Afferent axons in abdominal vagus mediate satiety effect of cholecystokinin in rats

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SMITH, GERARD P., CYNTHIA JEROME, AND RALPH NORGREN. Afferent axons in abdominal vagus mediate satiety effect of cholecystokinin in rats. Am. J. Physiol. 249 (Regulatory Integrative Comp. Physiol. 18): R638-R641, 1985.—Selective section of afferent vagal axons that reach below the diaphragm blocks the satiating effect of peripherally administered cholecystokinin in the rat. Section of the analogous efferent axons has no effect. After the behavioral tests, the selective axonal sections were confirmed with horseradish peroxidase histochemistry.

vagal axons; food intake

SMITH ET AL. (12) reported in 1981 that total abdominal vagotomy or selective gastric vagotomy abolished or markedly reduced the satiating effect of peripherally administered cholecystokinin (CCK-8). This effect of total vagotomy was confirmed by Lorenz and Goldman (5) and by Morley et al. (6). Because the abdominal vagal nerves contain afferent and efferent fibers, it is unclear whether the critical lesion involved afferent or efferent fibers. When peripheral anticholinergic blockade by atropine methyl nitrate, which provides a crude pharmacological mimic of a lesion of efferent vagal fibers, did not block the satiating effect of CCK-8, Smith et al. (12) proposed that the critical lesion involved afferent vagal fibers. By using a new surgical technique that permits selective sectioning of afferent or efferent vagal fibers, we can report evidence that confirms the afferent fiber hypothesis. A preliminary report of these results has appeared (13).

MATERIALS AND METHODS

Animals

Male Sprague-Dawley rats (Charles River, Cambridge, MA) weighing 220–450 g at the time of rootlet surgery were housed individually and tested in hanging wire cages in a room with lights on from 0700 to 1900 that was maintained at 22 ± 2°C. Rats were maintained on a sweet milk diet (Magnolia, Borden Foods, Columbus, OH) diluted 50% (vol/vol) with tap water containing Johnson’s Baby Vitamins, 0.2% by volume. The maintenance and test diets and tap water were presented in graduated drinking tubes (Wahmann Manufacturing, Timonium, MD). Tap water was available ad libitum.

Surgery

Vagal afferent and efferent rootlet surgery. We modified the ventral surgical approach to the medulla described by Travers and Norgren (15). This modification permits microscopic visualization of the afferent and efferent vagal rootlets as they approach the lateral surface of the medulla. Selective afferent or efferent rootlet section is possible because, in the rat, the afferent rootlets enter the medulla dorsal to the site where efferent rootlets exit (2-4). After pretreatment with atropine (0.1 mg) and anesthetization with pentobarbital sodium (Nembutal, 50 mg/kg), the rats were placed supine in a head holder. With the aid of an operating microscope, the basal aspect of the occipital bone was exposed by blunt dissection after tying off and sectioning the superior thyroid artery and removing the posterior wing of the hyoid bone with its attached musculature. The posterior lacerated foramen was expanded medially by thinning the occipital bone with a dental burr and then removing the remaining bone posteriorly to the level of the hypoglossal canal with fine forceps or a modified corneoscleral punch. This exposure revealed the vagus nerve as it penetrates through the dura mater and separates into two groups of nerve rootlets. The rootlets in the ventral group are smaller and more numerous, and many extend caudally before penetrating the ventrolateral medulla. The dorsal group consists of two to four rootlets that reach the dorsolateral surface of the medulla at the level of the posterior lacerated foramen. Once the dura is lanced, the ventral (efferent) rootlets can be sectioned with iris scissors. With this ventral approach the dorsal rootlets often are partially obscured by the overlying ventral

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Vagal afferent axons mediate CCK satiety

Rootlets and accompanying veins. These must be deflected gently before the dorsal rootlets can be sectioned. In addition to the vagus, efferent section involves both the accessory (XI) and glossopharyngeal (IX) roots. Likewise, an afferent transection includes both vagal and glossopharyngeal axons, because in the rat these two cranial nerves join in a common sheath at the level of the posterior lacerated foramen. All rats underwent rootlet section on the left side.

Abdominal vagotomy. About 2 wk after the rootlet operation, unilateral abdominal vagotomy was performed to lesion the afferent and efferent fibers connected contralateral to the side of the rootlet section (Fig. 1). Due to the partial rotation of the stomach during development, the left (or posterior) subdiaphragmatic vagus is continuous with the right cervical vagus nerve and connects to the right side of the medulla. Thus the unilateral abdominal vagotomy was conducted on the left trunk according to the procedure described by Smith and Jerome (11). Briefly, the left trunk was identified just below the diaphragm. Two 3-0 silk sutures were tied around the vagal trunk, 1-2 cm apart, and the nerve between the sutures was sectioned. The sutures restricted regeneration of transected fibers and facilitated anatomic verification of vagotomy at the conclusion of the experiment.

The rationale for this combination of intracranial rootlet and abdominal vagotomy lesions is twofold. First, anterograde and retrograde transport of horseradish peroxidase (HRP) from abdominal vagal nerves shows no significant exchange of fibers between the right and left vagal nerves from the level of the medulla to below the diaphragm (1, Norgren and Smith, unpublished observations) (Fig. 1). Second, unilateral abdominal vagotomy does not reduce the satiating potency of peripherally administered CCK-8 (10).

Food Intake Tests

About 2 wk after unilateral abdominal vagotomy rats were adapted to a 17-h deprivation schedule, and the intake of a high-carbohydrate liquid diet (Bio Serv EC116 liquid diet, Bio Serv, Frenchtown, NJ) was measured 15 and 30 min after intraperitoneal administration of CCK-8 (6 μg/kg body wt) or isovolumetric 0.15 M saline. Under these conditions the 30-min intake is the size of the meal.

The CCK-8 (a gift from Squibb, Princeton, NJ) was dissolved in 0.15 M saline just before each test. This dose was chosen because in other experiments it produced a nearly maximal inhibition of food intake without a significant inhibition of water intake (9).

Lesion Verification

Afferent and efferent vagal rootlets. At the conclusion of the behavioral experiments we anesthetized each rat with serial injections of atropine sulfate (0.1 mg ip), pentobarbital sodium (30 mg/kg ip), and ethyl carbamate (urethan, 0.7 g/kg ip) spaced over 30 min. The central end of the cut cervical vagal trunk ipsilateral to the rootlet lesion was then exposed to crystalline horseradish peroxidase (HRP, Boehringer Mannheim grade I) using a protocol described in detail by Hamilton and Norgren (3). The vagal trunk was always exposed to HRP crystals for 6 h.

After a 60- to 70-h survival the rats were reanesthetized with pentobarbital sodium (100 mg/kg ip) and then perfused via the left ventricle with 0.9% saline (4-5 min), 2.5% glutaraldehyde in 0.1 M phosphate buffer (pH 7.3, 20 min), and cold 5% sucrose in 0.1 M phosphate buffer (20 min). The caudal brain stem and upper spinal cord were removed immediately, cut coronally at 40 μm on a freezing microtome, and reacted as described by Hamil-
RESULTS AND DISCUSSION

Nine of 15 rats that underwent rootlet surgery had verified rootlet and vagotomy lesions: six had afferent rootlet lesions, two had efferent rootlet lesions, and one was a full surgical control. The marked difference in the pattern of HRP reaction product within the nucleus of the solitary tract and dorsal motor nucleus of the vagus after afferent or efferent rootlet section is illustrated in Fig. 2.

The effect of CCK-8 on the food intake of these rats is summarized in Table 1. The combination of a unilateral afferent rootlet lesion with section of the abdominal vagal trunk containing the afferent and efferent fibers connected to the contralateral medulla (Fig. 1A) abolished the satiating effect of CCK-8. However, the combination of a unilateral effferent rootlet lesion with section of the abdominal vagal trunk containing the afferent and efferent fibers connected to the contralateral medulla (Fig. 1B) did not appear to alter the satiating effect of CCK-8 from that observed in the full surgical control (Table 1).

The differential effect of afferent and efferent rootlet lesions in these experiments confirms the hypothesis that section of afferent fibers is the critical lesion for blocking the satiating effect of peripherally administered CCK-8. These results are supported by the electrophysiological experiments of Niijima demonstrating that peripherally administered CCK-8 increases the firing rate of gastric vagal afferent fibers (7). Taken together these results are compelling evidence for the role of afferent vagal fibers from the abdomen mediating the satiating effect of peripherally administered CCK-8.

The site of activation of these fibers by circulating CCK-8 is unknown. The most likely possibilities are that CCK-8 activates the vagal afferent fibers either indirectly through a smooth muscle contractile effect in the pyloric sphincter region (14) or directly through CCK-8 receptors on the axons themselves (16).

In addition to its specific application to the mediation of the satiety effect of CCK-8, we emphasize the usefulness of the afferent or efferent rootlet lesion procedure for analyzing the relative contribution of afferent or efferent abdominal vagal fibers to the effect of vagotomy on other aspects of eating (8) and drinking behavior (11), on gastrointestinal secretion and motility, and on neuroendocrine and metabolic functions of the abdominal viscera.

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TABLE 1. Effect of selective bilateral afferent or efferent section of abdominal vagal fibers on CCK-induced satiety

<table>
<thead>
<tr>
<th>Intake, ml/30 min</th>
<th>Saline</th>
<th>CCK-8</th>
<th>%Inhibition</th>
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<tr>
<td>Afferent lesion</td>
<td></td>
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<tr>
<td>1</td>
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</tr>
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</tr>
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<td>6</td>
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<td>Efferent lesion</td>
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</tr>
<tr>
<td>Control</td>
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<td>6</td>
<td>50</td>
</tr>
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</table>

Percentage of inhibition of food intake = 100 x [1 - 30 min intake after CCK-8/30 min intake after saline]. Negative inhibition indicates more was eaten after cholecystokinin (CCK) than after saline. Afferent lesion data are summarized as means ± SE. Control animal was a full surgical control.
REFERENCES


