**Editorial Focus:** role for neural growth factor in autonomically driven arrhythmogenesis? Focus on: “Structural neuroplasticity following T5 spinal cord transection: increased cardiac sympathetic innervation density and SPN arborization”

**Julia A. Moffitt**

*Department of Physiology and Pharmacology, Des Moines University, Des Moines, Iowa*

Submitted 9 August 2010; accepted in final form 10 August 2010

The autonomic nervous system has long been known to exert powerful influence on the genesis of and vulnerability to cardiac arrhythmias. With regard to ventricular arrhythmias, increased sympathetic outflow is generally thought to be proarhythmic, while parasympathetic drive is thought to be antiarhythmic. Imbalance in this relationship with a shift toward sympathetic dominance and away from parasympathetic dominance induces electrical destabilization of the myocardium, although the mechanisms of these effects remain largely unknown (14). The study by Lujan et al. (10) from Dr. Stephen DiCarlo’s group suggests that neural growth factors (NGFs) may play a role in the pathogenesis of autonomically driven ventricular arrhythmias within the setting of spinal cord injury (SCI). An extension of their previous work, which established that midthoracic level 5 (T5) spinal cord transection in rats, increases vulnerability to ventricular arrhythmias (5), Lujan’s study expands on these findings and provides further evidence of structural hyperinnervation of sympathetic neural supply to the myocardium following SCI in rats. Using injection of cholera toxin B into the left and right stellate ganglion, which provides over 90% of sympathetic supply to the heart, the authors determined that following SCI there was a significant increase in cardiac sympathetic preganglionic neuronal (SPN) arborization as compared to intact rats. Furthermore, there was a significant increase in left ventricular NGF content as well as increased left ventricular sympathetic density as measured through tyrosine hydroxylase immunohistochemistry. Thus, by using a combination of multiple techniques and lines of evidence, the authors concluded that SCI results in sympathetic hyperinnervation of the left ventricular myocardium.

The discovery of NGF by Levi-Montalcini (8, 9) has lead to expansive study and understanding of their well-known actions on neural growth and survival, particularly during development and injury. Less well understood are their actions on nonneural targets, including the cardiovascular system. More recently, however, a number of studies have provided evidence of a critical role for NGF in the heart following myocardial injury (3, 7). This has lead to the formulation of the nerve-sprouting hypothesis of sudden cardiac death. According to this hypothesis (Fig. 1) myocardial ischemia injures both the myocardium and the surrounding sympathetic innervation richly supplying the coronary arteries. Sympathetic nerve sprouting results from this injury, leading to sympathetic hyperinnervation, resulting in increasing risk for sudden fatal cardiac arrhythmias including ventricular tachycardia and ventricular fibrillation. NGF is thought to play a critical role in the cascade of these events, expressed by nonneural cells surrounding the site of injury (5).

Within the context of SCI, although not immediately obvious, evidence of myocardial injury has been postulated, likely driven by the high level of sympathetic outflow that occurs immediately following the acute SCI. SCIs at or below T5 result in loss of descending sympathetic drive to the vasculature innervated by SPNs, which exit the spinal cord below the level of transection. These levels of sympathetic outflow following SCI have been reported to be high enough to induce calcium overload (12) and induce left ventricular dysfunction and ST-segment elevation (11), thus likely establishing a setting where NGF is produced by either injured myocardium or lymphocytes recruited to the site of injury, and induces sympathetic sprouting and hyperinnervation of the heart. Although the points of entry for SCI in the hypothesized cycle of NGF-mediated increases in sympathetic hyperinnervation of the myocardium may differ from that of myocardial ischemia (Fig. 1), the result is essentially the same: establishment of electrical remodeling of the myocardium and arrhythmogenesis.
These results have important implications in not only addressing the mechanisms responsible for the high mortality rates and incidence of cardiovascular disease in chronic SCI patients (15) but also regarding other pathophysiologic states that are accompanied by high cardiac sympathetic drive.

Adaptation to a number of persistent physiologic and environmental stresses results in increased cardiac sympathetic drive, autonomic imbalance, and myocardial electrical destabilization. These include states, such as chronic stress, psychological depression, and orthostatic tachycardic syndromes (1, 4, 6). The study by Lujan et al. (10) provides evidence for a mechanism whereby initial sympathetic surges are maintained and augmented through a NGF-mediated mechanism, resulting in sustained sympathetic innervation of the myocardium even though the initial insult or injury is removed or ameliorated.

Although this study provides support for this hypothesis, further questions remain, and a number of potential mechanisms are left unidentified. For instance, Lujan et al. (10) only evaluated the changes in NGF, density of sympathetic innervation, and SPN arborization within the left ventricle, thus providing only a snapshot of neuroplastic changes within a discrete area of the left ventricle induced by SCI. Autonomically driven arrhythmogenesis may not purely be a function of the gross level of sympathetic innervation but rather may be most sensitive to the degree heterogeneity of that innervation. The relationship between regional heterogeneity of sympathetic innervation and vulnerability to ventricular arrhythmias has been established in both humans (2) and animal models (13). Thus, further examination of neuroplasticity within distinct and diverse regions of the myocardium may provide further insight into these mechanisms. In addition, in order to firmly establish NGF as a critical mediator of the sympathetic sprouting following SCI, further study in which the expression of NGF is blocked would be required to determine a definitive mechanistic role by this growth factor. Further remaining to be identified is the source of NGF within this process. Whether NGF is produced from the myocardium or possibly released from lymphocytes that infiltrate areas of injury, remains to be determined. Although questions remain, Lujan et al. (10) provides important new insight into the neuroplastic changes that occur within the myocardium following SCI with implication in the areas of both SCI and cardiovascular autonomic control and provides a robust model in which to investigate the role of growth factors in the pathogenesis of automatically mediated arrhythmogenesis.

REFERENCES