Glycolytic Inhibition by 2-Deoxyglucose Reduces Hyperglycemia-Associated Mortality and Morbidity in the Ischemic Rat

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SUMMARY Numerous laboratories have shown that hyperglycemia increases cerebral ischemic damage. This presumably results from increased lactate production and accumulation during ischemia. Although increased tissue lactate acidosis is associated with increased ischemic brain damage, this damage has not been directly linked to glycolytic flux. Because 2-deoxyglucose (2-DG) is a competitive inhibitor of glycolysis we tested its ability to reduce hyperglycemia-exacerbated ischemic brain damage. Severe forebrain ischemia was produced by the four-vessel occlusion model in rats. Four rats received 3 g/kg glucose and saline while a second group (n = 5) was injected with 3 g/kg glucose plus 1.6 g/kg 2-DG. A third group (n = 5) was treated with 1 g/kg glucose plus saline and a fourth group (n = 5) received 1 g/kg glucose and 1.6 g/kg 2-DG. All rats were injected i.p. 10 minutes prior to the ischemic insult with the same volume/kg body weight. All rats receiving the high dose of glucose alone (3 g/kg) were dead within 24 hours postischemia. Rats who received 2-DG in addition to 3 g/kg glucose showed only 40% mortality (p = 0.119 Fisher's Exact), 2-DG completely eliminated convulsions during the initial two hours of recovery which was significant (p = 0.008), however, all rats in both groups showed some convulsions by 24 hours postischemia. Among rats receiving the low glucose dose (1 g/kg), none of the rats receiving 2-DG died or convulsed by 24 hours postischemia. There was 80% mortality and 100% incidence of convulsions by 24 hours postischemia among rats receiving glucose alone which were statistically worse (p = 0.024 and 0.004 respectively by Fisher's Exact test) than the 2-DG treated group. Since 2-DG did not eliminate the hyperglycemia in either experiment, we conclude that augmented ischemic damage during hyperglycemia is a consequence of glycolytic flux because 2-DG, which decreases glucose uptake and glycolytic flux, decreased mortality and morbidity.

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and were placed in individual cages with free access to water; the cages were placed in a room with a 12 hour light/dark cycle. All rats were fasted until the cerebral ischemic insult 22–26 hours after the last supplement of sodium pentobarbital.

Each rat received two i.p. injections 10 minutes prior to 4-VO and the total injection volume, on a per kilogram basis, was the same for all animals. The treatment groups were: (1) 3 g/kg glucose (17% solution) and saline (isovolumetric to 2-DG treatment); (2) 3 g/kg glucose (17% solution) and 1.6 g/kg 2-DG (17% solution); (3) 1 g/kg glucose (5.67% solution) and saline (isovolumetric to 2-DG treatment); (4) 1 g/kg glucose (5.67% solution) and 1.6 g/kg 2-DG (17% solution).

Approximately 5 minutes before 4-VO, the EEG leads were connected to an oscillograph and a thermistor probe (YSI 402) inserted into the rectum. Body temperature was maintained at control levels by heat lamp throughout the ischemic insult and for two hours after. To induce 4-VO the rats were restrained by hand and the snares tightened to occlude the vessels. Any rat that did not show isoelectric EEG for the duration of the 20 minute ischemic event was eliminated from the study as were any rats that died during 4-VO. About three minutes before the end of ischemia, 2% lidocaine was injected into the wound area around the guide tubes. At 20 minutes of 4-VO, the guide tubes were removed and the wound reopened to verify the return of flow in the carotid arteries. The wound was then quickly reclosed with wound clips and the rats monitored for two hours prior to returning them to their cages. Patency of the carotid arteries was rechecked under halothane anesthesia at 24 hours postischemia or postmortem in order to exclude from the study any animal with evidence of a clotted carotid artery.

Blood Concentrations of Glucose and Beta-hydroxybutyrate Experiments

Non-operated male Wistar rats (200–250 g, fasted weight), maintained in 12 hour light/dark cycle quarters, were fasted 22–26 hours prior to pretreatment as described above for the 4-VO protocol. Blood samples were taken from conscious, restrained rats using the tail snip method at time points corresponding to a control period, the start of 4-VO, the end of 4-VO, and the end of the two hour monitoring period. Blood samples were collected and immediately deproteinized by adding one part of blood to three parts 1M perchloric acid (on ice). The mixture was vortexed, centrifuged, and the supernatants neutralized with 5M potassium carbonate. The neutral extracts were stored at −70°C until analysis.

Dose-response Study

Approximately 20 ml of rat blood were obtained by decapitation and collected in a heparinized container on ice. To aliquots of blood was added either 0.9% saline (control, baseline) or increasing amounts of 2.05 M 2-DG dissolved in 0.9% saline, and the samples deproteinized and neutralized as described above. The neutralized extracts were analyzed for glucose content both by spectrophotometric and fluorometric determinations.

Data Analysis

Statistical analysis was performed with the aid of the Michigan Interactive Data Analysis System (MIDAS) on an Amdahl 5860 computer. Comparison of average differences between fluorometric and spectrophotometric measurements were assessed with one way analysis of variance. All average data are expressed as mean ± one standard error of the mean (SEM). The sample size (n) for all experiments is the number of animals. Exact p values are given for Student’s t test and the Fisher’s Exact test. Survival and morbidity data were compared with the Fisher’s Exact test.

Results

All rats that received 3 g/kg glucose alone died within 24 hours of 4-VO. Only 40% of those rats which
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received 2-DG in addition to the glucose died within 24 hours, however, this difference only reached a significance level of \( p = 0.119 \) by Fisher's Exact Test (fig. 1). All rats receiving 3 g/kg glucose had convulsive activity by 24 hours postischemia, with the onset of convulsions markedly sooner in rats which received glucose only. All rats receiving glucose alone began to convulse during the initial two hour postischemic recovery period but none of the glucose plus 2-DG group of rats showed any convulsions during this time; this difference was significant \( (p = 0.008 \) Fisher's Exact test).

By 24 hours postischemia 80% of the rats given 1g/kg glucose plus saline died but all of those given 1.6 g/kg 2-DG with the glucose were alive \( (p = 0.024 \) Fisher's Exact Test) (fig. 1). The surviving rats were walking about the cage at 24 hours postischemia. Sixty percent of the rats receiving only glucose were convulsed by 24 hours postischemia and 100% were convulsed by 24 hours postischemia. None of the rats receiving 2-DG in addition to the glucose convulsed by either two or 24 hours postischemia. The difference in incidence of convulsive activity between the two groups at 24 hours postischemia was statistically significant \( (p = 0.004 \) Fisher's Exact).

Blood Glucose and Beta-hydroxybutyrate Analysis

Since cross-reaction of 2-DG in the determination of glucose was a potential problem, glucose was determined in the presence of varying concentrations of 2-DG by both the spectrophotometric and the fluorometric techniques (fig. 2). Analysis of the dose-response data indicated that approximately 2% of the 2-DG present (calculated on an “as glucose” basis using MW = 180.2) contributes to the concentrations determined in the spectrophotometric method and 0.6% in the fluorometric method.

Our routine determination of glucose is carried out by an automated, spectrophotometric procedure. Utilizing samples from this study, this method was compared to the manual fluorometric procedure. The variable analyzed was the spectrophotometric result minus the fluorometric result. These differences were much less variable for different times within rats than for different rats \( (F \) with 2 and 26 degrees of freedom = 0.42, significance level \( p \) greater than 0.5). When the mean differences for non-treated and 2-DG treated rats were compared, the effect of treatment was also non-significant relative to the variability between rats \( (F \) with 1 and 15 degrees of freedom = 0.085, significance level \( p = 0.77 \)). Moreover, the mean difference between the determinations by the two methods is actually less for the treated than for the non-treated samples (1.0 mg/dl and 1.6 mg/dl respectively). Based on both treated and non-treated samples from all rats \( (n = 17) \), the upper one-sided 95% confidence limit on the mean difference between determinations is 3.2 mg/dl, which is less than the difference of 3.7 mg/dl at zero whole blood concentration of 2-DG in figure 2. Using only data from the nine rats treated with 2-DG, the corresponding limit is 3.9 mg/dl, which translates into a 95% confidence that the whole blood concentration of 2-DG is less than 1.6 mM.

Blood glucose rose after i.p. injection of glucose, whether or not 2-DG was also given (fig. 3). At the 30 minute time point, the presence of 2-DG resulted in a statistically significant \( (p = 0.01, \) by Student's t test) increase in blood glucose in the groups given either the low or high dose of glucose. This time corresponds to the time at which carotid blood flow was restored in rats exposed to 4-VO. Blood glucose levels 150 minutes following injections were approximately 300 mg/dl in rats receiving 2-DG while they were only slightly elevated in the rats receiving glucose alone. In the same group of blood samples the concentration of the beta-hydroxybutyrate was high for the control value, reflecting, presumably, the effects of fasting (fig. 4). In the rats receiving the high dose of glucose, blood beta-hydroxybutyrate fell rapidly upon glucose pre-treatment. The reduction in blood beta-hydroxybutyrate was less severe in the group given the low glucose dose. 2-DG did not appear to effect ketone concentrations.

FIGURE 1. Cross hatched bars indicate percent mortality in rats given glucose but no 2-DG. Open bars indicate percent mortality in rats given 2-DG in addition to glucose. Fisher's Exact test was used for p values.
Hyperglycemia itself which is deleterious to cerebral ischemic outcome, but rather some metabolic event precipitated by hyperglycemia. Since 2-DG is known to competitively inhibit glucose transport in the brain as well as glycolytic flux, 2-DG may have exerted its protective effect by limiting brain glucose uptake or by directly inhibiting glycolytic flux to lactate. While suppression of glucose uptake may account for some of 2-DG’s action, Horton et al demonstrated that mice treated with 2-DG had significantly decreased brain lactate levels but had increased brain glucose concentrations. This would suggest that the inhibition of glycolytic flux was the dominant protective effect of 2-DG.

Since 2-DG reduced the onset and incidence of convulsive activity in this study, this may have contributed to the increased survival seen in 2-DG treated rats. Since there is little reason to suspect that 2-DG is an anticonvulsant per se, other reasons for 2-DG’s effect on convulsive activity should be considered. A reduction in ischemic damage may have prevented seizure foci from developing or a reduction in cerebral metabolism may have prevented potential foci from becoming active. A reduction in ischemic damage seems more likely, particularly in the case of the low glucose group, since a single dose of 2-DG resulted in no convulsions or mortality over a 24 hour period. In the high dose glucose group, a transient reduction in cerebral metabolism produced by the 2-DG may have delayed the onset of convulsions. In any case, convulsive activity and mortality were reduced by 2-DG.

The blood levels of glucose measured in the unoperated rats were probably somewhat lower than in the
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rats which actually underwent 4-VO since these animals did not have the stress of surgery or cerebral ischemia. Indeed, the blood glucose levels found by Pulsinelli et al in fasted rats treated with 3 g/kg ten minutes prior to 20 minutes of 4-VO were higher than the blood glucose levels seen in the high glucose animals in this study. Blood glucose was not measured in the rats exposed to ischemia because we wished to avoid the potential complication factor of hemorrhage in our 4-VO ischemic animals. It is reasonable to assume that the qualitative if not quantitative relationship between 2-DG and blood glucose still holds for the rat exposed to ischemia. The outcome which would have negated our conclusion of 2-DG’s protective effect would be if 2-DG produced a relative decrease in blood glucose among glucose-treated rats. This clearly was not the case (fig. 3) in that 2-DG treated rats not only had higher blood glucose concentrations but blood glucose remained high even 150 minutes after injection.

The presence of 2-DG in blood causes falsely elevated levels of D-glucose to be determined using the coupled enzymatic HK/G-6-PDH method (fig. 2). The interference is dose-related and, under the conditions of our assays, is about 3.3-fold greater in the spectrophotometric method than the fluorometric method. This is apparently due to the 50-fold higher dilutions of the samples in the latter procedure, which are necessitated by the greater sensitivity of the fluorometric determination.

Based on the finding that there was no significant difference between the determinations by the two methods when comparing the 2-DG treated rats with the non-treated rats, we conclude that the endogenous levels of 2-DG were not elevated enough to constitute a significant interference and that the conditions chosen for analysis of D-glucose in this study, i.e. fluorometric analysis using highly-diluted samples, were such that any 2-DG present was diluted to such an extent that it no longer interfered in the assay.

This study lends strength to the argument that hyperglycemia-aggravated cerebral ischemic damage is the result of increased lactate build up during ischemia due to increased glycolytic flux in the presence of increased glucose availability. The results are consistent with the observation in previous animal studies that high blood glucose levels before 1-4 or after cerebral ischemia 5-9 increase cerebral damage. Even posts ischemic treatment with 2-DG has been shown to decrease mortality in a gerbil study of unilateral common carotid ligation 9 although these animals were not intentionally made hyperglycemic. Two recent retrospective clinical studies 10-12 report a strong correlation between elevated blood glucose levels on admission to the hospital and poorer neurologic outcome from ischemic stroke or cardiac arrest. Although cause and effect relationships were not explored in these studies, when viewed together with the experimental laboratory work, they point to the possible clinical importance of close monitoring of blood glucose levels and the potential therapeutic advantage of limiting excessive brain glycolytic metabolism in the cerebral ischemic patient. The therapeutic potential of 2-DG in the control of glucose-induced damage in the cerebral ischemic patient is clearly suggested.

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Cerebral Glucose Metabolism During the Recovery Period After Ischemia — Its Relationship to NADH-Fluorescence, Blood Flow, ECoG and Histology

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SUMMARY Local cerebral glucose utilization (ICMRgI), NADH fluorescence, cerebral blood flow (CBF), electrocortical activity (ECoG) and histology were studied during a 4 hr recovery period following 2 hrs of left middle cerebral artery (MCA) occlusion in cats. Changes in relative reduced pyridine nucleotides and CBF were measured by fluororeflectometry, ECoG was obtained from the left middle cecostylivian gyrus (MEG), and ICMRgI was measured at the end of the recovery period autoradiographically with 14-C-2-deoxyglucose. A sham group was comprised of 4 cats. The ten animals subjected to the stroke were classified into 3 groups based on the amplitude of the ECoG at the end of the ischemic period. At the end of the recovery period, the relative reduced pyridine nucleotides showed a 22.5% oxidation (oxidation of NADH), a 66.2% reduction (reduction of NAD) and a 3.0% reduction compared to the sham group in the severe, moderate and mild groups, respectively. ICMRgI of the left MEG in the severe group was 64.2% of the corresponding sham value, whereas ICMRgI in the moderate and mild groups were 124.8% and 132.0% of the sham, respectively. CBF at the end of the recovery period ranged from 28.1% to 83.0% of the sham value, although there was no significant difference among these groups. Histologically, a large portion of the neurons in the left MEG in the severe group showed ischemic neuronal changes, while the damage was less severe in the moderate and mild groups. On the basis of these data, it is suggested that a relative substrate deficiency and/or a loss of mitochondrial enzymatic pool size may occur in the animals comprising the severe group. Conversely, anaerobic glycolysis may be activated in the moderate group, while the mild group exhibits an increase in glucose metabolism that is most likely aerobic. A gradient in the magnitude of changes in ICMRgI was noted from the central MCA territory to the surrounding brain regions in the ischemic hemisphere. In addition, there was a mild, but statistically significant (p < 0.05), depression in ICMRgI with no histological damage in the non-ischemic hemisphere of the severe group.

Under normal conditions, the energy production of brain tissue is almost totally dependent upon oxidative metabolism in the mitochondria. The mitochondrial mechanism of synthesizing energy-rich compounds in brain, however, seems to be very vulnerable to ischemia and it has been demonstrated that the dysfunction of brain mitochondrial metabolism deteriorates further during recirculation after incomplete ischemia. In addition, histopathological studies have shown that structural mitochondrial alterations are the first sign of ischemic cellular damage in brain tissue. Since the pyridine nucleotide coenzyme, reduced nicotinamide adenine dinucleotide (NADH), stands on the negative end of the chain of mitochondrial respiratory components, the pyridine nucleotide fluorescence correlates well with the ability of mitochondria to carry out energy-linked functions such as the production of adenosine triphosphate (ATP) and the removal of reducing equivalents. The method of surface fluororeflectometry, which enables us to continuously monitor the alterations of pyridine nucleotide fluorescence, vascular volume and cerebral blood flow (CBF) in the same volume of tissue, has been recently applied to various animal studies and a significant reduction...
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