The Effects of Norepinephrine on Active Hyperemia in the Canine Gracilis Muscle

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SUMMARY We studied the effects of intra-arterial norepinephrine (NE) on skeletal muscle blood flow (BF), oxygen consumption (VO₂), and arteriovenous oxygen difference (A-VO₂) at rest and during exercise in an autoperfused canine gracilis muscle preparation. Static continuous exercise at a fixed level of maximal developed tension (P₀) was induced by gracilis nerve stimulation; developed tension was monitored and used to control stimulation voltage. In one group of dogs (n = 10), data were collected before (rest) and at the end of each of a series of four 2-minute periods of exercise (10% P₀) in each preparation. During both the rest and the exercise phases, continuous intra-arterial infusions of isotonic saline alone (control) and saline plus NE (0.11, 0.22, and 0.44 µg/min) were made. Control resting data were: BF = 5.90 ml/min; A-VO₂ = 5.30 vol %; VO₂ = 0.31 ml/min. NE during rest reduced BF by 39-69%, increased A-VO₂ by 79-91%, and reduced VO₂ by an average of 41.9%. Control exercise data were: BF = 17.2 ml/min; A-VO₂ = 11.2 vol %; VO₂ = 1.06 ml/min. NE during exercise attenuated BF by 7-85% and widened A-VO₂ by 22-35%. VO₂ was maintained at control exercise levels during lower NE infusion levels but was attenuated by 56% at the highest NE level. In the second group of dogs (n = 6), data were collected at rest and at four times during a 10-minute exercise period (2.5% P₀). NE (0.089, 0.17, and 0.34 µg/min) or saline (control saline) was infused for 2 minutes each during the final 7 minutes of exercise. At the lower NE doses, no significant difference was observed relative to the control-saline experiment. At the highest NE dose BF and VO₂ were attenuated (BF: -22%, VO₂: -20%), and A-VO₂ was unchanged compared to control. The NE-induced attenuation in BF and VO₂ during exercise may in part result from a mechanism similar to that which occurs in congestive heart failure in which an exaggerated sympathoadrenal response during exercise and an attenuated exercise-induced rise in forearm VO₂ occurs. Circ Res 44: 660-666, 1979

THE MAJOR DETERMINANTS of blood flow to exercising skeletal muscle appear related to locally reduced oxygen tension and increased metabolite concentration (Skinner, 1975). However, a number of other factors such as the type and severity of exercise and the physical condition of the subject may affect flow to muscle. Congestive heart failure also may be a factor. Patients in this state appear to have an increased vascular stiffness as well as an excessive sympathoadrenal response to exercise (Chidsey et al., 1965; Higgins et al., 1972; Zelis et al., 1969) as evidenced by elevated circulating levels of catecholamines. This may explain partially the failure of oxygen consumption to rise normally when patients with heart failure exercise (Zelis et al., 1974; Longhurst et al., 1976). Although it is assumed that metabolic vasodilator stimuli can override the vasconstrictor action of α-adrenergic vascular receptor stimulation, there is considerable experimental evidence to suggest that a nearly complete “functional sympatholysis” occurs only during a maximal metabolic stimulus (Remensnyder et al., 1962; Kjellmer, 1965; Strandell and Shepherd, 1967; Costin and Skinner, 1971; Burcher and Garlick, 1973). With submaximal exercise, metabolites only attenuate sympathetic α-adrenergic constriction, and this attenuation is more pronounced for neuronally released than for humorally delivered norepinephrine (NE) (Burcher and Garlick, 1973).

Vascular α-adrenergic receptor stimulation in resting skeletal muscle causes a reduction in capillary surface area by closure of precapillary sphincters and a rerouting of arterial blood through shorter vascular channels. This “physiological shunting” of blood leads to a narrowing of the arteriovenous oxygen difference or a reduction in the calculated oxygen uptake of resting skeletal muscle (Nakamura, 1921; Rein and Schneider, 1938; Pappenheimer, 1941; Renkin and Rosell, 1962a; Bolme and Gagnon, 1972; Takashita et al., 1976). During exercise, there is opening of precapillary sphincters in skeletal muscle and an increased capillary surface area. This leads to an increased oxygen consumption, which varies with the magnitude of developed tension and the duration of contraction (Renkin and Rosell, 1962b; Kjellmer, 1964; Renkin et al., 1966; Stainsby and Fales, 1973). However, at low venous oxygen tensions, the control of microvascular perfusion shifts from the precapillary...
Preparation of Gracilis Muscle

The left gracilis muscle was exposed from the pubis to the tibia and was vascularly isolated except for the main gracilis artery and vein. The left femoral artery proximal to the gracilis artery was isolated, ligated, and cannulated to allow distal perfusion of the gracilis bed via a cannula from the right femoral artery after iv administration of heparin (300 U/kg). The left femoral vessels distal to the origin of the gracilis artery and vein were ligated and a cannula was inserted connecting the distal ends of the left femoral vein and the gracilis vein to allow venous sampling. For the first series of studies [10% maximal developed tension (P0)], blood flow to the gracilis muscle was measured directly by an electromagnetic flowmeter (Statham model SP 2202) positioned on the gracilis artery (Fig. 1). In the second series of studies (2.5% P0), gracilis muscle blood flow was determined by passing total gracilis muscle venous outflow through a rotameter (Shipley and Wilson, 1961) before returning it to the systemic circulation via the left femoral vein.

The distal aponeurosis of the gracilis muscle was detached from its insertion into the tibia, and the muscle was fixed to an isometric tension rack via clamps placed at the origin and insertion. The clamp attached to the distal aponeurosis was connected to a tension transducer (Statham UC-3, 60 g) with a Statham UL-4 load cell accessory adaptor (50 pounds) to measure tension.

The gracilis nerve was ligated, divided, and attached to bipolar hook electrodes. Before the beginning of the experiment, optimal length (Lo) and maximal developed tension (P0) were determined for each muscle preparation. For the determination of Lo, we obtained a length-tension curve by stimulating the gracilis nerve, using a square-wave impulse generator (Grass model S44), with a single impulse (duration = 8 msec, voltage = 2-5 V) at each length setting while measuring tension. Lo was chosen at the apex of the length-tension curve. P0 then was determined by setting the muscle to Lo and stimulating the nerve with a single brief (less than 3 seconds) train of stimuli (frequency = 20 Hz, duration = 8 msec, voltage = 2-5 V) while measuring tension. It should be noted that the voltages described here refer to stimulator settings, and that the actual voltages stimulating the nerve across a saline resistance were much less. For the muscles used in these studies, P0 averaged 15.9 ± 1.1 kg (mean ± SEM). For the studies described below, voltage to the gracilis nerve was automatically regulated by an analog feedback system controlled by gracilis muscle tension. The feedback system produced a voltage inversely proportional to the input voltage from the tension transducer and resulted in a constant static gracilis muscle contraction at the predetermined level of P0 (2.5% or 10%). The actual voltage ranges required to generate these tension levels were measured and were as follows: 2.5% P0,
FIGURE 1  The gracilis muscle preparation used to evaluate the effects of norepinephrine infusion on static exercise. The autoperfused canine gracilis muscle is held in a rack between two clamps (A, B). Muscle tension (1) is measured from a tension transducer attached to the clamp holding the distal tendon (A). Also measured are mean gracilis arterial flow (2) or mean venous flow with a rotameter (not shown) and systemic arterial perfusion pressure (3). Syringes note the points of sampling of blood for gas analysis. Also shown are the perfusion pump for intra-arterial infusions (C), electrodes for stimulating the gracilis muscle nerve (D), thermistors for measuring gracilis muscle and rectal temperatures (E), and heat lamp for controlling gracilis muscle temperature (F).

0.08-0.15 V; 10% Pao, 0.15-0.3 V. To generate exercise at 2.5% and 10% Pao, nerve stimulation at the appropriate voltage was continuous over the period of exercise (frequency = 20 Hz, duration = 8 msec).

Gracilis muscle temperature was measured with a Yellow Springs needle thermistor, and a heat lamp was used to maintain tissue temperature at 34-36°C. The muscle was wrapped with Saran wrap to prevent drying and heat loss.

Experimental Protocols

Recordings of muscle tension, mean systemic arterial pressure, and arterial or venous flow were made with an optical recorder (Electronics for Medicine DR-12) with rapid writer. Arterial and gracilis venous oxygen contents were determined with a LEX O2 CON total oxygen content analyzer. Infusions of saline or NE far upstream from the gracilis artery (to ensure adequate mixing) were performed with a constant infusion pump (Harvard model 907).

Series I

In this group of dogs, four experimental tests were conducted on each gracilis muscle preparation (n = 10). In each test, values for gracilis muscle blood flow (BF), arteriovenous oxygen difference (A-VO2), and oxygen consumption (VO2) were obtained at two data collection points. Data collection points for each test occurred before and at the end of a 2-minute period of exercise (10% Pao). The four experimental tests consisted of the continuous intra-arterial infusion (0.11 ml/min) of isotonic saline alone (control) and saline plus NE at each of three doses (0.11, 0.22, and 0.44 μg/min) delivered throughout the rest-exercise protocol. Infusion rates for all NE dosages were equal to the control-saline infusion rate. Between all experimental tests, preparations underwent a 40-minute rest-recovery period.

Series II

In this group of dogs, two experimental tests were conducted on each gracilis muscle preparation (n = 8). In each test, values for gracilis muscle BF, A-VO2, and VO2 were obtained before (control) and during a 10-minute period of static exercise (2.5% Pao). Exercise data were collected immediately prior to minutes 3, 6, 8, and 10. Immediately after the 3-minute exercise data point, an intra-arterial infusion at 0.11 ml/min was instituted which continued to the end of the experimental test. The first experimental test consisted of the intra-arterial infusion of isotonic saline alone. The second experimental test consisted of the infusion of saline plus NE. NE infusion was instituted at 0.08 μg/min, increased to 0.17 μg/min immediately after the 6-minute exercise data point, and increased again to 0.34 μg/min after the 8-minute exercise data point. The different NE infusions were delivered at proportionally increased volume flow rates. Identical increases in infusion rates were instituted during the saline control ex-
periment at the appropriate time points.

Analysis of Data

In Series I, the effects of intra-arterial NE infusion at rest and during exercise were tested according to ANOVA statistical procedures. In addition, data obtained during exercise experiments were compared to corresponding data obtained during rest experiments. In Series II, values obtained during saline runs were compared to corresponding values obtained during NE runs. Statistical comparisons were made with the use of Student's t-test for grouped observations for both series of data. P values less than 0.05 were considered significant. All data are presented as means ± standard error of the mean (SEM).

Results

In all experiments, no significant changes occurred in heart rate (HR) or mean systemic arterial blood pressure (BP) (HR = 124-145/min; BP = 123-130 mm Hg). Arterial P02 (150-300 mm Hg), Pco2 (30-50 mm Hg), pH (7.35-7.45), and O2 saturation (96-98%) remained within the normal ranges throughout all experimental procedures.

Effects of NE on the Resting Muscle

Control data obtained during saline infusion in the resting muscle were BF = 5.90 ± 0.76 ml/min; A-VO2 = 5.30 ± 0.73 vol %; VO2 = 0.31 ± 0.05 ml/min (n = 10). The effects of graded NE infusion on these parameters in the resting muscle are shown in Figure 2. BF was significantly reduced with NE as compared to the control level during saline infusion (Fig. 2, Panel A). A-VO2 was widened significantly by NE (Fig. 2, Panel B); VO2 was reduced at the highest NE level, but this change was not statistically significant (Fig. 2, Panel C). The mean values for the change in VO2 during NE were not significantly different for increasing NE concentrations: change in VO2 during NE at 0.11 μg/min = −0.04 ± 0.06 ml/min; change during 0.22 μg/min = −0.07 ± 0.05 ml/min; change during 0.44 μg/min = −0.12 ± 0.06 ml/min.

Effects of NE on the Muscle during Static Exercise (10% P0)

Control data obtained after 2 minutes of exercise during intra-arterial saline infusion were: BF = 17.2 ± 2.6 ml/min; A-VO2 = 11.2 ± 1.0 vol %; VO2 = 1.96 ± 0.36 ml/min. The effects of graded NE infusion on these parameters in the exercising muscle are shown in Figure 2. BF was significantly reduced with NE as compared to the control exercise plus saline level (Fig. 2, Panel A). Similarly, A-VO2 was widened significantly with NE (Fig. 2, Panel B). VO2 appeared to increase at the lower two NE levels but was attenuated significantly during the highest NE dose (Fig. 2, Panel C).

Evaluation of data obtained during exercise (10% P0) compared to the corresponding data obtained from resting muscle suggests that exercise significantly increased BF (Fig. 2, Panel A), A-VO2 (Fig. 2, Panel B), and gracilis muscle VO2 (Panel C) at rest (broken lines) and during static exercise (solid lines) (10% P0, 2 minutes). Data are presented as mean ± SEM (n = 10). P values indicate the level of significance (ANOVA) between norepinephrine infusion and the respective control observations (C). Asterisks indicate statistical significance (P < 0.026) between comparable rest and exercise data.

FIGURE 2 The effects of graded norepinephrine infusion on gracilis muscle blood flow (Panel A), A-VO2 (Panel B), and gracilis muscle VO2 (Panel C) at rest (broken lines) and during static exercise (solid lines) (10% P0, 2 minutes). Data are presented as mean ± SEM (n = 10). P values indicate the level of significance (ANOVA) between norepinephrine infusion and the respective control observations (C). Asterisks indicate statistical significance (P < 0.026) between comparable rest and exercise data.

Effects of NE on the Muscle at Rest and during Static Exercise (2.5% P0)

Prior to intra-arterial infusion, static exercises at 2.5% P0 increased BF, A-VO2, and VO2 compared to their respective levels in the resting muscle (Fig. 3, Panels A through C). Data obtained during intra-arterial infusion of the two lower NE doses were similar to comparable data obtained during saline infusion. All values through the 8-minute time point during both saline and NE infusion remained increased compared to their respective resting levels. At the highest NE dose (as compared to parallel data obtained during saline infusion), gracilis muscle BF (Fig. 3, Panel A) and VO2 (Fig. 3, Panel C) were reduced significantly, but A-VO2 did not
The increased extraction of oxygen allowed for the maintenance of regional oxygen consumption, which did not appear to change significantly during the resting state (Fig. 2, Panel C). This effect may be dose-dependent, because the highest concentration of NE infused in the present study produced a moderate reduction in skeletal muscle V\textsubscript{O\textsubscript{2}}. This change was not significant only because the drug induced an opposite response in one dog. It is likely that with a larger number of determinations, the reduction in V\textsubscript{O\textsubscript{2}} caused by norepinephrine in resting muscle would be statistically significant.

Static exercise at 10% of maximal developed tension for 2 minutes resulted in an increased BF, a widened A-V\textsubscript{O\textsubscript{2}}, and an increased V\textsubscript{O\textsubscript{2}} (Fig. 2). When NE infusion was begun prior to exercise, a significant attenuation of exercise hyperemia and a further widening of A-V\textsubscript{O\textsubscript{2}} occurred (Fig. 2). At the two lower levels of NE infusion, an increase in the extraction of oxygen appeared to compensate for the attenuation of exercise hyperemia, and, consequently, skeletal muscle V\textsubscript{O\textsubscript{2}} was maintained at its control level. However, during infusion of the highest NE dose, an imbalance between exercise BF and the extraction of oxygen occurred, which resulted in a fall in regional skeletal muscle V\textsubscript{O\textsubscript{2}} during exercise (Fig. 2, Panel C).

Because the level of exercise chosen (10% P\textsubscript{0}) was close to the level at which steady state conditions may cease to exist, and because the duration of the exercise period was brief (2 minutes), a longer period of exercise was studied (10 minutes) at a lower exercise intensity (2.5% P\textsubscript{0}). When a graded NE infusion was instituted during this 10-minute exercise period, similar results were obtained. The highest NE dose resulted in an attenuation of exercise BF and exercise V\textsubscript{O\textsubscript{2}} (Fig. 3, Panels A through C). Although the results of the two exercise studies are similar, minor differences were noted. These differences may be accounted for partially by the higher levels of BF and V\textsubscript{O\textsubscript{2}} observed during the resting state in the latter series of studies, in which a barbiturate anesthetic was employed as opposed to the chloralose-urethane mixture used during the first series of studies. Although a true steady state was achieved during 10 minutes of exercise when saline was infused, it may not have existed during all NE infusions, and only could be achieved if the NE infusion rate were instantaneously varied as a function of gracilis muscle BF.

It is generally known that skeletal muscle V\textsubscript{O\textsubscript{2}} in the dog as well as in humans is relatively independent of skeletal muscle BF (Honig, 1977). This relationship for the canine gracilis muscle has been described by Durán and Renkin (1974). They showed that in the majority of cases V\textsubscript{O\textsubscript{2}} in the resting muscle remained nearly constant over a wide range of passively controlled BF levels and fell only at flows below 2 ml/min X 100 g (Durán and Renkin, 1974). Stainsby and Otis (1964), furthermore, demonstrated similar findings for the resting as well as the exercising canine gastrocnemius-plan-
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Takeshita A, Mark AL, Abboud FM, Schmid PG, Heistad DD,
Intrarenal Vascular Effects of [Des-Asp¹]Angiotensin I and Angiotensin III in the Dog

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SUMMARY We determined the effects of direct renal intra-arterial injections of [des-Asp¹]angiotensin I (0.2-3.2 μg) and angiotensin III (0.00625-0.1 μg) on renal blood flow in 10 dogs anesthetized with pentobarbital. Both [des-Asp¹]angiotensin I and angiotensin III caused dose-dependent decreases in renal blood flow. The decreases in ipsilateral renal blood flow occurred in the absence of alterations in systemic arterial pressure and flow to the contralateral kidney, suggesting that the response was a local event. The renovascular responses to [des-Asp¹]angiotensin I were greatly attenuated during the intravenous administration of SQ 20881, a synthetic peptide that competitively inhibits angiotensin converting enzyme. SQ 20881 did not alter the vasoconstrictor responses to angiotensin II, angiotensin I, or norepinephrine. [Ile⁷]Angiotensin III (an angiotensin III antagonist) abolished decreases in renal blood flow produced by [des-Asp¹]angiotensin I, angiotensin II, angiotensin III, and angiotensin I, whereas the response to norepinephrine was unchanged. These results suggest that the decrease in renal blood flow produced by [des-Asp¹]angiotensin I is due to its local enzymatic conversion to angiotensin III. About 7% of [des-Asp¹]angiotensin I is converted to angiotensin III during one transit through the kidney. Circ Res 44:666-671, 1979

IT HAS BEEN demonstrated recently that [des-Asp¹]angiotensin II (angiotensin III) is as potent as angiotensin II in decreasing renal blood flow, and it was hypothesized that the local production of angiotensin III occurs at the level of the renal arteriolar receptor (Freeman et al., 1975). Data are available to support the existence of two pathways for the generation of angiotensin III: the first from angiotensin II by the cleavage of the N-terminal aspartic acid through the action of aminopeptidases (Glenner et al., 1962; Regoli et al., 1963), and the second from the nonapeptide [des-Asp¹]angiotensin I by the cleavage of the C-terminal dipeptide histidyl-leucine through the action of angiotensin converting enzyme (Tsai et al., 1975). The present experiments assessed the ability of the kidney to form angiotensin III by the second pathway. The effects of [des-Asp¹]angiotensin I and angiotensin III on renal blood flow were examined in the presence and absence of a synthetic nonapeptide, SQ 20881 (Pyr-Trp-Pro-Arg-Pro-Ghr-Ile-Pro-Pro), that inhibits angiotensin converting enzyme (Ferreira et al., 1970a, 1970b; Cushman et al., 1971; Ondetti et al., 1971; Schaeffer et al., 1971; Yang et al., 1971). Experiments also were performed in the presence and absence of [Ile⁷]angiotensin III, an angiotensin III antagonist (Peach, 1977). The results suggest that the renal vasoconstrictor effects of [des-Asp¹]angiotensin I are due to its local enzymatic conversion to angiotensin III. About 7% of [des-Asp¹]angiotensin I is converted to angiotensin III during one transit through the renal vasculature.
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