Arteriogenesis and ischemia impair functional vasodilation in resistance arteries

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Introduction
Patients with peripheral arterial occlusive (PAOD) disease have impaired vasodilation. Identifying the mechanism of this impaired vasodilation could lead to improved therapies. Co-morbidities common to PAOD, e.g., hypercholesterolemia, are known to impair vasodilation, but arterial occlusion alone also impairs vasodilation. Although impaired vasodilation in lower-leg arterioles is well described in animal models of PAOD, the impact of arterial occlusion on collateral and resistance arteries is unknown. Collateral resistance is the largest determinant of downstream flow and resistance arteries contribute up to half of the resistance to skeletal muscle blood flow, so identifying the impact of arterial occlusion on these vessels will likely provide the greatest potential therapeutic benefit. Therefore, the goal of this project is determine the impact of arteriogenesis and ischemia on collateral artery and resistance artery vasodilation, respectively. The long-term goal of this work is identify potential therapeutic targets for impaired vasodilation in patients with PAOD.

Surgical Model I - Arteriogenesis
To determine the impact of elevated flow and arteriogenesis on collateral artery vasodilation, we utilized an experimental model that involved ligation of the femoral artery between the profunda femoris and popliteal branches (proximal ligation, Figure 3a) or just distal to the popliteal (distal ligation, Figure 3b). These surgeries lead to arteriogenesis in the profunda femoris and its development as the stem region of a collateral circuit.

Surgical Model II - Ischemia
To determine the impact of ischemia on feed artery vascular reactivity, we utilized an experimental model that involved resection of the femoral artery-vein pair from just upstream of the profunda femoris to the distal saphenous. This study surgically produces ischemia in the profunda femoris artery and the downstream gracilis muscle microcirculation.

Ischemia Eliminates Functional Vasodilation in Response to Moderate Muscle Contraction
To test the hypothesis that ischemia impairs endogenous vasodilation pathways, measured profunda femoris artery diameter at day-14 following resection, before and after electrical stimulation of the gracilis muscles with tungsten microelectrodes with 1mA pulses of 200μs duration at 8Hz for 90sec, Figures 7 & 8.

Ischemia Impairs Endothelial & Smooth Muscle-dependent Vasodilation
To test the hypothesis that impaired vasodilation following ischemia was due to impaired endothelial-dependent vasodilation, measured proximal femoral artery diameter at day-14 following resection, before and after application of acetylcholine, sodium nitroprusside, and norepinephrine (10^-5M) to the physiological salt solution. The physiological salt solution was bubbled with 95%N2-5%CO2, and warmed to 35°C.

Ischemia Delays Return to Baseline Diameter Following Intense Muscle Contraction
As seen in Figure 9, a more intense muscle contraction does not cause a normal vasodilation in the ischemic profunda femoris artery. However, restoration of resting diameter seemed to be delayed in these studies. Therefore, we examined the time course of vessel diameter before and after the electrical stimulation of the gracilis muscles with tungsten microelectrodes with 1mA pulses of 500μs duration at 8Hz for 90sec, Figure 10.

Summary
• Arteriogenesis transiently reduces functional vasodilation in collateral resistance arteries. The degree of reduction appears to be impacted by the arteriogenesis stimulus, Figures 4 & 5.
• Ischemia reduces functional vasodilation in resistance arteries, Figures 7 & 8. The extent of this reduction is impacted by the muscle contraction intensity and presumably vasodilation stimulus, Figure 9. This reduction appears to be due to reduced smooth muscle responses, Figure 11.
• Ischemia delays the restoration of resting diameter in resistance arteries following intense muscle contraction, Figure 10. This delay is not due to impaired responsiveness to norepinephrine, Figure 11.

Figure 1. Intravital microscopy imaging station for functional vasodilation measurements.

Figure 2. Still images of the muscular branch artery at rest (left) and following 90 seconds of BH2 muscle contraction (right).

Figure 3. Medial aspect of the mouse hindlimb showing site of femoral artery ligation and primary collateral flow paths.

Figure 4. Left panel, profunda femoris artery diameter at rest and following muscle contraction in sham-operated animals and at day-7 and day-14 following distal femoral artery ligation. Right panel, percent increase in profunda femoris artery diameter following muscle contraction, same groups as left panel. *p < 0.05 vs sham vasodilation, #p <0.05 vs sham resting.

As a corollary to the overall hypothesis, we tested the hypothesis that a greater arteriogenesis stimulus would result in a greater impairment in vasodilation. The primary stimulus for arteriogenesis is elevated endothelial shear, so to test this corollary, we performed a two ligation surgeries. The distal femoral artery ligation (Figure 4) presumably results in a moderate increase in profunda femoris shear stress, because the popliteal artery can also serve as a collateral circuit in this model and the proximal femoral ligation (Figure 5) presumably results in a large increase in profunda femoris shear stress because the ligation is placed upstream of the popliteal.

Figure 5. Left panel, profunda femoris artery diameter at rest and following muscle contraction in sham-operated animals and at day-7 and day-14 following proximal femoral artery ligation. Right panel, percent increase in profunda femoris artery diameter following muscle contraction, same groups as left panel. *p < 0.05 vs sham vasodilation, #p <0.05 vs sham resting.

Figure 6. Medial aspect of the mouse hindlimb. The region of femoral artery-resection is indicated with a dashed line.

Figure 7. Profunda femoris artery diameter at rest (black bar) and immediately following the cessation of moderate muscle contraction (grey bar), stimulated at 1mA, 200μs, 8Hz, 2min. *p < 0.05 vs sham.

Figure 8. Functional vasodilation (% change from resting or 100%) of the ischemic profunda femoris artery with moderate intensity muscle contraction for sham (black) and day-14 ischemic (grey).

Figure 9. Muscular branch artery diameter at d14 following femoral artery resection in response to increasing stimulus frequency: 2, 4, or 8Hz and 1mA, 500μs, 90sec.

Figure 10. Functional vasodilation recovery in the ischemic profunda femoris artery following high intensity contraction. Sham operated (black circles) and day-14 ischemic arteries (grey circles). *p < 0.05 vs sham.