshwork-like or ring-like arrangement.

Fluorescent terminals were seen not only in the adventitia but also in the outer muscular layer of the media in 7 out of 13 specimens in both STA and MCA (table 1). In case 5 with minor completed stroke and STA-MCA bypass procedure, marked constriction and transient occlusion following a STA-MCA bypass procedure.1-4 Allen et al. reported in vitro contractile activity of vasoactive agents on human STA and MCA, and postulated that either the sympathetic nerves or serotonin could be the cause of arterial spasm in these segments.5 However, there have been no histochemical demonstrations of sympathetic nerve terminals in human STA and MCA. We present sympathetic nerve terminals in STA and MCA using wet-histochemical fluorescent techniques and discuss the possible role of these terminals in the development of vasospasm and arterial lesions.

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Table 1  Materials and Results

<table>
<thead>
<tr>
<th>Case</th>
<th>Age</th>
<th>Type of CVA</th>
<th>Arteriograms</th>
<th>Methods</th>
<th>Vascular lesions</th>
<th>MCA</th>
<th>STA$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 RT</td>
<td>57M</td>
<td>TIA*</td>
<td>L-MCA branch occlusions</td>
<td>FaGlu</td>
<td>mild</td>
<td></td>
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</tr>
<tr>
<td>2 HK</td>
<td>60M</td>
<td>TIA*</td>
<td>R-MCA branch occlusions</td>
<td>FaGlu</td>
<td>mild</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 YY</td>
<td>67M</td>
<td>CS*, mild</td>
<td>L-MCA branch occlusions</td>
<td>SPG</td>
<td>mild</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 KM</td>
<td>61M</td>
<td>RIND†</td>
<td>L-ICA stenosis</td>
<td>SPG</td>
<td>mild</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>5 TK</td>
<td>58M</td>
<td>CS, mild</td>
<td>L-carotid siphon stenosis</td>
<td>SPG</td>
<td>mild</td>
<td>+</td>
<td>+</td>
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<tr>
<td>6 UT</td>
<td>65F</td>
<td>CS, mild</td>
<td>L-ICA stenosis</td>
<td>SPG</td>
<td>mild</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>7 TK</td>
<td>37M</td>
<td>CS, mild</td>
<td>R-MCA branch occlusions</td>
<td>SPG</td>
<td>mild</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 SO</td>
<td>62M</td>
<td>CS, mild</td>
<td>R-MCA branch occlusions</td>
<td>SPG</td>
<td>moderate</td>
<td>+</td>
<td>+</td>
</tr>
</tbody>
</table>

CS* = completed stroke; RIND† = reversible ischemic neurological deficit; vascular lesions$^\dagger$ = severity of intimal thickening and medial fibrosis; MCA, STA$^\S$ = visualization of nerve terminals within the media of STA or MCA.

Discussion

A well-developed sympathetic nerve supply to the cerebral vascular bed was first presented in 1967 by Nielsen and Owman, using the Falck–Hillarp histofluorescent technique. These observations have been confirmed in both humans and in a number of laboratory animals, 9, 10 Electron microscopic studies have also shown that adrenergic nerve terminals come in close contact with the outer smooth muscle layer of the media, lose their Schwann cell sheath, and approach to within 80 to 100 nm of the smooth muscle cells.11 Therefore, there is no doubt that the arteries and arterioles of the human brain are enclosed by a plexus of adrenergic nerves which are superimposed on the media, and covered by the adventitia.10

Marked spasm is often seen angiographically during the first few days following an STA-MCA bypass procedure.5 Transient postoperative occlusion of STA-MCA branch anastomosis in three patients was shown by angiography within 12 days of operation.4 Allen et al. studied, in vitro, the contractile activity of vasoactive agents on human STA and the cortical branch of MCA.3 They showed that the sympathetic nerves supplying STA as well as MCA may play a physiological role in determining both small and large changes in the media.
diameter of these vessels, and postulated that the sympathetic nerves could be the cause of spasm in these arterial segments.

Catecholamine fluorescent intensity in the sympathetic nerve terminals of vessel walls was reduced after experimental subarachnoid hemorrhage. The amount of visible fluorescent nerve terminals in the adventitia was markedly reduced in experimental sub-

Figure 3.  

(a) Sympathetic adrenergic nerve terminals in STA. Strong fluorescence catecholamine fibers are seen within the media. They seem to appear along with elastic fibers. STA, Case TK 58y-o M, Completed Stroke (mild), L-Carotid Siphon Stenosis, SPG technique, × 200 in original magnification.  

(b) Hematoxylin and eosin staining of the same section as in Figure 3 a). Note location of fluorescent fibers in the media (arrow). × 200 in original magnification.

Figure 4.  

A whole mount view by fluorescence photomontage of the STA in a cross section. In many areas, as shown by enlarged views, sympathetic nerves are visible, not only in the border zone between the media and the adventitia, but also within the outer one-fifth of the media. STA, Case TK 58y-o M, Completed Stroke (mild), L-Carotid Siphon Stenosis, SPG technique.
FIGURE 5 a), b) Sympathetic adrenergic nerve terminals are seen within the vascular lesions in STA. Note the intimal thickening and proliferated collagenous and elastic tissue with supporting ground substance both in the adventitia and the media. Some of the fluorescence catecholamine fibers are observed along with this proliferation (arrows).

Arachnoid hemorrhage in the cat, while unusual accumulations of catecholamine within the media were observed during the reversible stage of acute vasospasm. Moreover, marked depletion of noradrenaline fluorescence was observed in the vessel wall with irreversible spasm, where myonecrosis was observed by electron microscopy. These results suggest that noradrenaline liberation to the vascular media plays an important role in the development of cerebral vasospasm and myonecrosis.

In this study, abundant sympathetic nerve terminals were observed not only in the adventitia but also in the outer muscular layer of the media of both STA and MCA. There was no distinct correlation between the severity of arteriosclerosis and the density of sympathetic nerve terminals. However, sympathetic nerve terminals within the media could be more often visualized in patients in whom vascular lesions such as intimal thickening and fibrosis were prominent. Sympathetic adrenergic terminals were observed in the media of the sheep carotid artery, rabbit saphenous artery, and aorta and mesenteric artery of various animals, but such terminals have not been demonstrated within the media of human cerebral vessels except by silver impregnation methods.

In the present study, sympathetic nerve terminals were also seen in the fibrous lesions of the vascular wall, where collagen and elastic tissue proliferate. Some of these terminals could be traced to the site of this proliferation. Several reports referred to a possible relation between monoamine liberation to the vascular wall and increased collagen synthesis. For instance, monoamine oxidase would deaminate lysine to produce the bridge formation of collagen, and cyclic AMP levels might modulate the differentiation of normal fibroblasts which produce collagen. These findings suggest that the sympathetic nervous system in the arterial wall may play a significant role in the development of cerebral atherosclerosis and in the development of cerebral vasospasm. However, it is not clear in our study whether sympathetic nerves sprouted into the collagen and elastic tissue or unusual noradrenaline liberation induced the collagen production in the neighboring area. It is also unclear whether the sympathetic nerves visualized in the present study, within the media might be due to ontogenically developed sympathetic nerve fibers in the arterial wall.

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References
Comparison of Local Cerebral Blood Flow Determined by Thermal and Hydrogen Clearance

CASEY GAINES, M.D., L. PHILIP CARTER, M.D., AND ROBERT M. CROWELL, M.D.

SUMMARY Local cerebral blood flow (ICBF) was measured simultaneously in ten cats with (1) a large surface thermal diffusion probe resting on the cortex and (2) hydrogen clearance curves from implanted electrodes surrounding the thermal probe. A close correlation was found between ICBF values obtained by the two methods. Since hydrogen clearance is accepted as quantitative, the data suggest that the thermal diffusion technique is a reliably quantitative means of measuring local cerebral blood flow.

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THE HEAT CLEARANCE METHOD for determining local cerebral blood flow (ICBF) may be useful for monitoring clinical patients.1 In 1973, Carter and Atkinson2 described a surface thermal probe which incorporates a Peltier stack and may be safely and conveniently applied to the brain surface during craniotomy. The method allows continuous monitoring of ICBF for detection of rapid changes. This probe has been used in different preparations, and the intercept differs under different recording conditions.3,4

To examine further the quantitative capability of the surface thermal probe, we have compared it to a hydrogen clearance method for simultaneous measurements of flow rates under a variety of conditions. The hydrogen clearance technique was selected because it has been widely accepted as quantitative, and it can be repeated frequently.

Methods

General Preparation

Ten mongrel cats (2.3–4.2 kg) were initially anesthetized with Ketamine hydrochloride (10 mg/kg IM, Bristol Laboratories) for placement of arterial and venous catheters. Arterial blood pressure and blood gases were monitored. Anesthesia was maintained with increments of intravenous pentobarbital (10–15 mg/kg) and pancuronium (0.2 mg/kg) as needed. The animals were placed on a ventilator (Harvard small animal respirator), and the P0\textsubscript{2} was maintained from 80 to 100 torr. PC0\textsubscript{2} was manipulated from 25 to 50 torr to change ICBF. The rectal temperature was maintained from 36.5°C to 38.5°C with an electric heating blanket. A right parietal craniectomy was performed, and the thermal flow probe was placed on the cortex. Three

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