THE \( M_2 \) MUSCARINIC RECEPTOR MEDIATES \textit{IN-VITRO} BLADDER CONTRACTIONS FROM PATIENTS WITH NEUROGENIC BLADDER DYSFUNCTION

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Running head: The \( M_2 \) muscarinic receptor subtype mediates neurogenic bladder contraction.
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ABSTRACT

Bladder muscle specimens from 7 patients with neurogenic bladder dysfunction were analyzed to determine whether the muscarinic receptor subtype mediating contraction shifts from M3 to the M2 subtype as found in the denervated, hypertrophied rat bladder. Seven bladder specimens were analyzed from 6 female and 1 male patients. Six of the patients had traumatic cervical spinal cord injuries (C4-C7) and the other patient had an L1 congenital myelomeningocele. This was compared to results from bladder specimens obtained from 8 organ transplant donors. The affinities of 3 subtype selective muscarinic receptor antagonists for inhibition of carbachol induced contractions were determined. The affinity of the M3 selective antagonists darifenacin or para-fluoro, hexahydroisladifenadol (p-F-HHSiD) was determined in 6 of the 7 spinal injury patient specimens. The affinity was consistent with M2 mediated contractions in 4 of these 6 specimens, intermediate between M2 and M3 in one specimen and within the M3 range in one specimen. The other specimen, tested only with the M2 selective antagonist methoctramine, showed an M3 affinity. In the organ donors, the affinity of p-F-HHSiD was within the M2 range for 6 of 7 specimens whereas the affinity of darifenacin was within the M3 range for 5 out of 6 and intermediate between M2 and M3 for the other specimen tested. The affinity of methoctramine in both organ donor specimens tested was within the M3 range. Whereas normal detrusor contractions are mediated by the M3 receptor subtype, in patients with neurogenic bladder dysfunction as well as certain organ transplant donors, contractions can be mediated by the M2 muscarinic receptor subtype.
INTRODUCTION

Bladder contraction during voiding is mediated by the neurotransmitter acetylcholine acting through muscarinic receptors located on urinary bladder smooth muscle cells. At least three subtypes of muscarinic acetylcholine receptors (M₁, M₂ and M₃) can be distinguished based on the actions of relatively subtype selective antimuscarinic agents. Five subtypes arising from five separate genes are identifiable by molecular techniques (5). Immunologic, functional and molecular studies indicate that most tissues, including the human bladder, contain a mixture of subtypes. Immunoprecipitation has determined that both M₂ and M₃ receptor protein is present in the human bladder (49), however, affinities of subtype selective antimuscarinic agents for inhibition of bladder contractions in neurologically intact animal models including rat, rabbit and mouse are consistent with the M₃ subtype mediating contraction under normal conditions in-vitro (11, 23, 29, 44). In the rat, the potency of subtype selective antagonists for inhibition of bladder contraction in-vivo correlates better with their affinity at M₂, than at M₃ receptors (29). The affinities of subtype selective antimuscarinic agents for inhibiting in-vitro human bladder contractions have only been published in a few studies using a very small number of specimens (18, 24, 30, 36, 37). These studies also conclude that, although the M₂ receptor subtype predominates, the minor population of M₃ receptor subtypes mediates contraction of the normal human bladder.

Denervation and spinal cord injury in the rat induce bladder hypertrophy and a change in muscarinic receptor subtype mediating urinary bladder contraction from M₃ to M₂ (7, 11). Bladder muscle specimens from patients with spinal cord injury were analyzed to determine whether in humans with neurogenic bladder, the muscarinic receptor subtype mediating contraction also shifts from M₃ to the M₂ subtype.
MATERIALS AND METHODS

Studies were performed with approval of the Temple University School of Medicine Institutional Review Board. At the time of open reconstructive surgery, 5 mm X 15 mm full thickness muscle specimens were removed from the bladder dome. A total of 7 bladder specimens were analyzed from 1 male and 6 female patients. Patient characteristics are listed in Table 1. Six of the patients had traumatic cervical spinal cord injuries (C4-C7) with an average time after injury of 2.6 ± 0.8 yrs. The other patient had an L1 congenital myelomeningocele. The average age of the patients was 18.6 ± 0.7 yrs (range 17-22). Pre operative bladder capacity was determined during filling cystometry using a fill rate of 30 ml/min. Bladder capacity was defined as the point at which an uninhibited bladder contraction occurred, or the intravesical pressure reached 40 cm of water pressure whichever came first. Prior to surgery, all patients were being treated with at least one anticholinergic agent for their neurogenic bladders (Table 1). In addition, bladder tissue was obtained from 8 organ donors from the National Disease Research Institute (Table 2). Tissue was extirpated as soon as possible after cessation of circulation, immersed in Viaspan (Belzer UW; Dupont Pharma) cold storage solution (composed of the following g/l: pentafracion 50, lactobionic acid 35.83, potassium phosphate monobasic 3.4, magnesium sulfate heptahydrate 1.23, raffinose pentahydrate 17.83, adenosine 1.34, allopurinol 0.136, total glutathione 0.922, potassium hydroxide 5.61, pH adjusted to 7.4 with sodium hydroxide or hydrochloric acid) and shipped to the laboratory by courier on wet ice. Six of the eight donors spent time on life support. Experiments were typically carried out the day after procurement in the organ donors, and on the same day in the patients with neurogenic bladder.

Muscle Strips: Multiple bladder smooth muscle strips approximately 2 x 8 mm (mucosa free)
were dissected from the specimen under 4 fold magnification such that the direction of the smooth muscle bundles were primarily aligned along the length of the strip. Strips were stretched slowly to 1.0 g of isometric tension in tissue baths containing 15 ml of modified Tyrode’s solution (125 mM NaCl, 2.7 mM KCl, 0.4 mM NaH₂PO₄, 1.8 mM CaCl₂, 0.5 mM MgCl₂, 23.8 mM NaHCO₃, and 5.6 mM glucose) and equilibrated with 95/5% O₂/CO₂ at 37 °C. The strips were tested for their ability to contract in response to electric field stimulation using bipolar platinum electrodes oriented 1 cm apart along the length of the strip and a stimulus intensity of 8 volts, 30 Hz, 1 ms duration. Strips that did not contract in response to this electric field stimulation were not used in the analysis.

**Carbachol Dose Response:** Following equilibration to the bath solution for 30 minutes, separate groups of bladder strips (n=3-8), were incubated for 30 minutes in the presence or absence of selected concentrations of subtype selective muscarinic receptor antagonists: methoctramine (0.1, 1.0 and 10 µM) para fluoro hexahydrosiladifenadol (p-F-HHSiD, 0.1, 1.0 and 10 µM) and darifenacin (0.03 µM). Each muscle strip was used as either an antagonist free control or exposed to one concentration of antagonist and thus each strip only underwent 1 cumulative dose response curve. Dose response curves were derived from the peak tension developed following cumulative addition of carbachol in one half log increments (10 nM to 1 mM final bath concentration). An EC₅₀ value for each strip was determined from a nonlinear least squares sigmoidal curve fit of the data (Origin, OriginLab Corp., Northampton, MA). Dose ratios were determined based on the average of the EC₅₀ values of antagonist free strips (n=3-8). The EC₅₀ values determined in the presence of antagonist were used to generate Schild plots in order to calculate antagonist pA₂ values for each individual patient specimen (3). If the slope of the Schild plot was not significantly different from unity, the slope of the Schild plot was constrained to unity in order to calculate the
pKb value. Not all of the antagonists could be tested in all of the specimens due to insufficient specimen size.

**Statistical and data analysis:** Results are reported as means ± S.E.M. or 95% confidence intervals for affinity values. Statistically significant differences in the affinity values and departure from unity in the slopes derived from the Schild plots were determined using the 95% confidence intervals.
RESULTS

Preoperative bladder capacity in the neurogenic bladder patients averaged 202 ± 41 mls (range 63-360). Of the seven patients with neurogenic bladder, six had uninhibited detrusor contractions during filling. The average uninhibited bladder contractions was 77 ± 21 cm of water pressure (range 30-140). The other patient reached 40 cm of water pressure before an uninhibited contraction occurred thus filling was stopped and that infused volume was defined as bladder capacity. At the concentrations used, the inhibition of in-vitro contraction by all of the antagonists was surmountable by carbachol and thus all behaved as competitive antagonists. The affinity of the M₃ selective antagonist darifenacin or p-F-HHSiD was determined in 6 of the 7 specimens (figure 1, patients 2-7). The affinities were consistent with M₂ mediated contractions in 4 of these 6 specimens (patients 3,5,6 and 7), intermediate between M₂ and M₃ in one specimen (patient 2) and consistent with M₃ mediated contractions in one specimen (patient 4). One of these 6 neurogenic bladder specimens (patient 3) and the other neurogenic specimen (patient 1) were tested with the M₂ selective antagonist methoctramine and low affinities were found for both, consistent with M₃ mediated contractions. There was no striking relationship between antagonist affinity and preoperative bladder capacity, level of spinal injury, time after injury or preoperative medications.

In 5 bladder specimens from the organ donors (figure 2, donors 3-6 and 8), the affinity of both p-F-HHSiD and darifenacin were determined. In 4 of the 5 (donors 4-6 and 8), the affinity of p-F-HHSiD was within the reported range for M₂ mediated contractions while the affinity of darifenacin was not different from the range of affinities reported for the M₃ subtype. In the other specimen (donor 3), the affinity of p-F-HHSiD was within the reported M₂ range, and was intermediate between M₂ and M₃ range for darifenacin. In 1 tissue, only p-F-HHSiD was used.
(donor 1), and had an affinity consistent with M₃ receptors mediating contraction. In one tissue (donor 7), only darifenacin was used and an affinity not different from the M₃ range was found. In one specimen (donor 2), p-F-HHSiD and methoctramine were used, the p-F-HHSiD affinity was consistent with M₂ receptors while the methoctramine affinity was consistent with M₃ receptors mediating contraction. Strikingly, the methoctramine affinity was low (consistent with M₃ mediated contractions) in all specimens tested (patients 1 and 3, and donors 2 and 4). In every study we have previously performed, with the single exception of rat bladder following selective alkylation of M₃ receptors in the presence of isoproterenol (12), we have always found a low methoctramine affinity consistent with M₃ receptors mediating contraction. After confirming this in 2 human specimens from each group, we did not continue to determine the affinity of methoctramine using this limited patient and donor tissue.
DISCUSSION

Human detrusor contractions are thought to be mediated by the M3 receptor subtype. This assumption is based in part on data from animal studies and very limited data in human tissue (18, 24, 30, 36, 37). Our study is the first to demonstrate that in individuals with a neurogenic bladder dysfunction from spinal cord injury or myelodysplasia, detrusor contractions can also be mediated by the M2 muscarinic receptor subtype receptor. This was also seen in certain bladders from organ donors.

Bladder contraction occurs from acetylcholine induced excitation of post junctional muscarinic cholinergic receptors on bladder smooth muscle. Subtype selective antimuscarinic agents are available that are at least 10 fold selective for each of the M1 - M3 subtypes (15, 16). The MT3 toxin is at least 30 fold selective for the M4 subtype (15, 16, 31). No M4 selective antagonists are currently available. M1 receptors have a high affinity for pirenzepine (PZP), a low affinity for methoctramine and an intermediate affinity for para-fluoro-hexahydro-sila-diphenidol (p-F-HHSiD). M2 receptors have a high affinity for methoctramine and a low affinity for PZP and p-F-HHSiD. M3 receptors have a high affinity for 4-diphenlacetoxy-N-methyl piperidine methiodide (4-DAMP), darifenacin and p-F-HHSiD, an intermediate affinity for PZP and a low affinity for methoctramine (15). Affinity values derived from Schild plot analysis of the inhibition of carbachol induced contractions of the rat urinary bladder are consistent with M3 receptors mediating contraction (10, 49). This is also consistent with the response seen in other animal models, demonstrating that, although M2 receptors are more abundant (27, 49), it is the M3 receptor subtype that is important in the control of bladder contractions across a range of species.

Muscarinic receptor subtypes have been analyzed in human bladder using several different approaches. Binding studies in human bladder as well as cultured human bladder smooth muscle
cells have demonstrated greater numbers of M₂ than M₃ receptors (27, 28, 32, 33, 39). The mRNA encoding M₂ and M₃ have been reported to be present in equal amounts (50). Using antibodies to the muscarinic subtypes, approximately 80% of precipitable receptors are M₂, with the rest mainly M₃ (49). There is limited functional data from human bladder. Muscarinic receptor stimulation of human bladder tissue induces phosphatidyl inositol (PI) hydrolysis (2, 39, 48) which is consistent with involvement of the M₃ subtype because M₁, M₃ and M₅ subtypes preferentially couple to PI turnover. This is further supported by a study similar to ours using “normal” human bladders. In these bladder strips, darifenacin had a high pA₂ value similar to that for guinea pig bladder, with low affinities of methoctramine and pirenzepine. The authors concluded that contraction in human bladder is mediated through M₃ receptors, although the exact source of this human tissue and patients characteristics were not specified in this abstract (37). Similarly, in a series of bladder specimens taken from 10 males and 11 females undergoing cystectomy for bladder cancer, the affinities of 6 different muscarinic antagonists (PZP, methoctramine, 4-DAMP, tropicamide, oxybutynin and tolterodine) were consistent with M₃ mediated contractions (18).

Studies in normal bladders from all species studied to date indicate that the M₃ subtype mediates bladder contraction. These determinations are based on the assumption that only one of the receptor subtypes mediates the response. In some of our pathological human bladder specimens from patients with neurogenic bladder dysfunction or organ donors, it appears that both M₂ and M₃ receptors may be mediating the contractile response depending on which subtype selective antagonist was used. We interpret the apparent contradictory data (i.e. a low p-F-HHSiD affinity indicating M₂ mediated contractions together with a low methoctramine affinity indicating M₃ mediated contractions) to be consistent with a scenario in which either the M₂ or the M₃
receptor can mediate contraction. When the M₂ receptor is inhibited by methoctramine, the M₃ receptor mediates contraction. When the concentration of methoctramine is high enough to block both the M₂ and the M₃ receptor, contraction is inhibited. This would yield an affinity consistent with blockade of the least sensitive receptor to methoctramine, in this case the M₃. The converse is also true, i.e. p-F-HHSiD would not affect contraction until both M₂ and M₃ receptors are inhibited and thus a low affinity would be obtained. In 5 of the organ donor specimens, the affinity of 2 different M₃ selective antagonists (darifenacin and p-F-HHSiD) was determined. In 4 of these 5, an affinity consistent with M₂ receptors was found using the less selective antagonist (p-F-HHSiD) whereas the affinity of the antagonist with a greater selectivity for M₃ receptors (darifenacin) was high, consistent with M₃ receptors mediating contractions. The relative selectivity of these 2 antagonists may offer some explanation of these findings.

There are multiple reports of an M₂ receptor contribution to bladder contraction under certain experimental conditions or in different pathologic states. Bilateral removal of the major pelvic ganglia in rats renders the bladder denervated since unlike other mammalian species, the adult rat bladder does not contain intramural ganglia (25, 46). Since these bladders cannot empty on their own, they become hypertrophic within 24 hours after denervation even though they are emptied with manual external abdominal pressure twice a day. In denervated bladders, the affinity of subtype selective antimuscarinic receptor drugs to inhibit carbachol induced contractions is consistent with M₂ or a combination of M₂ and M₃ mediated bladder contractions, while non denervated sham operated control bladders display affinities consistent with M₃ mediated contractions. After denervation, there is a 60% increase in M₂ receptor density with no change in M₃ receptor density compared to sham operated controls (11). M₂ receptors also participate in contraction of the bladder from rats with a T9 level spinal cord injury who do not spontaneously
regain the ability to urinate (7). Rats with the T9 level injury who were able to spontaneously
urinate, and control animals demonstrate bladder contractions mediated by the M3 receptor
subtype. Other conditions affecting smooth muscle in which there is M2 mediated contraction
include experimental esophagitis in cat (41), a model of acute cholecystitis in guinea pig (8) and in
arterial hypertension (47). In addition, alteration of experimental conditions in smooth muscle
studies can shift the subtypes mediating contraction from M3 to M2. This includes inhibition of the
sarcoplasmic reticulum ATPase (13) and after inactivation of M3 receptors using the irreversible
inhibitor 4-DAMP mustard in an environment of increased intracellular cAMP (12, 29).

There are several mechanisms through which M2 receptors may produce bladder contraction.
Data obtained after selective alkylation of M3 receptors with 4-DAMP mustard suggest that M2
receptors, through activation of a GTP binding protein associated with inhibition of adenylyl
cyclase (G_i), may be involved in inhibition of β-adrenergic receptor induced relaxation (12, 29).
Based on cloned receptors expressed in CHO cells, a particular receptor subtype does seem to
preferentially couple with one type of G-protein. However, there is substantial evidence of
significant promiscuity in this coupling mechanism such that, depending on the type of cell and the
biochemical state of the cell, a given receptor may be able to couple with several different types of
G-proteins so that a single receptor subtype may mediate several different cellular signals (45, 49).
Whereas M2 receptors are traditionally thought to couple to the G_i class of GTP binding proteins,
we have demonstrated, using a co-immunoprecipitation assay, that M2 receptors can also couple to
G_q in human bladder (49). Thus, differential coupling of M2 to different G proteins under different
conditions may alter its effect on bladder tissue. There are several different mechanisms of M2
action, demonstrated in smooth muscle other than the bladder, that may also be active in the
detrusor. These include opening of non selective cation channels resulting in depolarization and influx of calcium which is seen in ileum (4) and inhibition of conductance through potassium channels as seen in canine colon (21). M₂ receptors could also activate protein kinase C to induce contraction (21, 48).

Selective alkylation experiments in mice demonstrates that in most strains, no indirect contractile role for M₂ receptors exists (19, 20) as can be shown in rat bladder (12, 29) and guinea pig ileum (43). This is confirmed by muscarinic receptor subtype knockout experiments in mice. In M₃ knockout mice, very little residual M₂ mediated contractions are found (35), and in M₂ knockout mice, maximal contractions to carbachol in bladder are not reduced and carbachol potency is only slightly decreased (42). The regulation of the interplay between M₂ and M₃ mediated contractions is not clear, however, receptor density may play a role. Following denervation in the rat, there is an increase in the number of M₂ receptors but not M₃ (11). There is also evidence that the M₂/M₃ interaction is regulated by intracellular calcium. Low levels of muscarinic stimulation and hence low levels of calcium induce a translocation in PKC to the membrane, while at greater levels of receptor stimulation PKC activation is inhibited (40). We have shown, using combinations of M₂ and M₃ selective antagonists, that there is no synergy between these subtypes in normal rat bladder contraction. However, in the denervated, hypertrophied bladder there is a synergistic interaction between the two subtypes in that the contractile response from the combination of M₂ and M₃ subtypes is greater than what would be predicted from the sum of each subtype acting alone (13).

As a result of using specimens from patients with neurogenic bladder dysfunction, our results differ from previous published results in human bladder that concluded that the M₃ subtype mediates bladder contraction (18, 37). Some of our donor tissue also shows M₂ mediated
contractions. While it is not likely that bladder hypertrophy or neurogenic lesions are responsible for this finding, one explanation is that the physiology of this tissue is different from normal, because of the transport solution and ischemia or anoxia. Another possible reason is due to bladder inactivity while the donor was on life support or due to long transport times. An additional explanation may be that we determined antagonist affinities in each individual patient specimen as opposed to averaging results from all individuals. Many studies in the past have correlated the affinities of antagonists in inhibition of bladder contraction with their affinities for each of the 5 muscarinic receptor subtypes expressed in clonal cell lines, assuming that the subtype that gives the highest correlation coefficient mediates bladder contraction (1, 18, 22, 29). This method gives the same weight to drugs with no subtype selectivity as those which are highly selective. Often this type of analysis yields similar significant correlations for more than one subtype. An underlying assumption is that a single subtype mediates contraction. Our data and others indicates that both M2 and M3 muscarinic receptor subtypes are involved in mediating contraction of bladder smooth muscle (9, 12, 26, 29). Another issue in determining the muscarinic receptors that mediate normal human bladder contraction is that tissue is taken at the time of surgery performed for some pathologic process, so whether this tissue truly represents normal bladder must be questioned. This also includes organ transplant donor controls, some of which we found in this investigation to have M2 mediated bladder contractions. A major difference in our study from those published previously is that we are looking at neurogenic bladder which is different from that used in other studies. Irrespective of the physiologic changes from the neurologic injury, another factor to consider in these patients may be the concomitant use of antimuscarinic and other medications.

Prior studies described above have used inactivation of the M3 receptor with 4-DAMP mustard
to produce M$_2$ mediated contractions (12, 24, 29). At least 6 of the 7 patients were on long-term antimuscarinics to treat their neurogenic bladders prior to surgery (see table 1 for specifics).

Although these medications do not covalently inactivate the muscarinic receptor like 4-DAMP mustard does, it is possible that the long term use of muscarinic antagonists may serve to modulate the M$_3$ or M$_2$ contractile response. Chronic atropine treatment may increase muscarinic receptor density, however, this is dependent on the method of drug administration. When atropine was administered for 14 days through an osmotic pump at 5 mg/kg/day to rats, we found that muscarinic receptor density increased by about 43% (34). In another study in which atropine was given for 14 days by daily intraperitoneal injection (20 mg/kg), we found that no increase in muscarinic receptor density occurred (17). The effect of the anti-muscarinics on the density of muscarinic receptors in our patients is unknown. Nonetheless, the only issue that this would cloud is whether contraction in the untreated neurogenic bladder is predominantly mediated by the M$_3$ receptor. Our data shows that bladder contractions in these patients are mediated by the M$_2$ receptor, whether it is due to the physiologic changes of the injury, or due to any contribution of their concomitant medications. Another factor in our neurogenic bladder patients may be the effect of functional bladder outlet obstruction from vesico sphincter dyssynergia. Bladder outlet obstruction for 3 days in the rat yields a hypertrophied bladder, some degree of functional denervation and an M$_2$ mediated component of contraction (9).

Our data may have clinical implications. In patients with a supra sacral spinal cord injury, some of the bladder contraction can be M$_2$ mediated. Thus in these patients, addition of a relatively selective M$_2$ antagonist or a drug which has both M$_2$ and M$_3$ blocking activity might be expected to be more effective in increasing bladder capacity than one that is predominantly M$_3$ selective. However, intravenous administration of the highly M$_3$ selective antagonist darifenacin
has been shown to effectively suppress unstable bladder contractions provoked by rapid fluid infusion (50-100 ml infused at 20 ml/sec) in a group of 8 male patients with supra sacral spinal cord injury (14). An advantage of an M₂ selective agent would be less dry mouth because salivation is primarily mediated by M₃ receptors (38). On the other hand, an M₂ selective antagonist might be expected to produce increased cardiac side effects since the M₂ receptor mediates the effects of the vagus nerve on the heart. A larger unanswered question is whether these results are applicable to the large number of patients who are clinically neurologically intact and use antimuscarinic medications for overactive bladder. One theory of overactive bladder in otherwise neurologically intact individuals is that of partial detrusor denervation (6). In our rat model of bladder denervation, there is a shift in the muscarinic receptor subtypes responsible for bladder contraction from M₃ to M₂. In these patients who have decentralization of their bladders, there was also a shift in the muscarinic receptor subtype mediating contraction from M₃ to M₂. These data indicate that if there is some element of denervation in patients with overactive bladder, then there might also be a shift from M₃ to M₂ mediated contraction. This deserves further investigation.

Whereas normal detrusor contractions are thought to be mediated by the M₃ receptor subtype, in patients with neurogenic bladder dysfunction and certain organ donors, contractions can be mediated by the M₂ muscarinic receptor subtype. These findings challenge the assumption upon which medical therapy is based for treatment of patients with voiding dysfunction. There may also be implications for drug development. If the change in function and number of receptor subtypes in denervated bladder is a common phenomenon in other pathologic states, then the therapies developed for the treatment of these conditions based on the effect in normal tissue may be
clinically ineffective. Results from clinical trials with the M₃ selective receptor antagonist, darifenacin, may help to clarify the relative importance of M₂ and M₃ receptors in overactive bladder. To our knowledge, there are currently no M₂ subtype selective antagonists in development for clinical use. Our data also points out the variability between individual patient response to selective antimuscarinic therapy. Thus the present data indicate that different individuals or groups of patients might benefit from different antimuscarinic profiles i.e., M₃ selective, M₂ selective, or non-selective drugs. Caution should be used therefore in pooling data from different patients and assuming the average results represents all patients. Currently, clinical trials require this pooling of patient data since there is currently no way of stratifying patients a priori into separate groups based on their potential clinical response to antimuscarinic drugs with different selectivity profiles.
References:


9. **Braverman AS, Karlovsky M, Pontari MA, and Ruggieri MR.** Aging and hypertrophy change the muscarinic receptor subtype mediating bladder contraction from M3 towards M2. *J


### Table 1 Spinal Cord Injured Patient Information

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<th>SCI Level</th>
<th>DOI</th>
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Abbreviations: PT#: patient number, SCI: spinal cord injury, DOI: date of injury, NA: not available, BID: twice per day, QID: once per day, TID: three times per day, QID: taken four times per day, QHS: taken at bedtime. Oxybutynin (oxy)-M₃ selective antimuscarinic. Tolterodine (tol)-non-selective antimuscarinic. Hyoscyamine (hyos) is a non-selective antimuscarinic. Imipramine (imip) is a tricyclic antidepressant which inhibits the reuptake of serotonin and norepinephrine which has some antimuscarinic effects. Propantheline (prob) non subtype selective antimuscarinic. Doxazosin (dox), a non specific alpha-1 antagonist.
### Table 2 Donor Information

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<td>5</td>
<td>2000/05/19</td>
<td>m</td>
<td>35</td>
<td>17.5</td>
<td>2000/05/17</td>
<td>2000/05/17 19:32</td>
<td>Gun Shot Wound</td>
</tr>
<tr>
<td>6</td>
<td>2000/07/08</td>
<td>m</td>
<td>22</td>
<td>13.5</td>
<td>2000/07/6</td>
<td>2000/07/07 5:37</td>
<td>Gun Shot Wound</td>
</tr>
<tr>
<td>7</td>
<td>2001/01/16</td>
<td>f</td>
<td>69</td>
<td>16</td>
<td>2001/01/14</td>
<td>2001/01/15 15:45</td>
<td>Mitral Valve Prolapse</td>
</tr>
<tr>
<td>8</td>
<td>2001/01/22</td>
<td>f</td>
<td>43</td>
<td>16</td>
<td>2001/01/19</td>
<td>2001/01/21 21:08</td>
<td>Hypertension, Crohn’s, Chronic Sinusitis</td>
</tr>
</tbody>
</table>

Hours post indicates time the tissue was on ice in transport media between the time of organ harvest and the *in-vitro* assay. Harvest time indicates hours:minutes that the donor was on life support between declaration of brain death and organ harvest. Abbreviations: as in figure 1, CVA: cerebral vascular accident.
Table 3 Summary of Experimental Data

<table>
<thead>
<tr>
<th>Spinal Injured Patients</th>
<th>Organ Donors</th>
</tr>
</thead>
<tbody>
<tr>
<td>#</td>
<td>Meth</td>
</tr>
<tr>
<td>1</td>
<td>6.2±0.5 (M₃)</td>
</tr>
<tr>
<td>2</td>
<td>7.3±0.3 (INT)</td>
</tr>
<tr>
<td>3</td>
<td>6.2±0.2 (M₃)</td>
</tr>
<tr>
<td>4</td>
<td>7.7±0.5 (M₃)</td>
</tr>
<tr>
<td>5</td>
<td>6.9±0.3 (M₂)</td>
</tr>
<tr>
<td>6</td>
<td>7.6±0.5 (M₂)</td>
</tr>
<tr>
<td>7</td>
<td>7.7±0.3 (M₃)</td>
</tr>
<tr>
<td>8</td>
<td>6.6±0.2 (M₂)</td>
</tr>
</tbody>
</table>

For each specimen, the affinity of the muscarinic receptor antagonists was determined as described in the methods for inhibiting carbachol induced bladder contraction. The determined value was compared to the published affinity of the M₂ and M₃ receptors for the antagonists. If the determined affinity (95% confidence range) overlaps the range of the reported values for either subtype, the subtype within the range is shown in parenthesis following the affinity value. If the determined value (95% confidence interval) is between the reported range for the two subtypes or within the range of both subtypes, this affinity value is considered intermediate (INT) between the two subtypes.
Figure legends:

**Figure 1:** Affinity of subtype selective antimuscarinics for inhibiting carbachol induced contraction of urinary bladder muscle strips *in-vitro* from spinal injured patients. The shaded areas represent the affinity ranges of antimuscarinics (p-F-HHSiD, methoctramine and darifenacin) for the individual receptor subtypes reported in the literature (15, 29). The reported affinity ranges for the M₂ subtype is shaded with horizontal lines and reported affinity for the M₃ subtype is shaded with vertical lines. The symbols refer to the affinities which were determined by Schild analysis of the bladder tissue obtained from the individual patient numbers indicated in Table 1.

**Figure 2:** Affinity of subtype selective antimuscarinics for inhibiting carbachol induced contraction of urinary bladder muscle strips *in-vitro* from organ donors. Notation is the same as indicated for figure 1 except characteristics of donor numbers are indicated in Table 2.
Spinal Injured Patients

- **M₂ affinity**
  - #1
  - #5

- **M₃ affinity**
  - #2
  - #6
  - #3
  - #7

**p-F-HHSiD**

**Methoc.**

**Darifenacin**

**AFFINITY VALUE** (pKᵢ or pA₂)

Figure 1
Organ Donors

- M₂ affinity
- M₃ affinity

Organ Donors:
- #1
- #2
- #3
- #4
- #5
- #6
- #7
- #8

Affinity Value (pKᵦ or pA₂)

Figure 2