Cilostazol Attenuates Gray and White Matter Damage in a Rodent Model of Focal Cerebral Ischemia

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Background and Purpose—To evaluate whether delayed treatment with the antiplatelet agent cilostazol reduces the volume of infarction in the gray and white matter in a rodent model of permanent focal cerebral ischemia and to explore the mechanism of the neuroprotective effect in vivo.

Methods—Cilostazol (30 or 50 mg/kg) or vehicle was administered by gavage 30 minutes and 4 hours after the induction of cerebral ischemia by permanent occlusion of the left middle cerebral artery (MCA). Animals were euthanized 24 hours after MCA occlusion, and the volume of gray matter damage was evaluated by quantitative histopathology. Axonal damage was determined with amyloid precursor protein immunohistochemistry. Dynamic susceptibility contrast MRI was used to assess regional cerebral blood volume (CBV) and cerebral blood flow (CBF).

Results—Treatment with the higher dose of cilostazol (50 mg/kg) significantly reduced the volume of gray matter damage and axonal damage in the cerebral hemisphere by 45.0% (P<0.02) and 42.4% (P<0.002), respectively, compared with the control group. Relative CBV in the peri-infarct area after MCA occlusion was significantly increased in the cilostazol-treated group (50 mg/kg) compared with the control group (P<0.05). Relative CBF tended to be higher in the cilostazol-treated group compared with the control group.

Conclusions—Treatment with cilostazol significantly reduced the gray and white matter damage associated with permanent focal ischemia. Cilostazol improved CBV and CBF in the peri-infarct area. The major action of cilostazol is to increase perfusion in the ischemic penumbra. (Stroke. 2006;37:223-228.)

Key Words: cerebral ischemia, focal | neuroprotection | white matter
School of Medicine. Male Sprague-Dawley rats (300 to 330 g) obtained from Charles River Japan (Tsukuba, Japan) were anesthe-
tized with halothane in nitrous oxide–oxygen (70:30), then intubated
and artificially ventilated. The femoral artery was cannulated for
recording arterial pressure and blood gases. Rats were maintained
normothermic, normocapnic, adequately oxygenated, and normother-
mic during anesthesia.

Focal cerebral ischemia was induced using a modification of the
permanent MCA occlusion method. Briefly, a 2-cm skin incision was
made, then a small subtemporal craniectomy was made. Cere-
bral ischemia was then induced by electrococagulation of the MCA
from a point proximal to the origin of the lenticulostrate artery to
the point crossing the inferior cerebral vein. The MCA was then
transected at the olfactory tract to ensure completeness of occlusion.
The time of transection was taken as the exact time of MCA
occlusion.

**Drug Treatment**

Rats were randomly divided into 3 groups and given cilostazol (30 or
50 mg/kg; n = 7) or vehicle (control group, n = 8). Cilostazol dis-
olved in 25% dimethyl sulfoxide solution was given orally by gavage
as a bolus 30 minutes and 4 hours after MCA occlusion. During this period, physiological variables were continu-
ously monitored and the animal’s behavior observed.

**Tissue Processing**

Rats were perfusion fixed for neuropathological study. Briefly, the
rats were deeply anesthetized with 5% halothane, placed in the
supine position, and the thorax opened through bilateral incisions. A
catheter was inserted into the left ventricle, the right atrium was
incised, and heparinized saline was infused at a pressure equal to the
mean arterial blood pressure (90 to 110 mm Hg) of the animal until
the perfusate from the right atrium was bloodless. The saline was
followed by 0.3 mL of 4% paraformaldehyde in PBS. After removal
of the brain, the forebrain was processed, embedded in paraffin wax, and cut into 6-μm sections at multiple levels.

**Histology and Immunohistochemistry**

Sections at 8 preselected coronal levels were stained with hema-
toxylin and eosin for assessment of ischemic damage to neuronal
perikarya. Adjacent sections were processed for immunohistochem-
istry using amyloid precursor protein (APP) antibody to label
ischemically damaged axons (disruption of axoplasmic flow leads to
APP accumulation). Sections were mounted on amino-silane-coated
slides, dried at 37°C overnight, placed in xylene to remove the wax,
and dehydrated in absolute alcohol. Sections were microwaved for
30 minutes and for 1 hour in 50 mmol/L PBS, pH 7.2, containing 0.03%
H2O2 in methanol for 30 minutes and for 1 hour in 50 mmol/L PBS,
pH 7.2, containing 0.5% BSA and 10% normal horse serum.

**Statistical Analysis**

Parametric data were compared between multiple groups by 1-factor
ANOVA followed by the Holm test and pairs of groups by Student’s
unpaired 2-tailed t test. Data are presented as mean ± SD. Nonpara-
metric data were compared between multiple groups by the Kruskal–
Wallis test followed by the Mann–Whitney U test.
Results

The physiological variables are shown in the Table. There were no significant differences in physiological variables between the 3 experimental groups.

Gray Matter Damage

Neuronal perikarya in the ipsilateral cerebral cortex and caudate putamen clearly exhibited the characteristic morphological features of ischemic damage (ie, shrinkage and triangulation of the nucleus and cytoplasm and increased eosinophilia of the cytoplasm). The boundaries between the ischemic and nonischemic neuronal perikarya were identifiable in control and cilostazol-treated groups (Figure 1A through 1C). Rats treated with both doses of cilostazol (30 and 50 mg/kg) had significantly reduced volumes of infarction in the cerebral hemisphere and cerebral cortex (Figure 2A). Treatment with the higher dose of cilostazol (50 mg/kg) significantly reduced the volume of gray matter damage in the cerebral hemisphere and cerebral cortex by 45.0% and 48.5%, respectively, compared with the control group (P<0.02). Treatment with the lower dose of cilostazol (30 mg/kg) significantly reduced the volume of ischemic damage in the cerebral hemisphere by 43.2% (P<0.05) and cerebral cortex by 40.4% (P<0.05). Neither dose of cilostazol had a significant protective effect on the caudate nucleus in this model.

Axonal Damage

Axonal damage was recognized as intense APP immunoreactivity in swollen or bulbous axons within the ipsilateral subcortical white matter fiber tracts (Figure 1D through F). The anatomically defined zones of APP immunoreactivity allowed scoring for the presence or absence of APP axonal profiles in each region throughout the rostrocaudal extent of the MCA territory. Axonal damage was less extensive in cilostazol-treated animals. Total APP score in the cilostazol-treated groups (30 and 50 mg/kg) was significantly lower than in the control group (P<0.002; Figure 2B). Treatment

<table>
<thead>
<tr>
<th>Physiological Variables Before and After MCA Occlusion</th>
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<tr>
<td>MABP (mm Hg)</td>
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<tr>
<td><strong>Vehicle</strong></td>
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<td>Before</td>
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<td>30 min after</td>
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<td><strong>Cilostazol (30 mg/kg)</strong></td>
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<td>30 min after</td>
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<td>24 h after</td>
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<tr>
<td><strong>Cilostazol (50 mg/kg)</strong></td>
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<tr>
<td>Before</td>
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<tr>
<td>30 min after</td>
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<tr>
<td>4 h after</td>
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Values are mean±SD. MABP indicates mean arterial blood pressure.

Figure 1. A through C, Histological features of hematoxylin and eosin-stained sections after MCA occlusion showing both hemispheres (A), normal perikarya in the cerebral cortex (B), and ischemic damage to gray matter (pyknotic perikarya; C). D through F, APP immunohistochemical staining showing intense immunoreactivity in the white matter surrounding the caudate nucleus (arrows) (D), minimum immunoreactivity in the contralateral caudate nucleus (E), and intense immunoreactivity indicating axonal damage in the ipsilateral caudate nucleus (F). Bar=20 μm.
with the higher dose of cilostazol (50 mg/kg) significantly reduced the axonal damage in the corpus callosum, internal capsule, and caudate putamen, and treatment with the lower dose (30 mg/kg) in the caudate putamen (Figure 3B). APP scores in the external capsule, anterior commissure, globus pallidus, and ventral axon-rich structures such as the optic tract, median forebrain bundle, and fornix were not significantly different between the cilostazol-treated and control groups.

**CBF and CBV Study**

Representative ADC, CBV, and CBF images of control and cilostazol-treated groups are shown in Figure 4. The ADC image shows no remarkable difference in area of ischemic damage at 1 hour after MCA occlusion between the 2 groups. However, statistical analysis showed that CBV in ROI 1, located in the dorsomedial area where cerebral blood was supplied by leptomeningeal anastomosis from the anterior cerebral artery, was significantly increased in the cilostazol-treated group ($P<0.05$ versus control group; Figure 5). The area of ischemic damage had extended to the dorsomedial area between 1 hour and 24 hours after MCA occlusion in the control group. On the other hand, no such expansion of ischemia was seen in the cilostazol-treated group. Interestingly, the magnetic resonance perfusion study clearly demonstrated this phenomenon by revealing that the CBV in ROI 2 at 24 hours after MCA occlusion was significantly increased in the cilostazol-treated group ($P<0.05$ versus control group) and that the CBV in other areas at 1 and 24 hours after ischemia tended to be higher in the cilostazol-treated group compared with the control group. The CBF in all areas, but particularly in ROI 1, tended to be higher in the cilostazol-treated group compared with the control group.

**Discussion**

The major finding of this study is that the treatment with cilostazol provides significant protection against ischemic damage in gray and white matter. Quantitative methods demonstrated reduced ischemic damage to cortical neuronal perikarya and axons after administration of cilostazol. Evaluation of gray and white matter damage is equally important to assess the efficacy of potential protective agents. The neurological consequences of an ischemic insult reflect the effect of the stroke on gray and white matter. Despite this, gray matter damage has attracted much more attention than white matter damage, particularly in the experimental stroke model because of the lack of appropriate methodology for the assessment of white matter damage in vivo.

Over the last decade, >180 clinical trials of so-called neuroprotectants, including antagonists of glutamate release and receptor activation, Ca$^{2+}$ channel blockers, and antioxidants, have failed to demonstrate significant benefits on stroke outcome. One possible explanation of the poor
clinical performance of most neuroprotective compounds is that the extensive damage in the white matter is not reduced.14 The processes involved in white matter ischemia are only now beginning to be understood and recognized as equal in importance to gray matter ischemia.

The quantification of APP accumulation showed significant, cilostazol-induced reduction of axonal damage in the ischemic hemisphere. Interestingly, cilostazol was not equally effective in all white matter regions (Figure 3). The most marked reductions in white matter damage were found in peri-infarct regions such as the corpus callosum, internal capsule, and caudate putamen, whereas other white matter regions showed severe ischemia,15 such as the fiber tracts of the external capsule and anterior commissure. Cilostazol also produced significant attenuation of neuronal perikaryal damage (45% salvage of hemisphere), which was principally attributable to reduction in cortical damage (48.5%; Figure 2). Apparently, the white and gray matter contain zones that can and cannot be salvaged by pharmacological intervention. Therefore, whether cilostazol elicits CBF increase in the peri-infarct zone (penumbra) in acute focal ischemia is important.

Dynamic susceptibility contrast, MRI can provide accurate relative CBF and CBV measurement even in the presence of pathological hemodynamics such as MCA occlusion.16 This bolus tracking MRI technique allows repeated measurements of blood flow reduction in the left hemisphere at 1 hour and 24 hours after MCA occlusion. The present study found that CBV was significantly increased in ROI 1 at 1 hour and ROI 2 at 24 hours after MCA occlusion in the cilostazol-treated group ($P<0.05$ versus control group), and that CBV in other areas at 1 and 24 hours tended to be higher in the cilostazol-treated group compared with the control group (Figure 5). CBF in all areas, particularly in ROI 1, tended to be higher in the cilostazol-treated group compared with the control group. The beneficial effect of cilostazol can be attributed to vasodilation17 as well as antiplatelet activity and antiapoptotic action.18 Cilostazol causes vasodilation of isolated, pressur-
ized rabbit spinal arterioles, which may be extrapolated to the cerebral microcirculation as the same arterioles feeding the central nervous system. Cilostazol also dilates the pial arteries and inhibits formation of thrombosis during focal ischemia in the cat. Although the detailed mechanisms of action of cilostazol on vascular smooth muscle still remain unknown, presumably, phosphodiesterase 3 inhibition and corresponding cAMP increase in smooth muscles of arterioles are involved to some extent because phosphodiesterase 3 is strongly expressed in these cells. These observations suggest that cilostazol improves brain ischemic outcome in this model by restoring local CBF, resulting in minimization of the extent of brain damage and prevention of further brain injury attributable to long-term exposure to ischemic insult in the penumbra. This action of cilostazol is notable because aspirin, which is the most widely prescribed antiplatelet agent for stroke, was reported to acutely reduce CBF by ≈20% in a rabbit model. The aspirin irreversibly inhibits platelet aggregation by inhibiting cyclooxygenase. This, in turn, inhibits the conversion of arachidonic acid to prostacyclin or NO, a potent vasodilator.

The future use of antiplatelet therapy for the treatment of acute cerebral ischemia depends on greater understanding of the activity of these agents on platelet function and on the cerebrovasculature within the brain parenchyma, especially as related to CBF. Treatment with cilostazol has the potential to minimize brain injury in acute stroke.

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References

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