Time-dependent changes in amplitudes of LF (0.04–0.15 Hz) and HF (0.15–0.35 Hz) components of MSNA, mean AP, and R-R interval variability were assessed continuously by complex demodulation using a custom-designed computer program (8, 9, 13). The complex demodulation technique is a nonlinear time-domain method of time series analysis suitable for investigation of nonstationary/unstable oscillations within an assigned frequency band (8, 9, 13). This method provides instantaneous amplitudes and frequency of LF and HF component variables as a function of time (8, 9, 13). For example, for a signal with 0.09- and 0.22-Hz oscillations at a given moment, this method calculates the instantaneous frequency of the LF and HF components as 0.09 and 0.22 Hz, respectively. In addition, the method provides the instantaneous amplitude of each oscillation. All neural and cardiovascular variables and their LF and HF components were averaged every 2 min during 0° supine rest and every 20 s during 60° HUT.

The squared coherence function was calculated as the square of the cross-spectrum normalized by the product of the spectra of the two different signals in the LF and HF bands (13). The periods analyzed were 0° supine (6 min), early HUT (first 5 min of HUT), from 100 to 60 s before onset of syncope, and from 60 s before to onset of syncope. The coherence function quantifies the amount of linear link between oscillations with the same frequency contained in two different signals. Coherence values >0.5 were considered significant.

Statistical analysis. Values are means ± SE. Repeated-measures analysis of variance was used to compare variables for time (every 2 min at 0° supine rest and every 20 s at HUT) and group (syncopal and nonsyncopal subjects). When the main effect or interaction term was significant, post hoc comparisons were made with Scheffé's F test. $P < 0.05$ was considered statistically significant.

RESULTS

All the syncopal subjects ($n = 10$) experienced neurally mediated syncope in the 60° HUT test. The end-of-HUT time was 10 ± 2 (range 7.8–13.8) min. All nonsyncopal subjects ($n = 10$) completed the 15-min 60° HUT test without a sign or symptom of neurally mediated syncope. Typical representative recordings of AP and MSNA in the nonsyncopal and syncopal subjects are shown in Fig. 1.

Nonsyncopal group. AP (systolic, diastolic, and mean) was maintained throughout HUT (Figs. 2 and 3). Pulse pressure decreased at the start of HUT and remained decreased below 0° supine levels throughout HUT ($P < 0.001$; Fig. 2). LF and HF amplitudes of mean AP increased at the start of HUT and remained above 0° supine levels throughout HUT ($P < 0.05$; Fig. 3). Magnitudes of MSNA (burst rate and total activity), as well as LF and HF amplitudes of MSNA variability, increased at the start of HUT and remained elevated above 0° supine levels throughout HUT ($P < 0.001$; Fig. 4). R-R interval and HF amplitude of R-R interval variability decreased below 0° supine levels throughout HUT ($P < 0.001$), whereas LF amplitude did not change (Fig. 5). Respiratory rate was nearly constant at 15 cycles/min. Instantaneous frequencies for LF and HF bands of all variables remained fixed at ~0.09 and 0.25 Hz, respectively (Figs. 2–5).

Syncopal group. Up to 100 s before the end of HUT, AP (systolic, diastolic, and mean) was well maintained (Figs. 2 and 3). MSNA, mean AP, pulse pressure, and R-R interval, as well

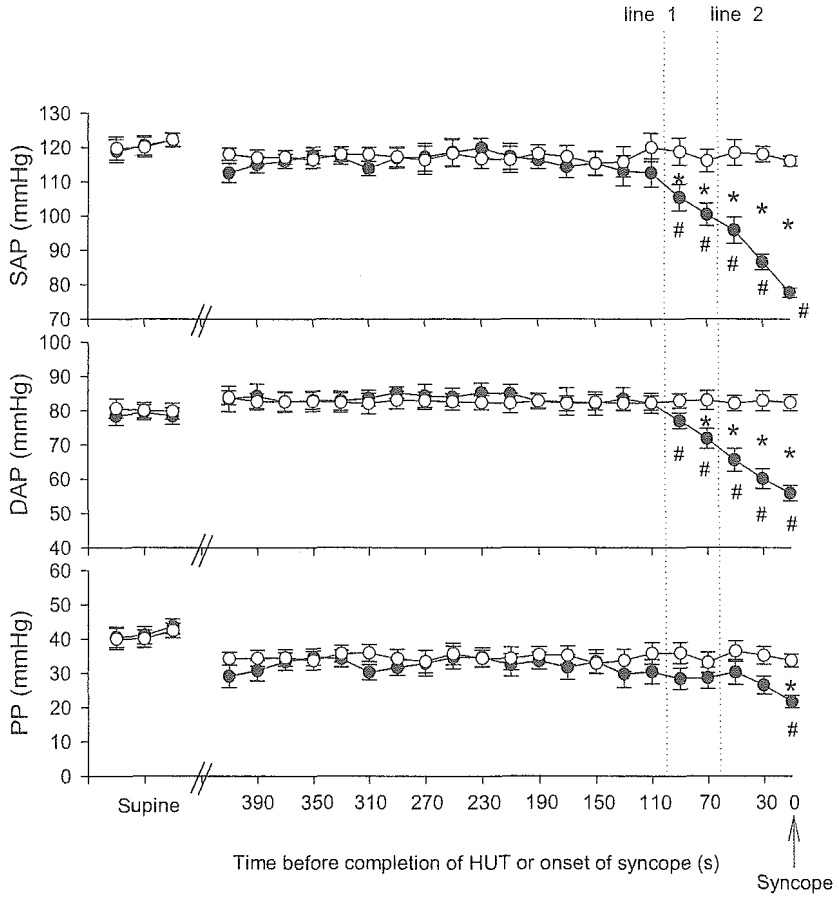

Fig. 2. Systolic AP (SAP), diastolic AP (DAP), and pulse pressure (PP) in syncopal (●) and nonsyncopal (○) subjects during 6 min of supine rest (averaged every 2 min) and during 410 s before completion of HUT test or onset of syncope in HUT posture (averaged every 20 s). *Line 1* and *line 2*, 100 and 60 s, respectively, before completion of HUT test or onset of syncope in HUT test. Pulse pressure in both groups is lower throughout HUT test than in supine posture ($P < 0.05$). $^{*}P < 0.05$, syncopal vs. nonsyncopal. $^{\#}P < 0.05$ vs. mean for the first 100 s of HUT. Error bars, SE.

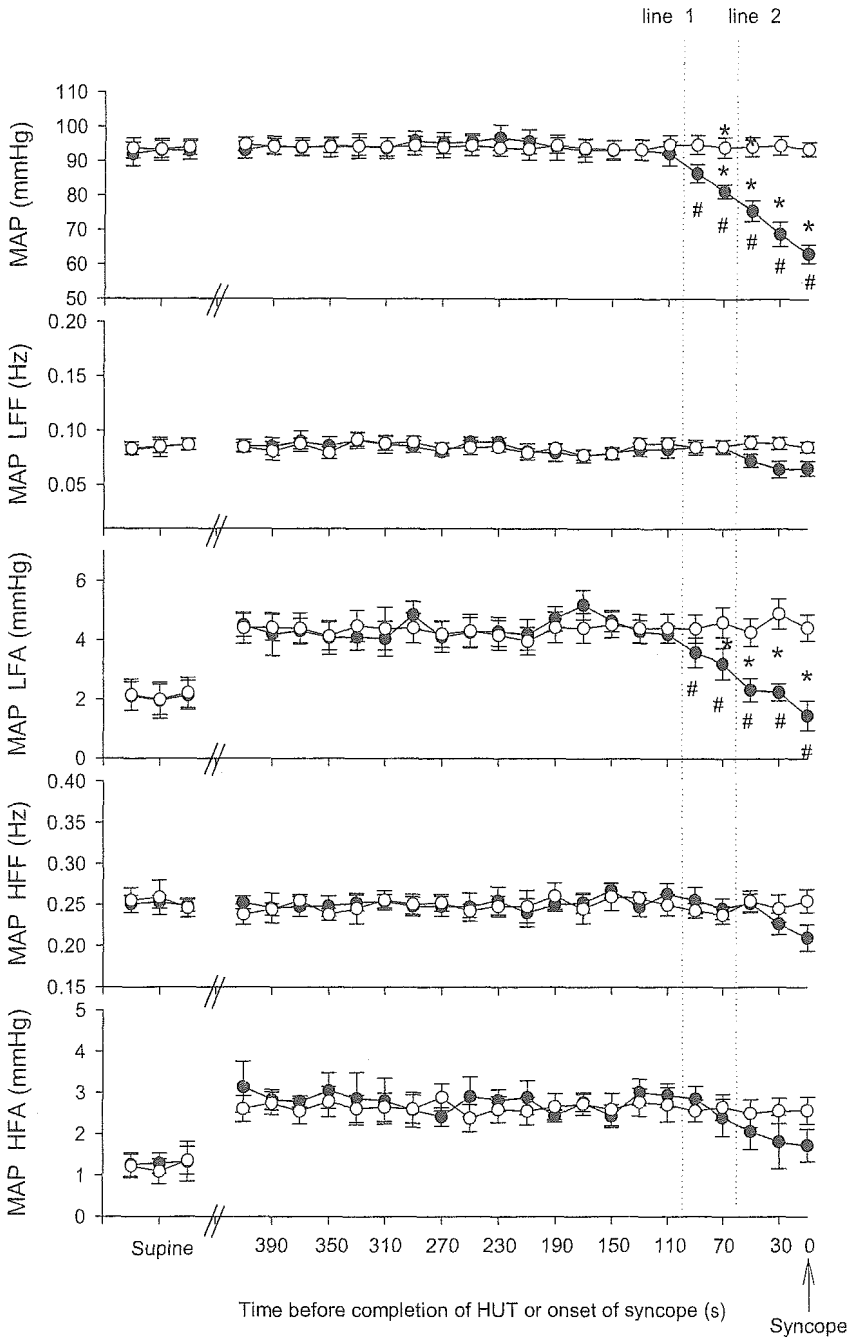

Fig. 3. Mean AP (MAP), frequency of LF component of MAP variability (MAP LFF), amplitude of LF component of SAP variability (MAP LFA), frequency of HF component of SAP variability (MAP HFF), and amplitude of HF component of MAP variability (MAP HFA) in syncopal (●) and nonsyncopal (○) subjects during 6 min of supine rest (averaged every 2 min) and during 410 s before completion of HUT test or onset of syncope in HUT (averaged every 20s). LF and HF amplitudes in both groups are higher throughout HUT than in supine posture ($P < 0.05$), except LF in the syncopal group, which is higher only until 60 s before onset of syncope ($P < 0.05$). $^{*}P < 0.05$, syncopal vs. nonsyncopal. $^{\#}P < 0.05$ vs. mean for the first 100 s of HUT. Error bars, SE.

as LF and HF amplitudes of their variability, were similar in nonsyncopal and syncopal groups (Figs. 2–5). Respiratory rates were also similar in the two groups. LF oscillation of MSNA and the mirrored oscillation in AP are clearly demonstrated in the representative recording (Fig. 1).

From 100 s before onset of syncope, AP (systolic, diastolic, and mean) started to decrease, and LF oscillation of MSNA weakened, as shown in the representative recording in Fig. 1. Data from all subjects showed that, from 100 to 60 s before onset of syncope, LF amplitude of MSNA variability started to decrease (Fig. 4). In contrast, magnitudes of MSNA (burst rate and total activity) and HF amplitude of MSNA variability remained elevated above 0° supine levels (Fig. 4; $P < 0.05$). AP (systolic, diastolic, and mean) started to decrease, but pulse pressure did not change (Fig. 2). LF amplitude of mean AP variability started to decrease, whereas HF amplitude of the variability remained increased above 0° supine levels (Fig. 3; $P < 0.05$). R-R interval and HF amplitude of R-R interval variability remained decreased below 0° supine levels (Fig. 5; $P < 0.05$). Respiratory rate was nearly constant at 15 cycles/min. Instantaneous frequencies in LF and HF bands of all variables remained fixed at ~0.09 and 0.25 Hz, respectively (Figs. 2–5).

From 60 s before to onset of syncope, AP (systolic, diastolic, and mean) further decreased (Fig. 2). Pulse pressure decreased in the last 20 s (Fig. 2). LF amplitude of MSNA variability further decreased (Fig. 4). Magnitudes of MSNA (burst rate and total activity) decreased markedly (Fig. 4), as seen in the representative recording in Fig. 1. HF amplitude of MSNA

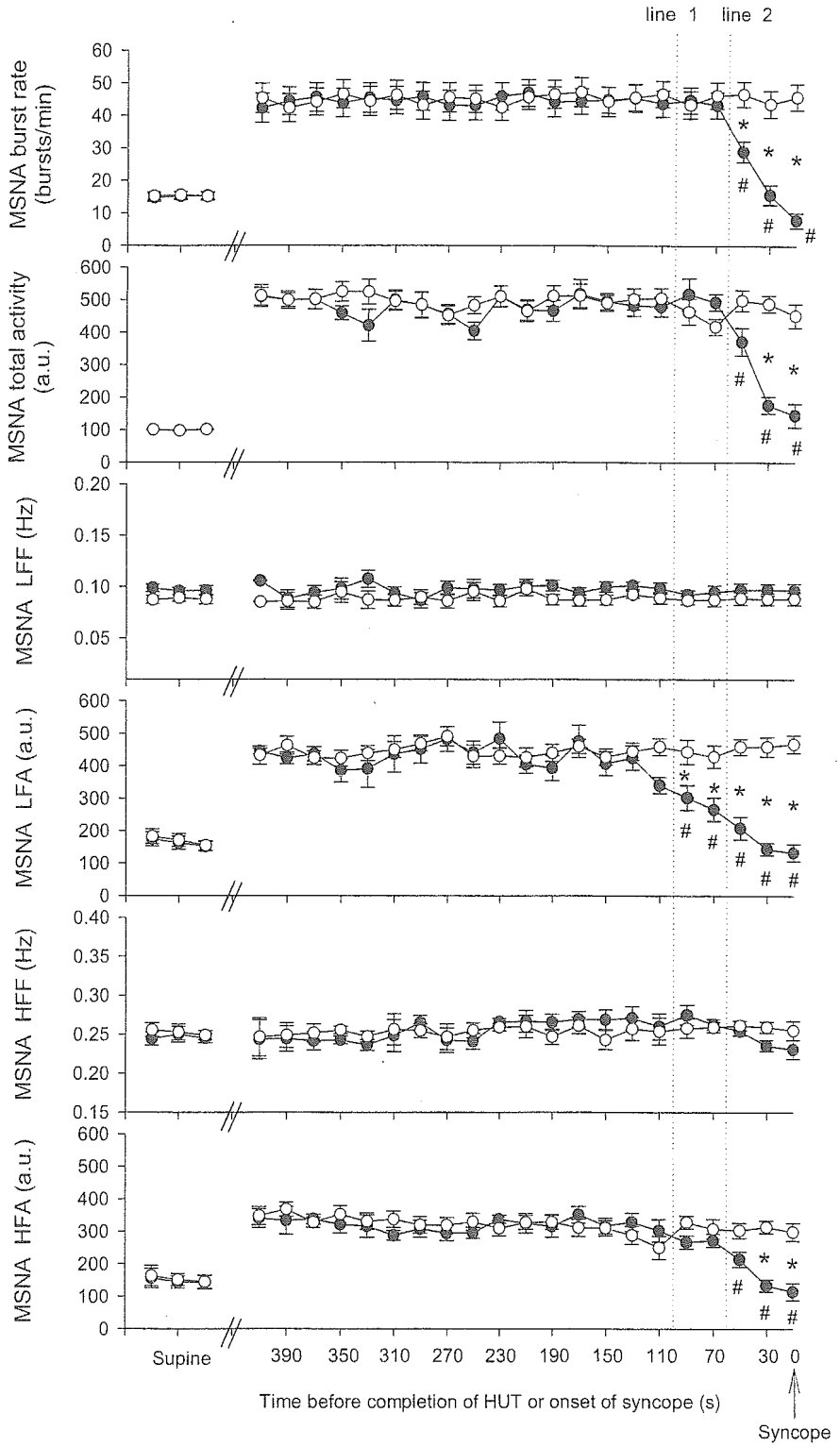

Fig. 4. Muscle sympathetic nerve activity (MSNA) burst rate, MSNA total activity, frequency of LF component of MSNA variability (MSNA LFF), amplitude of LF component of MSNA variability (MSNA LFA), frequency of HF component of MSNA variability (MSNA HFF), and amplitude of HF component of MSNA variability (MSNA HFA) in syncopal (●) and nonsyncopal (○) subjects during 6 min of supine rest (averaged every 2 min) and during 410 s before completion of HUT test or onset of syncope in HUT (averaged every 20 s). LF and HF amplitudes in nonsyncopal subjects are higher throughout HUT than in supine posture ($P < 0.05$). In contrast, LF and HF amplitudes in syncopal subjects are higher until 100 and 60 s, respectively, before onset of syncope in HUT test. $^{*}P < 0.05$, syncopal vs. nonsyncopal. $^{\#}P < 0.05$ vs. mean for the first 100 s of HUT. Error bars, SE.

variability decreased (Fig. 4). LF amplitude of mean AP variability further decreased, whereas HF amplitude of the variability remained elevated above 0° supine levels (Fig. 3; $P < 0.05$). R-R interval and LF and HF components of R-R interval variability greatly increased (Fig. 5). Respiratory rate was nearly constant at 15 cycles/min. Instantaneous frequencies for LF and HF bands of all variables remained fixed at ~0.09 and 0.25 Hz, respectively (Fig. 2–5).

Coherence function. In the LF band, MSNA exhibited coherence with the R-R interval and AP during 0° supine rest and significantly stronger coherence during HUT in syncopal and nonsyncopal subjects (Table 1). In the HF band, MSNA exhibited coherence with the R-R interval, AP, and respiration during 0° supine rest and coherence did not change during HUT in syncopal and nonsyncopal subjects (Table 1).

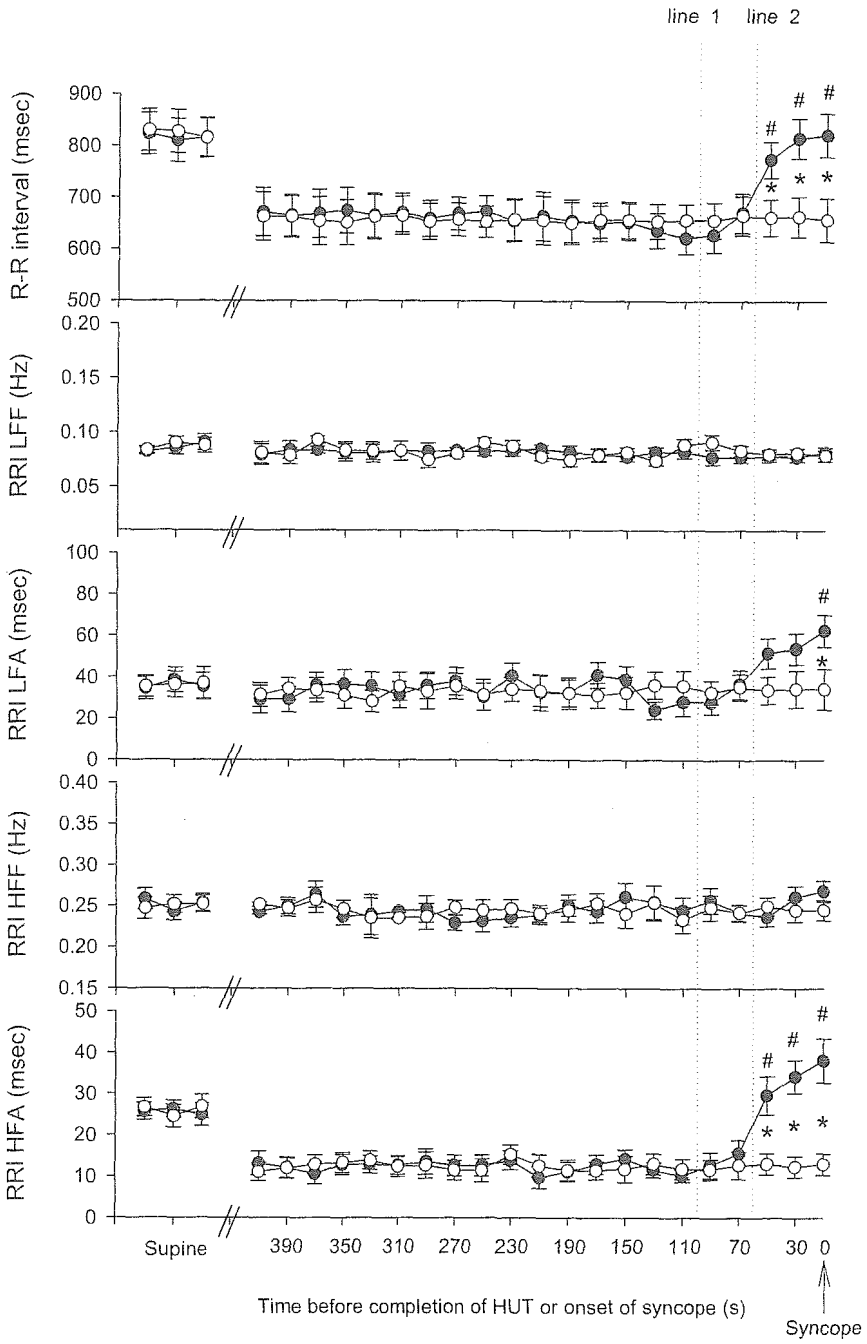

Fig. 5. R-R interval (RRI), frequency of LF component of RRI variability (RRI LFF), amplitude of LF component of RRI variability (RRI LFA), frequency of HF component of RRI variability (RRI HFF), and amplitude of HF component of RRI variability (RRI HFA) in syncopal (●) and nonsyncopal (○) subjects during 6 min of supine rest (averaged every 2 min) and for 410 s before completion of HUT test or onset of syncope in HUT (averaged every 20 s). LF amplitude in both groups is similar throughout HUT compared with supine posture, except at the last HUT time point in syncopal subjects, when it is higher than in supine posture ($P < 0.05$). HF amplitude in both groups is lower throughout HUT than in supine posture ($P < 0.05$), except at the last HUT time point in syncopal subjects, when it is higher ($P < 0.05$). *$P < 0.05$, syncopal vs. nonsyncopal. #$P < 0.05$ vs. mean for the first 100 s of HUT. Error bars, SE.

DISCUSSION

Orthostatic sympathetic activation plays a crucial role in maintaining AP under orthostatic stress. Sympathetic activation is accompanied by marked LF oscillation of SNA variability. However, because LF oscillation of MSNA has been investigated only in steady-state orthostasis, when AP is well maintained, LF oscillation during the course of development of orthostatic neurally mediated syncope remains unknown. We used complex demodulation to assess nonstationary time-dependent changes in MSNA variability in 10 healthy subjects in whom neurally mediated syncope was evoked by HUT. In agreement with earlier studies (16–18), our present data show that orthostatic neurally mediated syncope was accompanied by a marked reduction of MSNA. Our new major finding is that LF oscillation of MSNA decreased during development of orthostatic neurally mediated syncope. Unexpectedly, the decrease in LF oscillation of MSNA preceded the reduction in magnitudes of MSNA. The result supports our hypothesis that LF oscillation of SNA decreases during orthostatic neurally mediated syncope.

As far as we are aware, the present study is the first that addresses the time course of changes in MSNA oscillation in development of orthostatic neurally mediated syncope. The change in MSNA oscillation consisted of two stages. The first stage (from 100 to 60 s before onset of syncope) is marked by a decrease in LF oscillation of MSNA at the initial development of orthostatic neurally mediated syncope, when AP starts to decrease. MSNA and heart rate remain elevated above horizontally supine levels. The second stage (from 60 s before to onset of

Table 1. *Coherence between MSNA and R-R interval, mean AP, and respiration during HUT in syncope and nonsyncope*

	RRI-MSNA		AP-MSNA		Resp-MSNA
	LF	HF	LF	HF	HF
			Syncope		
0° baseline	0.59±0.11	0.58±0.12	0.56±0.10	0.64±0.11	0.61±0.08
Early HUT	0.75±0.12*	0.55±0.11	0.74±0.09*	0.65±0.13	0.61±0.07
Initial development of syncope	0.72±0.11*	0.53±0.13	0.69±0.11*	0.64±0.12	0.62±0.11
Just before onset of syncope	0.67±0.11*	0.54±0.12	0.68±0.11*	0.65±0.14	0.60±0.12
			Nonsyncope		
0° baseline	0.60±0.11	0.61±0.12	0.61±0.10	0.58±0.11	0.62±0.07
Early HUT	0.72±0.10*	0.57±0.15	0.72±0.10*	0.62±0.12	0.61±0.09
Mid-HUT	0.72±0.12*	0.58±0.14	0.71±0.09*	0.59±0.13	0.58±0.08
Last HUT	0.74±0.11*	0.57±0.13	0.73±0.09*	0.61±0.12	0.59±0.09

Values are means ± SE. MSNA, muscle sympathetic nerve activity; AP, arterial pressure; HUT, head-up tilt; LF, low frequency (0.05–0.15 Hz). HF, high frequency (0.15–0.35 Hz). RRI, R-R interval; Resp, respiration. *$P < 0.05$ vs. 0° baseline.

syncope) is characterized by the total disappearance of MSNA oscillation during further development of orthostatic neurally mediated syncope, when AP further decreases to the level at syncope. Sympathetic withdrawal and bradycardia occur, consistent with earlier studies (16–18).

Increase in LF oscillations of AP and MSNA in normotensive HUT. In agreement with previous studies (1, 5), when AP was well maintained, early HUT increased the amplitude of LF oscillation of MSNA and caused mirrored changes in the amplitude of LF oscillation of mean AP (Figs. 3 and 4). In

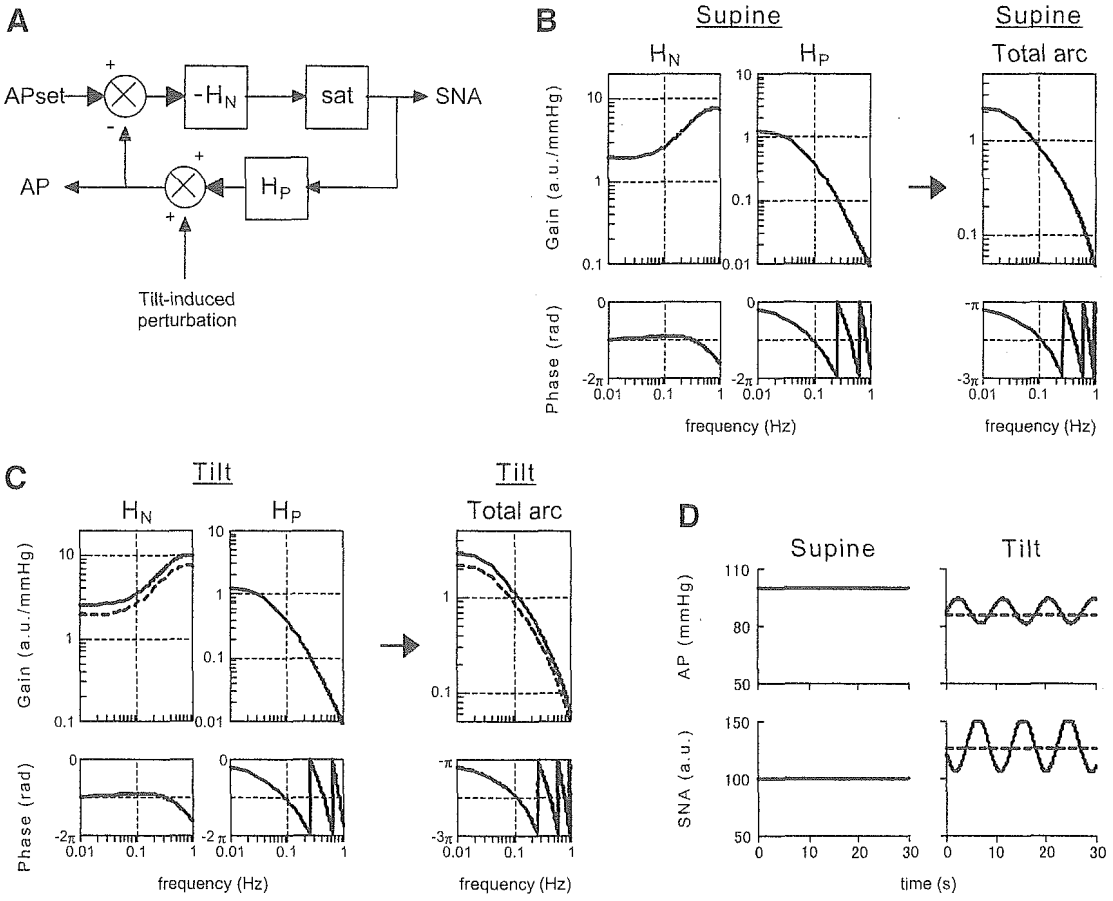

Fig. 6. Simulation of generation of LF oscillation of AP and sympathetic nerve activity (SNA) by the baroreflex theory. *A*: block diagram of total arc baroreflex system, which consists of neural arc transfer function (H_N), saturation function (sat), and neural arc transfer function (H_P). We assigned tilt-induced perturbation of −50 mmHg in simulations during HUT. We set AP_{set} at 100 mmHg and baseline SNA at 100 arbitrary units (AU) when AP = AP_{set}. *B*: H_N, H_P, and resultant total arc transfer function (shown as gain and phase) in supine posture. In the model of H_N, we set K_N at 1.9 AU/mmHg (see APPENDIX). *C*: H_N, H_P, and resultant total arc transfer function (shown as gain and phase) in tilt position. In the model of H_N, we set static gain of H_N (i.e., K_N) at 1.9 AU/mmHg (dashed line) when H_N is constant regardless of postural change (see APPENDIX). In this case, G_0 (see Fig. 7) in the total arc is <1 (dashed line). In addition, we set static gain of H_N (i.e., K_N) at 2.5 AU/mmHg (solid line) when gain of H_N increases with postural change. In this case, G_0 in the total arc is >1 (solid line). Phases are similar regardless of the increase in gain. *D*: simulated time series of AP and SNA set in *B* and *C* in supine and tilt positions. In the tilt position, simulated data show K_N = 1.9 and 2.5 AU/mmHg (dashed and solid lines, respectively). Increasing gain of H_N in the tilt position generates 0.1-Hz oscillation of AP and SNA.

addition, a high coherence between the two in the LF band was observed during HUT, consistent with results of an earlier study (5). These findings indicate that HUT induces a common LF oscillatory pattern in the variability of sympathetic discharge and AP (5).

Possible mechanism for the increase in LF oscillations of mean AP and MSNA: baroreflex-loop theory. Two mechanisms have been speculated to generate LF oscillation of mean AP and MSNA in normotensive HUT. The first mechanism is the baroreflex-loop theory (2, 6). First, we examined how the baroreflex-loop system may explain generation of LF oscillation of AP and MSNA. Figure 6*A* shows a block diagram of the arterial baroreflex system. The total arc baroreflex is a negative-feedback control system that senses AP by baroreceptors and regulates AP. The total arc baroreflex system consists of the neural arc transfer function (H_N), saturation function (sat), and peripheral arc transfer function (H_P; Fig. 6*A*) (12). H_N, coupled with saturation, represents central processing from baroreceptor pressure to SNA, whereas H_P represents processing from SNA to systemic AP. According to our previous studies, we used derivative and high-cut filter characteristics with a pure delay to model H_N and the second-order low-pass filter with a pure delay to model H_P (see APPENDIX; Fig. 6, *B* and *C*) (12). The saturation function simulates the upper and lower saturation of SNA. Because the total arc baroreflex transfer function is a multiplication of these subsystem transfer functions, it approximates a first-order low-pass filter with a pure delay, consistent with previous studies (see APPENDIX; Fig. 6, *B* and *C*) (10).

The key point of baroreflex-loop theory is whether the total arc baroreflex transfer function gain is >1 at the frequency at which the phase reaches -2π radians. The phase in the total arc transfer function is delayed as the frequency increases and reaches -2π radians at a given frequency, which we define as f_0 (Fig. 7). We also define the gain at f_0 as G_0 (Fig. 7). The total arc low-pass filter has the following important characteristics: at $G_0 > 1$, closing the feedback loop generates oscillations of AP and SNA at f_0, whereas at $G_0 < 1$, closing the loop does not generate the oscillation. Because LF oscillation of AP and SNA is not significant in the supine position, G_0 may be <1 (Fig. 6, *B* and *D*). If G_0 remains unchanged in HUT, the closed-loop baroreflex system will increase SNA in response to tilt-induced pressure perturbation by gravity but will not produce oscillation of AP and SNA (Fig. 6, *C* and *D*). However, if G_0 increases to >1 in HUT, the closed-loop baroreflex system will generate LF oscillations of AP and SNA (Fig. 6, *C* and *D*). Therefore, we raise the possibility that HUT increases G_0, resulting in generation of LF oscillations of AP and SNA.

In this baroreflex-loop model, the saturation function, which limits the magnitude of SNA, is necessary to represent the stabilized amplitude of LF oscillation of AP and MSNA observed in humans. This occurs because absence of the saturation function of SNA progressively will increase amplitudes of LF oscillations of AP and MSNA manyfold at $G_0 > 1$.

Furthermore, we can propose how the baroreflex system generates LF oscillations. Interestingly, our data showed that frequency of the LF component of AP and MSNA variability was constant in supine rest and HUT (Figs. 3 and 4). This indicates that f_0 remains unchanged during HUT. Accordingly, the possible increase in G_0 during HUT may be the result of an increase in total baroreflex transfer gain. Such an increase in total arc gain may be caused by an increase in H_N, but not H_P, gain (Fig. 6*B*). This occurs because HUT shifts body fluid toward the lower body, including the third space, and may result in deterioration of the peripheral transduction from SNA to AP.

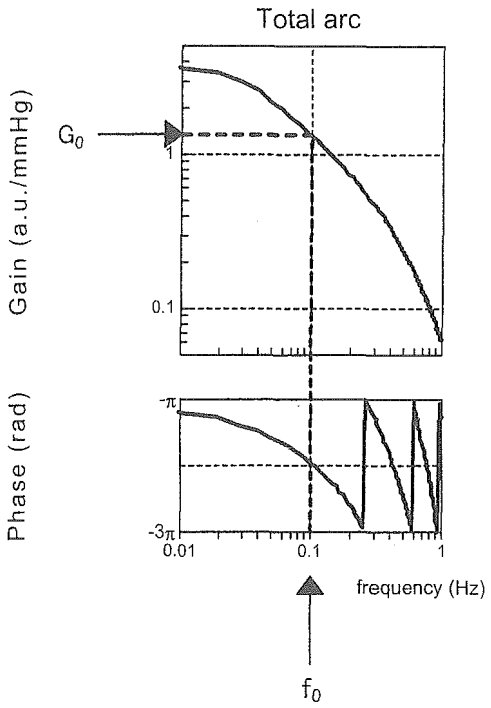

Fig. 7. Total arc transfer function obtained from the block diagram of the total arc baroreflex system (Fig. 6*A*), which approximates a 1st-order low-pass filter with a pure delay (see APPENDIX). Frequency when phase is at -2π rad is defined as f_0 and gain at f_0 as G_0. This figure shows an example when $G_0 > 1$.

Possible mechanism for increase in LF oscillations of AP and MSNA: pacemaker oscillator theory. The second mechanism that has been speculated to generate LF oscillation of AP and MSNA is the pacemaker oscillator theory (1). This theory is supported by earlier studies in dogs showing that LF oscillation of SNA persisted even after baroreceptor afferent activity was abolished by spinal section and bilateral vagotomy (11) and that LF oscillation was preserved even after baroreceptor pressure fluctuations were abolished by a pressure-stabilizing device (22). Such evidence supports the concept that the LF pacemaker oscillator generates LF oscillation of MSNA.

Next, we attempted to apply the pacemaker oscillator theory to explain LF oscillation of AP and MSNA. We added elements of the pacemaker oscillator theory to the baroreflex-feedback-loop model and modeled the pacemaker oscillator as a 0.1-Hz sine wave in a block diagram (Fig. 8*A*). The numerical simulation indicates that increasing the amplitude of SNA pacemaker oscillation will increase amplitudes of LF oscillations of MSNA and AP (Fig. 8*C*), while the baroreflex system remains constant (Fig. 8*B*). Therefore, it is possible that HUT activates the pacemaker oscillator, resulting in enhancement of LF oscillations of MSNA and AP. Details of the mechanism responsible for activation of the pacemaker oscillator are unclear.

Decrease in LF oscillations of AP and MSNA during development of tilt-induced syncope: possible involvement of baroreflex-loop and pacemaker oscillator theories. During development of tilt-induced syncope (from 100 s before to

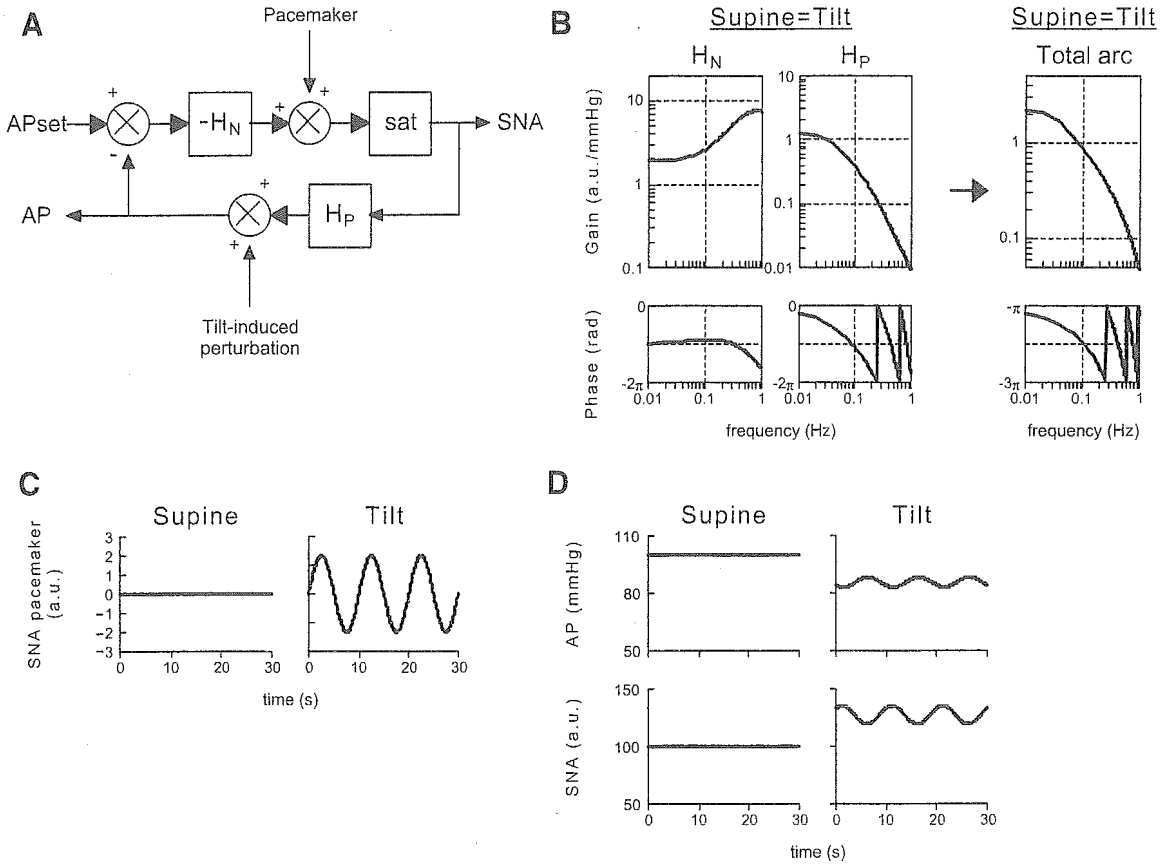

Fig. 8. Simulation of generation of LF oscillation of AP and SNA by the pacemaker oscillator theory. *A*: block diagram of total arc baroreflex system coupled with the SNA pacemaker oscillator. Total arc baroreflex system consists of the neural arc transfer function (H_N), the saturation function (sat), and the neural arc transfer function (H_P). We modeled the SNA pacemaker oscillator as a 0.1-Hz sine wave and assigned tilt-induced perturbation of −50 mmHg in simulations during HUT. We set AP_{set} at 100 mmHg and baseline SNA at 100 AU when AP = AP_{set}. *B*: H_N, H_P, and resultant total arc transfer function (shown as gain and phase). All transfer functions are similar in supine and tilt positions. Because we set K_N = 1.9 AU/mmHg in the model of H_N (see APPENDIX) so that G_0 in total arc is <1 (see Fig. 7), only baroreflex-loop theory cannot generate oscillations of AP and SNA (see Fig. 6). *C*: model of SNA pacemaker oscillator. We set the pacemaker at 0.1-Hz sine wave with amplitude of 2 AU during tilt. Sine wave is absent in supine position. *D*: simulated time series AP and SNA in supine and tilt positions. Increasing amplitude of 0.1-Hz sine wave of the pacemaker oscillator from 0 to 2 AU during tilt generates 0.1-Hz oscillation of AP and SNA.

onset of syncope), AP, MSNA, and their LF oscillations decreased progressively, whereas MSNA remained elevated, during the first stage of development (from 100 to 60 s before onset of syncope). We cannot provide a definitive explanation for the mechanism(s) responsible for this new finding, but we propose the following possibilities.

The first possible explanation is a decrease in neural arc baroreflex transfer gain. A recent finding suggests that the total and neural arc baroreflex gains largely decrease during tilt-induced syncope (19). Our numerical simulation indicates that decreasing H_N gain will attenuate the total arc baroreflex transfer function gain and attenuate G_0 to <1 (Fig. 9*A*). As a result, the baroreflex system could not sustain LF oscillations of AP and SNA (Fig. 9*C*). Although an increase in pure delay of the total baroreflex system theoretically decreases G_0 and suppresses LF oscillations, it might not relate to the decrease in G_0, because our data showed that the frequencies of LF components of AP and MSNA variability were constant during development of tilt-induced syncope. A possible decrease in the baroreflex subsystem transfer gain may also explain the hypotension and sympathetic withdrawal in addition to reductions of LF oscillations (Fig. 9*C*), except withdrawal of MSNA lags behind decreases of AP and LF oscillations of AP and MSNA (from 100 to 60 s before onset of syncope).

The second possible explanation is deactivation of the LF pacemaker oscillator. Our numerical simulation indicates that attenuation of the pacemaker oscillator (Fig. 10*B*) will decrease LF oscillations of AP and SNA (Fig. 10*C*), while the baroreflex system remains constant (Fig. 10*A*). However, the simulation also indicates that the deactivation will not decrease AP and MSNA (Fig. 10*B*). Accordingly, deactivation of the LF pacemaker oscillator does not explain changes in magnitude of AP and MSNA together, whereas the decrease in baroreflex transfer gain explains both decreases.

LF oscillation of MSNA parallels the magnitude of MSNA. Our results may support the concept that LF oscillation of MSNA parallels the magnitude of MSNA. There is increasing evidence that an increase in sympathetic neural firing is accompanied by a proportional enhancement of LF oscillation of MSNA. Consistent with earlier studies (1, 5), we observed that, during early HUT, when AP was well maintained, an increase in MSNA was accompanied by an increase in its LF oscillation. This finding agrees with earlier studies in which stimuli inducing sympathetic activation [nitroprusside administration (20, 24), occlusion of the inferior vena cava (15) and bilateral

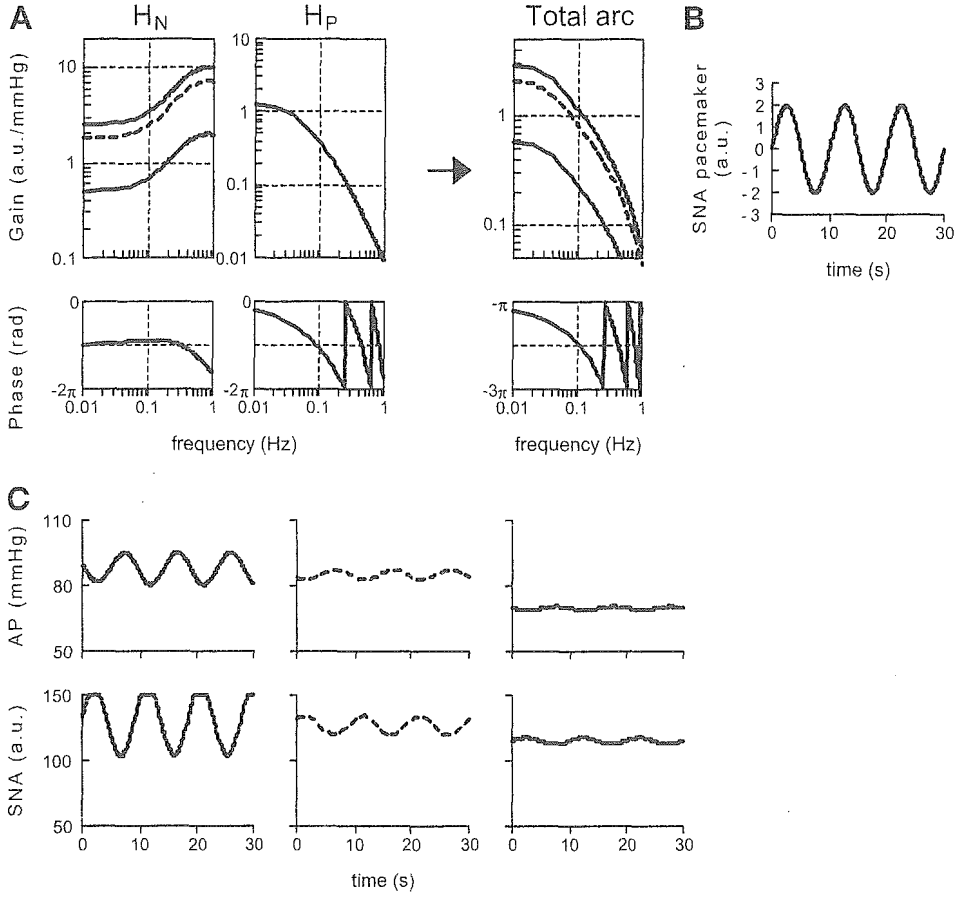

Fig. 9. Simulation of baroreflex impairment during progression of tilt-induced syncope. *A*: H_N, H_P, and resultant total arc transfer function (shown as gain and phase). Static gain of H_N (i.e., K_N) decreases from 2.5 (top solid line) to 1.8 (dashed line) to 0.5 (bottom solid line) AU/mmHg (see APPENDIX). Consequently, G_0 decreases from >1 (top solid line) to <1 (dashed and bottom solid lines). Phase is similar regardless of decrease in gain. *B*: model of SNA pacemaker oscillator. We set the pacemaker at 0.1-Hz sine wave with amplitude of 2 AU throughout tilt. *C*: simulated time series of AP and SNA in supine and tilt positions. *Left*, *middle*, and *right*: simulated data when static gain of H_N was 2.5 (solid line), 1.8 (line), and 0.5 (solid line) AU/mmHg, respectively. We used block diagram of total arc baroreflex system coupled with the SNA pacemaker oscillator in this simulation shown in Fig. 8*A*. We assigned a tilt-induced perturbation of −50 mmHg in simulations during HUT. We set AP_{set} at 100 mmHg and baseline SNA at 100 AU when $AP = AP_{set}$. Decreasing static gain of H_N attenuates 0.1-Hz oscillation of AP and SNA.

common carotid artery (22), and increase of cerebrospinal fluid pressure (11)] increased LF oscillation of SNA. In addition to demonstrating a link between magnitude of MSNA and LF oscillation of MSNA during sympathetic excitation, our data also suggest that the link may persist even during sympathetic withdrawal in tilt-induced syncope, because we observed that magnitude and LF oscillation of MSNA decreased during HUT-induced syncope.

Respiratory HF component of MSNA variability. As reported earlier (1), the respiratory HF oscillation of MSNA increased during early HUT, when AP was maintained. Several mechanisms may contribute to this increase. *1*) It is likely that downward displacement of the diaphragm reduces inspiratory intrathoracic pressure and inspiratory left ventricular stroke volumes (1, 7). This increases the respiratory HF fluctuation of AP and would increase the respiratory HF oscillation of MSNA via the baroreflex neural arc, in particular, its dynamic high-pass characteristics of H_N (10, 12). If the H_N gain increases during HUT, increases in HF oscillation of MSNA and AP may be further enhanced. *2*) Because early HUT decreases the respiratory HF fluctuation of the R-R interval, which is known to decrease the respiratory HF fluctuation of AP (25), it would increase the HF fluctuation of AP (1). *3*) Because HUT induces hyperpnea during normotensive HUT (13), the respiratory-related oscillation of MSNA might be increased. Unfortunately, because numerical data are not available for the transfer characteristics involved in these possible explanations, we cannot simulate how these possibilities generate the respiratory HF oscillations.

This study investigated respiratory HF oscillation of MSNA during tilt-induced syncope. We found that HF oscillation of MSNA decreased just before onset of tilt-induced syncope. We cannot determine the mechanism(s) for this observation but propose the following explanations. The first possibility is that the baroreflex neural arc gain decreases during the progression of tilt-induced syncope, resulting in a decrease of the respiratory HF oscillation of MSNA. This can explain our finding that HF oscillation of MSNA decreased whereas HF oscillation of AP remained elevated during tilt-induced syncope, because the peripheral arc low-pass filter characteristics (12) would limit the reduction of HF oscillation of AP and keep HF oscillation of AP elevated. The second possibility is that tidal volume decreases during development of tilt-induced syncope. When tidal volume decreases, the lung will be less inflated. Consequently, MSNA will be less suppressed by lung inflation, reducing respiratory modulation of MSNA.

Our results indicate a decrease in MSNA and an increase in cardiac vagal nerve activity in development of tilt-induced syncope. In contrast to HF amplitude of MSNA variability, HF amplitude of R-R interval variability increased markedly just before onset of orthostatic syncope, consistent with earlier reports (4). This finding indicates an excitation of cardiac vagal outflow to the heart. In addition, LF amplitude of R-R interval variability also increased just before onset of syncope, in agreement with a previous study (13). This might also be explained by excitation of vagal, but not sympathetic, nerve activity, because MSNA and heart rate decrease in this stage.

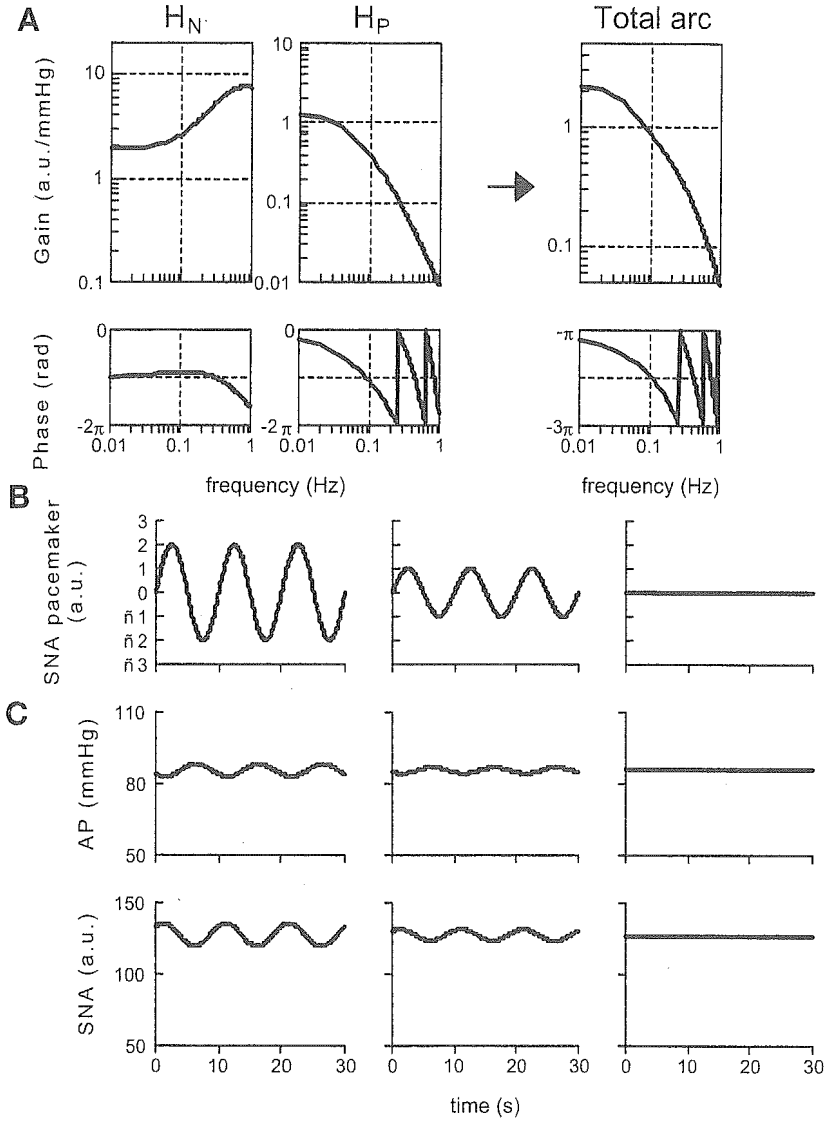

Fig. 10. Simulation of pacemaker oscillator attenuation during progression of tilt-induced syncope. *A*: H_N, H_P, and resultant total arc transfer function (shown as gain and phase) are constant. Static gain of H_N (i.e., K_N) was set at 1.9 AU/mmHg (see APPENDIX), and, as a result, $G_0 < 1$. *B*: model of SNA pacemaker oscillator. We set pacemaker at 0.1-Hz sine wave with amplitudes of 2, 1, and 0 AU (*left, middle*, and *right*, respectively). *C*: simulated time series of AP and SNA in supine and tilt positions. *Left, middle*, and *right*: simulated data when pacemaker oscillator was set as shown in *left, middle*, and *right* of *B*. We used the block diagram of total arc baroreflex system coupled with SNA pacemaker oscillator in this simulation, as shown in Fig. 8*A*. We assigned tilt-induced perturbation of −50 mmHg in simulations during HUT. We set AP_{set} at 100 mmHg and baseline SNA at 100 AU when $AP = AP_{set}$. Decreasing amplitude of the 0.1-Hz sine wave of the pacemaker oscillator from 2 (*left*) to 1 (*middle*) to 0 (*right*) AU progressively decreases the 0.1-Hz oscillation of AP and SNA.

Limitations. This study has several limitations. *1*) We studied healthy subjects with no recent history of spontaneous syncope. Therefore, it is difficult to generalize our findings to patients with recurrent and chronic orthostatic hypotension (3, 17, 18). *2*) We did not measure tidal volume, arterial P_{CO_2}, and pH, which may affect MSNA and AP and their fluctuations. *3*) We measured AP wave changes during HUT by noninvasive photoplethysmography. Nevertheless, the photoplethysmographic pressure waveform correlated very well with invasive intra-arterial pressure during tilt (21). *4*) Because the baroreflex transfer functions of total, neural, and peripheral arcs have not been determined in humans, we used the characteristics of transfer function derived from animal studies (rabbits) (10, 12) in numerical simulations of AP, MSNA, and their oscillations. *5*) Our model used in the numerical simulation focused on baroreflex-loop and pacemaker theories governing SNA and did not incorporate vagal nerve activity into the model.

In conclusion, LF oscillation of MSNA decreases at the initial development of orthostatic neurally mediated syncope, before sympathetic withdrawal, bradycardia, and severe hypotension, to the level of syncope.

APPENDIX

In rabbits, the transfer function of the baroreflex neural arc (baroreceptor pressure to SNA) approximates derivative characteristics of frequencies <0.8 Hz and high-cut characteristics of frequencies >0.8 Hz (12). Therefore, according to our previous study, we model the neural arc transfer function (H_N) as follows

$$H_N(f) = -K_N \frac{1 + \frac{f}{f_{c1}} j}{\left(1 + \frac{f}{f_{c2}}\right)^2} \exp(-2\pi f j L) \qquad (A1)$$

where f and j represent frequency (in Hz) and imaginary units, respectively; K_N is static gain (in AU/mmHg), f_{c1} and f_{c2} ($f_{c1} < f_{c2}$) are corner frequencies (in Hz) for derivative and high-cut characteristics, respectively, and L is a pure delay (in s), which would represent the sum of delays in the synaptic transmission at the baroreflex central pathways and the sympathetic ganglion. The dynamic gain increases from f_{c1} to f_{c2} and decreases above f_{c2}. We set f_{c1}, f_{c2}, and L at 0.1, 0.8, and 0.2, respectively, in all simulations in Figs. 6, 8, 9, and 10. We set K_N appropriately in each simulation (Figs. 6, 8, 9, and 10).

In addition, the transfer function of the baroreflex peripheral arc (SNA to systemic AP) approximates the second-order low-pass filter with a lag time in rabbits (12). Therefore, we model the peripheral arc transfer function (H_P) as follows

$$H_P(f) = \frac{K_P}{1 + 2\zeta \frac{f}{f_N} j + \left(\frac{f}{f_N} j\right)^2} \exp(-2\pi f j L) \qquad (A2)$$

where K_P is static gain (in mmHg/AU), f_N and ζ represent natural frequency (in Hz) and damping ratio, respectively, and L is a pure delay (in s), which would represent the sum of delays in the synaptic transmission at the neuroeffector junction and the intracellular signal transduction in the effector organs. We set K_P, f_N, ζ, and L at 1.3, 0.07, 1.4 and 2.4, respectively, in all simulations in Figs. 6, 8, 9, and 10 by modifying these parameter values observed in rabbits (12) to simulate AP oscillation at ~0.1 Hz in humans.

Consequently, the transfer function of the total arc baroreflex system (baroreceptor pressure to systemic AP) in our model (Fig. 6*A*) approximates the first-order low-pass filter with a pure delay (10) as follows

$$H(f) = \frac{K_T}{1 + \frac{f}{f_c} j} \exp(-2\pi f j L) \qquad (A3)$$

where K_T is static gain (in mmHg/mmHg), f_c is corner frequency (in Hz), and L is pure delay (in s) of the total arc system. The "sat" function in Figs. 6*A* and 8*A* is a saturation function that determines minimum (−50 AU) and maximum SNA (50 AU).

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Static interaction between muscle mechanoreflex and arterial baroreflex in determining efferent sympathetic nerve activity

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Yamamoto, Kenta, Toru Kawada, Atsunori Kamiya, Hiroshi Takaki, Masaru Sugimachi, and Kenji Sunagawa. Static interaction between muscle mechanoreflex and arterial baroreflex in determining efferent sympathetic nerve activity. *Am J Physiol Heart Circ Physiol* 289: H1604–H1609, 2005. First published May 20, 2005; doi:10.1152/ajpheart.00053.2005.—Elucidation of the interaction between the muscle mechanoreflex and the arterial baroreflex is essential for better understanding of sympathetic regulation during exercise. We characterized the effects of these two reflexes on sympathetic nerve activity (SNA) in anesthetized rabbits ($n = 7$). Under open-loop baroreflex conditions, we recorded renal SNA at carotid sinus pressure (CSP) of 40, 80, 120, or 160 mmHg while passively stretching the hindlimb muscle at muscle tension (MT) of 0, 2, 4, or 6 kg. The MT-SNA relationship at CSP of 40 mmHg approximated a straight line. Increase in CSP from 40 to 120 and 160 mmHg shifted the MT-SNA relationship downward and reduced the response range (the difference between maximum and minimum SNA) to 43 ± 10% and 19 ± 6%, respectively ($P < 0.01$). The CSP-SNA relationship at MT of 0 kg approximated a sigmoid curve. Increase in MT from 0 to 2, 4, and 6 kg shifted the CSP-SNA relationship upward and extended the response range to 133 ± 8%, 156 ± 14%, and 178 ± 15%, respectively ($P < 0.01$). A model of algebraic summation, i.e., parallel shift, with a threshold of SNA functionally reproduced the interaction of the two reflexes ($y = 1.00x - 0.01$; $r^2 = 0.991$, root mean square = 2.6% between estimated and measured SNA). In conclusion, the response ranges of SNA to baroreceptor and muscle mechanoreceptor input changed in a manner that could be explained by a parallel shift with threshold.

muscle stretch; exercise pressor reflex; exercise; subliminal fringe

ARTERIAL PRESSURE (AP) during exercise is regulated by neural inputs from three principal sources (19): efferent inputs from supramedullary regions, known as the central command; afferent inputs from contraction-sensitive skeletal muscle receptors, known as the exercise pressor reflex; and afferent inputs from baroreceptor populations such as the arterial and cardiopulmonary baroreflexes. Elucidation of the interaction among these inputs is essential for understanding the AP regulation during exercise, and it has been extensively studied (2–6, 11, 14–18, 22, 26). We previously demonstrated (26) that activation of muscle mechanoreceptors (muscle mechanoreflex) resets the arterial baroreflex control of sympathetic nerve activity (SNA), possibly compensating for a reduction in AP resulting from exercise-induced vasodilation. However, how these reflexes quantitatively interact with each other in regulating SNA over a wide range of inputs remains unknown.

Recent studies (13, 26) demonstrated that treadmill exercise or the muscle mechanoreflex extends the response range of SNA (i.e., the difference between maximum and minimum SNA) in the arterial baroreflex. The extension of the response range was mainly attributed to an increase in maximum SNA but not to changes in minimum SNA. On the other hand, Potts and Li (16) showed that higher carotid sinus pressure (CSP) attenuates the pressor response induced by the muscle mechanoreflex compared with lower CSP. We therefore hypothesized that the response range of SNA to either the muscle mechanoreflex or the arterial baroreflex would be changed depending on the afferent inputs from the other reflex.

To test the above-described hypothesis, we examined the static SNA responses to a combination of a wide range of inputs (4 different levels of baroreceptor input and 4 different levels of muscle mechanoreceptor input) in anesthetized rabbits. The results indicated that the response ranges of SNA to baroreceptor and muscle mechanoreceptor input can change depending on the input from the other reflex.

MATERIALS AND METHODS

Surgical preparations. Animals were cared for in strict accordance with the "Guiding Principles for the Care and Use of Animals in the Field of Physiological Sciences" approved by the Physiological Society of Japan. All protocols were approved by the Animal Subjects Committee of the National Cardiovascular Center. Seven Japanese White rabbits weighing 2.6–3.0 kg were anesthetized via intravenous injection (2 ml/kg) of a mixture of urethane (250 mg/ml) and α-chloralose (40 mg/ml) and were mechanically ventilated with oxygen-enriched room air. Supplemental anesthetics (0.2–0.3 $ml \cdot kg^{-1} \cdot h^{-1}$) were administered continuously to maintain stable AP and heart rate levels during intervals of experimental protocols, which were indicative of an appropriate level of anesthesia. Arterial blood was sampled from the left common carotid artery. The rabbits were slightly hyperventilated to suppress chemoreflexes (arterial P_{CO_2} ranged from 30 to 35 mmHg, arterial $P_{O_2} > 300$ mmHg). Arterial blood pH was within the physiological range when examined at the end of surgical preparation, as well as at the end of the experiment. The body temperature of each animal was maintained at ~38°C with a heating pad. AP was measured with a high-fidelity pressure transducer (Millar Instruments, Houston, TX) inserted from the right femoral artery.

We isolated bilateral carotid sinuses from the systemic circulation by ligating the internal and external carotid arteries and other small branches originating from the carotid sinus region. The isolated

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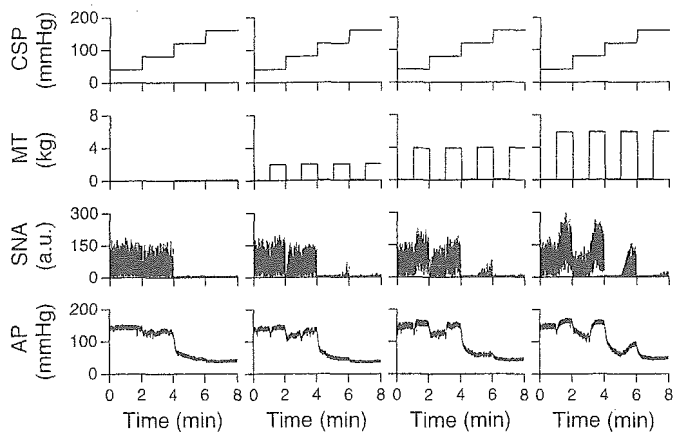

Fig. 1. Typical time series of intracarotid sinus pressure (CSP), muscle tension (MT), sympathetic nerve activity [SNA: in arbitrary units (a.u.)], and arterial pressure (AP) obtained from 1 animal. The 4 panels correspond to MT of 0, 2, 4, and 6 kg, in that order. SNA and AP decreased in response to increments in CSP at all MT levels. SNA and AP increased in response to the increments in MT at CSP below 120 mmHg in this animal. Data were resampled at 10 Hz.

carotid sinuses were filled with warmed physiological saline via catheters inserted through the common carotid arteries. CSP was controlled by a servo-controlled piston pump (model ET-126A, Labworks, Costa Mesa, CA). Bilateral vagal and aortic depressor nerves were sectioned at the neck to minimize reflexes from the cardiopulmonary region and from the aortic arch.

We exposed the left renal sympathetic nerve retroperitoneally and attached a pair of stainless steel wire electrodes (Bioflex wire AS633, Cooner Wire) to record SNA. The nerve bundle peripheral to the electrodes was tightly ligated and crushed to eliminate afferent signals from the kidney. The nerve and electrodes were secured with silicone glue (Kwik-Sil, World Precision Instruments, Sarasota, FL). The preamplified nerve signal was band-pass filtered at 150–1,000 Hz, full-wave rectified, and low-pass filtered with a cutoff frequency of 30 Hz to quantify the nerve activity. Pancuronium bromide (0.1 mg/kg) was administered to prevent muscular activity from contaminating the SNA recordings.

With the rabbit in the prone position, the sacrum, left ankle, and knee were clamped with a custom-made apparatus to prevent body trunk and hindlimb movement during muscle stretch. The left triceps surae muscle, Achilles tendon, and calcaneus bone were exposed. The left triceps surae muscle was isolated from surrounding tissue. The Achilles tendon was severed from the calcaneus bone and attached to a force transducer (Load Cell LUR-A-SA1, Kyowa Electronic Instruments, Tokyo, Japan). During muscle stretch, the other side of the force transducer was connected to a weight via a pulley; muscle tension (MT) was quantified with this force transducer.

Protocols. We measured the steady-state SNA response to a number of combinations of CSP and MT as follows. CSP was initially decreased to 40 mmHg. After attainment of a steady state, CSP was increased from 40 to 160 mmHg in increments of 40 mmHg. Each pressure step was maintained for 120 s. Passive muscle stretch was applied during the last 60 s of each CSP step to develop MT. We repeated the stepwise CSP input four times while varying MT by 0, 2, 4, and 6 kg in random orders.

Data analysis. We recorded CSP, MT, SNA, and AP at a sampling rate of 200 Hz with a 12-bit analog-to-digital converter. Data were stored on a dedicated laboratory computer system for later analyses.

We calculated mean SNA and AP during the last 10 s of each CSP step. Because the absolute magnitude of SNA depended on recording conditions, SNA was presented in arbitrary units (a.u.) so that the minimum and maximum values of SNA data during the stepwise CSP input under 0-kg MT became 0 and 100 a.u., respectively, for each animal. We calculated the response range of SNA (the difference between maximum and minimum SNA) to the carotid sinus baroreflex based on the CSP-SNA relationship obtained at each MT level. We also calculated the response range of SNA to the muscle mechanoreflex based on the MT-SNA relationship obtained at each CSP level.

Statistical analysis. All data are presented as means ± SE. Differences were considered significant when $P < 0.05$. The effects of CSP and MT on SNA were tested by two-way ANOVA with repeated measurements. The response range of SNA in the CSP-SNA relationship or in the MT-SNA relationship was compared by one-way ANOVA with repeated measurements. In the case of a significant F-value, a post hoc test with the Newman-Keuls method was used to identify significant differences between any two of the conditions.

RESULTS

Figure 1 shows a typical time series of CSP, MT, SNA, and AP obtained from one animal. Although the panels are arranged in Fig. 1 in increasing order of MT, the MT levels were applied randomly in the experiments. SNA and AP decreased in response to the increments in CSP with all MT levels. SNA and AP increased in response to the increments in MT at CSP below 120 mmHg in this animal.

Figure 2*A* illustrates the mean MT-SNA relationship at each CSP level. SNA proportionally increased in response to the increments in MT at CSP of 40 and 80 mmHg. However, SNA did not increase at CSP of 120 mmHg, except at MT of 6 kg. Furthermore, the level of MT did not affect SNA at CSP of 160 mmHg.

Figure 2*B* illustrates the mean CSP-SNA relationship at each MT level. SNA decreased in response to increments in CSP with all MT levels. The CSP-SNA relationship approximated a sigmoid curve and was shifted upward with increasing MT. The increase in MT extended the response range of SNA to the carotid sinus baroreflex.

Two-way ANOVA indicated a significant interaction between MT and CSP in determining SNA ($P < 0.001$), suggest-

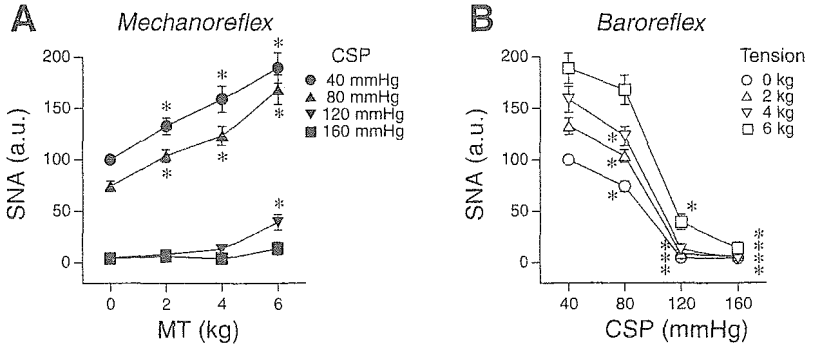

Fig. 2. Muscle mechanoreflex at each CSP level (*A*) and carotid sinus baroreflex at each MT level (*B*). In the MT-SNA relationship (*A*), SNA proportionally increased in response to increments in MT at CSP of 40 and 80 mmHg. However, SNA did not increase except at MT of 6 kg at CSP of 120 mmHg and did not change at any MT level at CSP of 160 mmHg. In the CSP-SNA relationship (*B*), SNA decreased in response to increments in CSP at all MT levels. Two-way ANOVA indicated that there was a significant interaction between CSP and MT in determining SNA ($P < 0.001$). *$P < 0.05$ compared with MT of 0 kg at each CSP in the muscle mechanoreflex (*A*) and compared with CSP of 40 mmHg at each MT in the carotid sinus baroreflex (*B*).

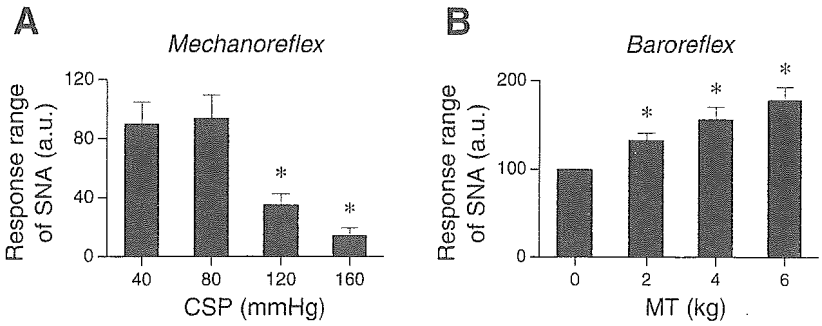

Fig. 3. Response range of SNA to the muscle mechanoreflex (*A*) and to the carotid sinus baroreflex (*B*). The response range to the muscle mechanoreflex (*A*) was smaller at CSP of 120 and 160 mmHg than at CSP of 40 mmHg. The response range to the carotid sinus baroreflex (*B*) was greater at MT of 2, 4, and 6 kg than at MT of 0 kg. $*P < 0.05$ compared with CSP of 40 mmHg in the muscle mechanoreflex (*A*) and compared with MT of 0 kg in the carotid sinus baroreflex (*B*).

ing that the effects of the muscle mechanoreflex and the arterial baroreflex could not be explained by algebraic summation (15, 16).

The response range of SNA to the muscle mechanoreflex obtained at each CSP level is shown in Fig. 3*A*. The response range of SNA was significantly smaller at CSP of 120 and 160 mmHg than at CSP of 40 mmHg.

The response range of SNA to the carotid sinus baroreflex obtained at each MT level is shown in Fig. 3*B*. The response range of SNA was significantly greater at MT of 2, 4, and 6 kg than at 0 kg.

Figure 4 illustrates the relationship between SNA and AP obtained by 16 combinations of 4 levels of CSP and 4 levels of MT. The relationship between SNA and AP can be characterized by a single sigmoid curve, indicating that the relationship between SNA and AP does not differ between the muscle mechanoreflex and the carotid sinus baroreflex.

DISCUSSION

The key findings of the present study were as follows. First, an increase in CSP from 40 to 80 mmHg caused a parallel downward shift in the MT-SNA relationship, and a further increase in CSP reduced the response range of SNA for the muscle mechanoreflex. Secondly, an increase in MT shifted the CSP-SNA relationship upward, extending the response range of SNA for the carotid sinus baroreflex. These results suggest that the response ranges of SNA to baroreceptor and muscle mechanoreceptor inputs can change depending on the input from the other reflex.

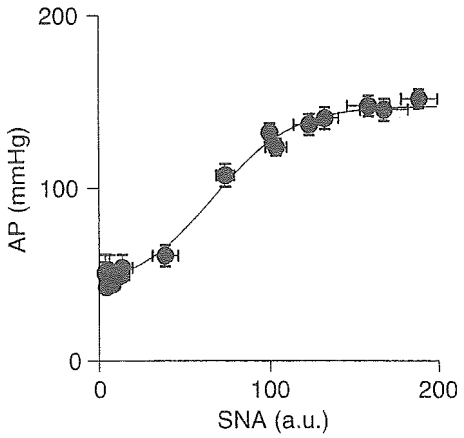

Fig. 4. Relationship between SNA and AP obtained by 16 combinations of 4 levels of CSP and 4 levels of MT. The relationship between SNA and AP can be characterized by a single sigmoid curve, indicating that the SNA-AP relationship did not differ between the muscle mechanoreflex and the carotid sinus baroreflex.

Interaction between muscle mechanoreflex and arterial baroreflex. We determined the maximum MT based on a preliminary study in which the SNA response to MT did not saturate at 6 kg. The accurate range for MT to mimic the physiological activation of muscle mechanoreceptor afferents was unclear. The maximum MT in the present study was threefold as strong as that which could occur if the configuration of Achilles tendon and calcaneus bone was kept intact (23). Although the maximum MT of 6 kg was nonphysiological and might have recruited nociceptive or nonspecific fiber activation, the SNA increased linearly with MT at CSP of 40 and 80 mmHg (Fig. 2*A*). Accordingly, the transition of physiological nonnociceptive stimulation to nonphysiological nociceptive stimulation was not clearly determined in the present experimental settings. The muscle mechanoreflex is mediated by group III and IV afferents (10, 12). The proportion of contraction-sensitive units with presumably mechanical mechanism of activation is higher among group III than group IV afferents (7). Discharge of group IV afferents is enhanced when the muscle is made ischemic. The dominant fiber type might have changed when the stimulation changed from nonnociceptive to nociceptive. Another concern is that because nociceptive stimulation of muscle afferents by metabolic products of contraction is likely to be related to exercise but stimulation by nonphysiological levels of stretch is not, the physiological significance of the present results should be interpreted carefully.

The effect of baroreceptor input on muscle mechanoreflex control of SNA has never been analyzed quantitatively over a wide range of inputs. SNA proportionally increased in response to increments in MT at CSP of 40 and 80 mmHg (Fig. 2*A*). However, SNA did not increase at CSP of 120 mmHg until MT of 6 kg was applied (Fig. 2*A*). As a result, the response range of SNA to MT was reduced by an increase in CSP (Fig. 3*A*). These data suggest that greater tension development above a certain level is necessary to evoke sympathoexcitation by the muscle mechanoreflex at higher CSP. Stebbins et al. (23) demonstrated that mean AP increased with increasing passive muscle stretch up to 8 kg, which suggests the SNA increase during passive muscle stretch. However, the AP response to passive muscle stretch might be modified by the accompanying arterial baroreflex in their study, because they did not open the arterial baroreflex negative-feedback loop. Potts and Li (16) demonstrated that higher CSP attenuated the sympathoexcitatory responses induced by muscle mechanoreflex. The present study extended the results by Potts

and Li (16) by directly measuring SNA over a wide range of mechanoreceptor and baroreceptor inputs.

Elevation of MT increased the response range of SNA to CSP to ~130%, 160%, and 180% at MT of 2, 4, and 6 kg, respectively, relative to that observed under MT of 0 kg (Fig. 3*B*). These results are consistent with results by Miki et al. (13), who demonstrated that treadmill exercise increases the response range of SNA in the arterial baroreflex. Muscle mechanoreflex may contribute to the extended response range of SNA in the arterial baroreflex during exercise. The pressor response was observed during tetanic contraction of the hindlimb induced by femoral nerve stimulation at 100 Hz in anesthetized and baroreceptor-deafferentiated rabbits (24). The static contraction also induces the pressor response in decerebrated rabbits (25). However, rhythmic contraction of the hindlimb by 3-Hz stimulation of the femoral nerve decreases mean AP (24). Both pressor and depressor responses were initiated from the contracting limbs, as both responses were eliminated after sectioning of the somatic nerves. To what extent the opposing reflexes participate in the regulation of SNA and AP during exercise awaits further investigation.

Our data are the first to demonstrate that sympathoexcitation induced by the muscle mechanoreflex requires development of a strong tension when CSP is high. On the other hand, weak tension development is sufficient to evoke sympathoexcitation at a lower CSP, possibly antagonizing a further reduction in AP during exercise (1, 16). An increased response range of SNA to CSP by muscle mechanoreceptor activation may also improve the pressure-stabilizing capacity of the arterial baroreflex against larger pressure disturbances such as those occurring during exercise (26). Furthermore, the muscle mechanoreflex and the carotid sinus baroreflex share a common output variable of SNA with regard to the regulation of AP, because the SNA-AP relationship cannot be discriminated between MT and CSP perturbations (Fig. 4). Together, these findings suggest that interaction of the two reflexes is beneficial to compensate for AP decreases resulting from exercise-induced vasodilation while maintaining the stabilization of AP against pressure disturbances.

Functional model for interaction between muscle mechanoreflex and carotid sinus baroreflex. A functional model of a given system is useful for understanding the physiological system through a simulation study. One can examine the performance of a given physiological system by simulating what would happen if the parameters of the model deviated from their normal physiological values. For instance, we have reported (8) the importance of high-cut baroreflex neural arc transfer characteristics in AP regulation by removing the high-cut characteristics in the simulation. Another application of a functional model is that it can provide a basis for development of an artificial device to support or replace the impaired physiological system. For instance, we have identified dynamic characteristics of the arterial baroreflex system and developed a framework of an artificial baroreflex center that can replace the failed vasomotor center (20, 21, 27). Currently, the artificial baroreflex center does not take account of any interactions from afferent inputs other than the baroreceptors. Quantitative analysis of interaction between the mechanoreflex and the arterial baroreflex is the first step toward the future improvement of the artificial baroreflex center, when the artificial baroreflex center will be able to adjust its function during exercise.

We constructed a functional model to reproduce the interaction between the muscle mechanoreflex and the carotid sinus baroreflex. The CSP-SNA relationship has been modeled by a sigmoid curve as follows (9):

$$SNA_B(CSP) = \frac{P_1}{1 + \exp[P_2(CSP - P_3)]} + P_4 \qquad (1)$$

where SNA_B is SNA derived from the baroreflex, P_1 denotes the response range (i.e., the difference between the maximum and minimum values of SNA), P_2 is the coefficient of gain, P_3 is the midpoint of the logistic function on the CSP axis, and P_4 is the minimum value of SNA.

The MT-SNA relationship can be modeled by a linear function as follows:

$$SNA_M(MT) = A_1 \cdot MT + A_2 \qquad (2)$$

where SNA_M is SNA derived from the mechanoreflex, and A_1 and A_2 represent the slope and intercept, respectively. The linear model was based on the MT-SNA relationship at CSP of 40 and 80 mmHg (Fig. 2*A*).

We then constructed an integrative model from the above two models. We first constructed an algebraic summation model based on the MT-SNA relationship, which showed a parallel shift between CSP of 40 and 80 mmHg. To remove apparent changes in parameters in *Eq. 1* for different MT and nonlinearity observed in the MT-SNA relationship for higher CSP, we introduced threshold in the summation model as follows:

$$SNA(CSP, MT) = \max[SNA_B(CSP) + SNA_M(MT), Th] \qquad (3)$$

where Th is a threshold value for SNA. The function $\max(a, b)$ gives the greater or equal value between a and b.

Figure 5 illustrates a hypothetical interaction between the muscle mechanoreflex and the arterial baroreflex in a model of algebraic summation with threshold (*Eq. 3*). Figure 5*A* is a simplified block diagram of the functional integration of two reflexes. The SNA control signals derived from the muscle mechanoreflex and the arterial baroreflex are summed, and then SNA is evoked if the sum exceeds a threshold Th. In the muscle mechanoreflex analysis (Fig. 5*B*), the increase in CSP input induces a parallel downward shift in the MT-SNA relationship from the solid thin line to the dashed line. Because of the threshold, SNA does not respond up to ~4 kg of MT, resulting in the MT-SNA relationship shown by the solid thick line in Fig. 5*B*. In the arterial baroreflex analysis (Fig. 5*C*), the increase in MT input induces a parallel upward shift in the CSP-SNA relationship from the dashed line to the solid thick line. The observed CSP-SNA relationship at a low MT is shown as the solid thin line rather than the dashed line in Fig. 5*C* because of the threshold for SNA. Because of the subliminal fringe (gray area in Fig. 5, *B* and *C*), the response ranges of SNA for the muscle mechanoreflex and the arterial baroreflex can change depending on the input of the other reflex.

An iterative nonlinear least-squares fitting of *Eq. 3* was performed on 16 combinations of SNA data for 4 CSP levels and 4 MT levels to determine 7 parameters (P_1–P_4, A_1, A_2, and Th) in each animal. The model successfully reproduced the

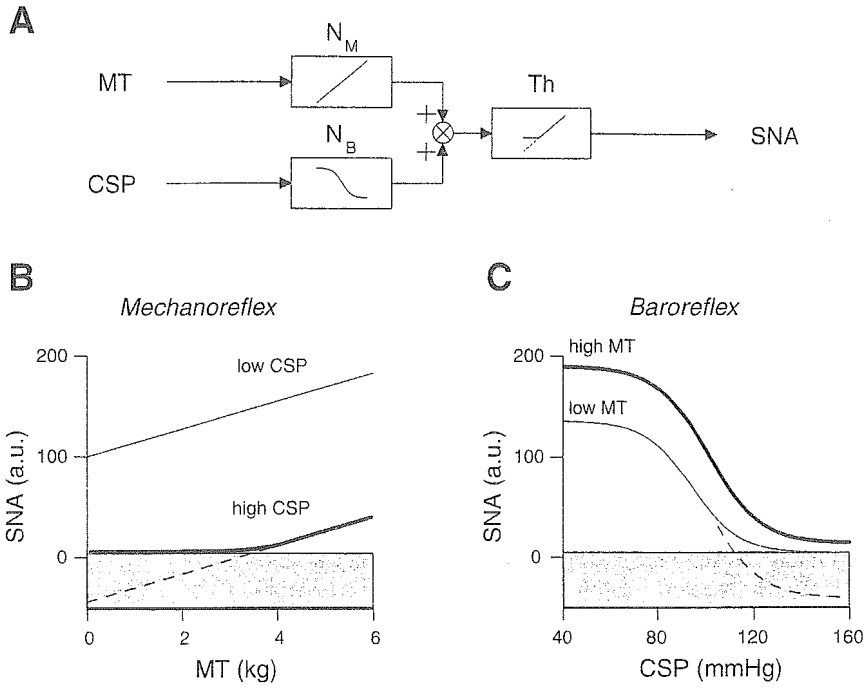

Fig. 5. Hypothetical model of interaction between the muscle mechanoreflex and the arterial baroreflex. *A*: simplified block diagram showing how the muscle mechanoreflex and the arterial baroreflex are functionally integrated based on the model of algebraic summation with a threshold (Th) (see *Functional model for interaction between muscle mechanoreflex and carotid sinus baroreflex* in DISCUSSION for details). N_M and N_B, neural arc subsystems for the muscle mechanoreflex and the arterial baroreflex, respectively. The signals derived from the muscle mechanoreflex and arterial baroreflex compartments were summed, and then the sum was compared with Th to yield SNA. *B*: muscle mechanoreflex. The increase in CSP input induces a parallel downward shift of the MT-SNA relationship from the solid thin line to the dashed line. SNA does not respond up to ~4 kg of MT because of the threshold for SNA (solid thick line). *C*: arterial baroreflex. The increase in MT input induces a parallel upward shift in the CSP-SNA relationship from the dashed line to the solid thick line. The CSP-SNA relationship at a low MT would follow the solid thin line because of the threshold for SNA.

characteristics of the interaction between the two reflexes (Fig. 6, *A* and *B*). Figure 6*C* shows the relationship between SNA estimated from the model and SNA that was actually measured. A linear regression analysis indicated that the estimated SNA in the model was similar to the measured SNA. This result reinforces our summation-threshold model of interaction between the muscle mechanoreflex and the arterial baroreflex.

Limitations. The first limitation of the present study is that we performed the experiment in anesthetized animals. Anesthesia might have modified both the carotid sinus baroreflex and the muscle mechanoreflex.

Second, we only focused on the static interaction and did not investigate the dynamic interaction between the muscle mechanoreflex and the arterial baroreflex in the present study.

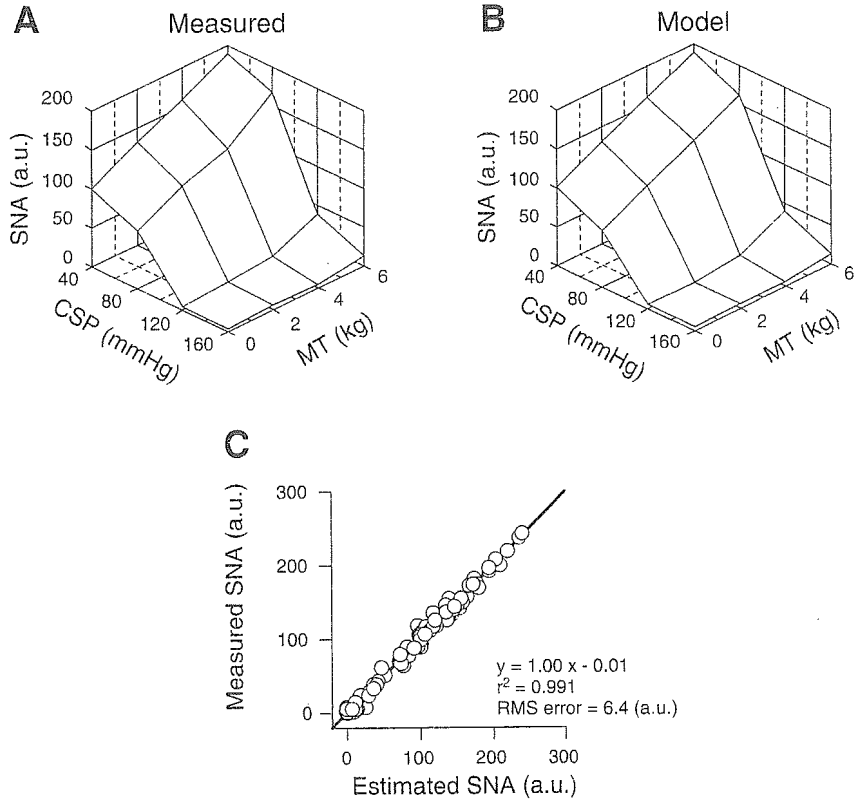

Fig. 6. *A*: averaged surface depicting the interaction between the muscle mechanoreflex and the carotid sinus baroreflex in determining SNA. *B*: surface depicting interaction, estimated by a model of algebraic summation, between the muscle mechanoreflex and the carotid sinus baroreflex with a SNA threshold. *C*: relationship between SNA estimated from the model and SNA actually measured. Each animal provided 16 data points (112 data points in total). The SNA estimated by the model was similar to the measured SNA. RMS, root mean square. Mean parameter values from *Eq. 3* least-squares fitting on SNA data are as follows: P_1, 193 a.u.; P_2, 0.10 a.u./mmHg; P_3, 101 mmHg; P_4, −54 mmHg; A_1, 15 a.u./kg; A_2, −36 a.u.; Th, 3.0 a.u., where P_1 is difference between maximum and minimum SNA; P_2 is coefficient of gain; P_3 is midpoint of logistic function on CSP axis, P_4 is SNA minimum; A_1 is slope; A_2 is intercept; and Th is SNA threshold.

Further investigations focusing on the dynamic interaction are required.

Third, stretch of skeletal muscle provides a stimulus for activation of mechanoreceptors that is different from that which occurs during muscle contraction. During contraction, mechanoreceptors are activated by a shortening of skeletal muscle and by compression of the receptors. Thus mechanoreceptors may be stimulated in a very different manner during stretch, which would likely affect the magnitude of the corresponding reflex response. In addition, stretch may activate different afferents than contraction. Further studies are required to elucidate the interactions between baroreflex and muscle mechanoreflex induced by different modes of activation.

In conclusion, activation of afferents from baroreceptors shifted the MT-SNA relationship downward and reduced the response range. The activation of mechanosensitive afferents from skeletal muscles shifted the CSP-SNA relationship upward and extended the response range. A model of algebraic summation with a threshold may explain the integration of the two reflexes. The existence of the subliminal fringe may increase the capacity of the arterial baroreflex to stabilize AP during exercise and express the sympathoexcitatory responses induced by weak muscle mechanoreceptor input at lower AP.

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Muscle Sympathetic Nerve Activity Averaged Over 1 Minute Parallels Renal and Cardiac Sympathetic Nerve Activity in Response to a Forced Baroreceptor Pressure Change

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Background—Despite the accumulated knowledge of human muscle sympathetic nerve activity (SNA) as measured by microneurography, whether muscle SNA parallels renal and cardiac SNAs remains unknown.

Method and Results—In experiment 1, muscle (microneurography, tibial nerve), renal, and cardiac SNAs were recorded in anesthetized rabbits (n=6) while arterial pressure was changed by intravenous bolus injections of nitroprusside (3 μg/kg) followed by phenylephrine (3 μg/kg). In experiment 2, the carotid sinus region was vascularly isolated in anesthetized, vagotomized, and aorta-denervated rabbits (n=10). The 3 SNAs were recorded while intracarotid sinus pressure was increased stepwise from 40 to 160 mm Hg in 20-mm Hg increments maintained for 60 seconds each. Muscle SNA averaged over 1 minute was well correlated with renal (r=0.96±0.01, mean±SE) and cardiac (r=0.96±0.01) SNAs in experiment 1 (baroreflex closed-loop condition) and also with renal (r=0.97±0.01) and cardiac (r=0.97±0.01) SNAs in experiment 2 (baroreflex open-loop condition).

Conclusions—Muscle SNA averaged over 1 minute parallels renal and cardiac SNAs in response to a forced baroreceptor pressure change. (***Circulation.*** **2005;112:384-386.**)

Key Words: catecholamines ■ muscles ■ nervous system, autonomic ■ nervous system, sympathetic

Sympathetic nerve activity (SNA) plays a crucial role in controlling circulation both in healthy humans and in patients with cardiovascular diseases.[1] Activation of SNA increases heart rate, cardiac contractility, peripheral vascular resistance, and arterial pressure. Pathologically elevated SNA worsens survival in chronic heart failure and can induce lethal arrhythmias. Therefore, SNA has been an important target in the study of cardiovascular physiology and pathophysiology. In humans, activities of sympathetic nerves innervating blood vessels in skeletal muscles (muscle SNA) have been measured directly by microneurographic techniques[2–4] and considered a proxy of systemic SNA. Those studies have contributed greatly to the understanding of the significance of SNA in circulatory physiology[5] (including exercise,[6] aging,[7,8] and baroreflex[9]) and pathophysiology (including hypertension,[10] heart failure,[11] myocardial infarction,[12] and neurally mediated syncope[13]).

Despite the accumulated knowledge about muscle SNA, whether muscle SNA parallels other SNAs innervating visceral organs, including the kidney and heart, remains unknown. The reason is that the human microneurographic technique is limited to measurements in the upper and lower extremities, face, and mouth.[2,5] Because the kidney and heart are important organs for circulatory control, the relation between muscle SNA and renal or cardiac SNA is very important. Accordingly, by recording calf muscle SNA by microneurography simultaneously with renal and cardiac SNAs in anesthetized rabbits, we sought to determine whether muscle SNA averaged over 1 minute truly parallels renal and cardiac SNAs in response to baroreflex forcing.

Methods

Animals were cared for in accordance with the Guiding Principles for the Care and Use of Animals in the Field of Physiological Science approved by the Japanese Physiological Society. Sixteen Japanese white rabbits (2.4 to 3.3 kg) were anesthetized by intravenous injection (2 mL/kg) of a mixture of urethane and α-chloralose[14] and were mechanically ventilated with O_2-enriched room air. Body temperature was maintained at 38°C with a heating pad. Arterial pressure (AP) was measured with a high-fidelity pressure transducer (Millar Instruments) inserted retrogradely from the right femoral artery.

After a retroperitoneal incision was made and a middle thoracotomy performed, left renal and left cardiac SNAs were recorded by stainless steel wire electrodes (Bioflex wire AS633, Cooner Wire).[14] After the flexors in the dorsal middle region of the right thigh were incised, a tungsten microelectrode (model 26-05-1, Federick Haer

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Co) was inserted into the left tibial nerve to record muscle SNA, based on human[2,15] and animal[16] microneurography. We identified muscle SNA by the following discharge characteristics: (1) afferent activity induced by tapping of the calf muscles but not by gently touching the skin and (2) excitatory and inhibitory responses to a decrease and an increase in baroreceptor pressure, respectively. The nerve fibers peripheral to the electrodes were ligated securely to eliminate afferent signals. The preamplified signals of SNAs were bandpass filtered at 150 to 1000 Hz except those of muscle SNA in experiment 2 (480 to 5000 Hz). These signals were full-wave rectified and lowpass filtered (cutoff frequency, 30 Hz) to quantify nerve activity.

Experiment 1: Baroreflex Closed-Loop Condition

The rabbits were maintained in a supine position (n=6). All baroreceptor afferents and vagal nerves were intact. Three SNAs and AP were recorded at a 200-Hz sampling rate with a 12-bit analog-to-digital converter. After 2 minutes of baseline recording, nitroprusside (3 μg/kg) and, after a 2-minute delay, phenylephrine (3 μg/kg), was injected as a bolus via the right femoral vein. The data were stored on the hard disk of a dedicated laboratory computer system for later analysis.

Experiment 2: Baroreflex Open-Loop Condition

To strictly control baroreceptor pressure (n=10 rabbits), a baroreflex loop was opened by vascular isolation of the carotid sinuses.[14] Bilateral intracarotid sinus pressure (CSP) was controlled by a servo-controlled piston pump.[14] Bilateral vagal and aortic depressor nerves were sectioned at the middle of the neck to eliminate reflexes from the cardiopulmonary region and the aortic arch. After surgical preparation, CSP was increased stepwise from 40 to 160 mm Hg in increments of 20 mm Hg. Each pressure step was maintained for 60 seconds. The 3 SNAs were recorded and stored as in protocol 1.

Data and Statistical Analysis

We averaged SNAs over 1 minute and generated scatterplots for muscle SNA against renal or cardiac SNA. For each type of SNA, 100 and 0 arbitrary units (AU) were assigned to the maximum 1-minute SNA value and the noise level determined by intravenous infusion of hexamethonium bromide (6 mg/kg),[16] respectively. The other SNA signals were then normalized to these values. The correlation coefficients (r) for muscle SNA versus renal or cardiac SNA were determined.

In protocol 2, the relation between CSP and SNA was characterized by a 4-parameter logistic equation model: $y=P_4+(P_1/\{1+\exp[P_2(x-P_3)]\})$, where y is SNA and x is CSP; P_1 is the response range of SNA; P_2 is the coefficient for calculation of gain; P_3 is the CSP corresponding to the midpoint of the operation; and P_4 is minimum SNA. All data are presented as mean±SD, and $P<0.05$ was considered significant.

Results

In experiment 1 (baroreflex closed-loop condition), nitroprusside injection decreased AP by 16±3 mm Hg while muscle SNA was increased. Subsequent phenylephrine injection increased AP by 41±9 mm Hg while muscle SNA was decreased. Thereafter, as AP gradually decreased, muscle SNA was again increased. These responses of muscle SNA were similar to those of renal and cardiac SNAs (Figure 1A). When presented as SNA averaged over 1 minute, the relations of muscle SNA against renal SNA and cardiac SNA were both close to the line of identity (Figure 1B). All animals showed strong correlations between 1-minute muscle and renal SNAs (r=0.96±0.01, mean±SE; range, 0.93 to 0.98) and between 1-minute muscle and cardiac SNAs (r=0.96±0.01; range, 0.93 to 0.99).

In experiment 2 (baroreflex open-loop condition), muscle SNA decreased in response to nonpulsatile and stepwise

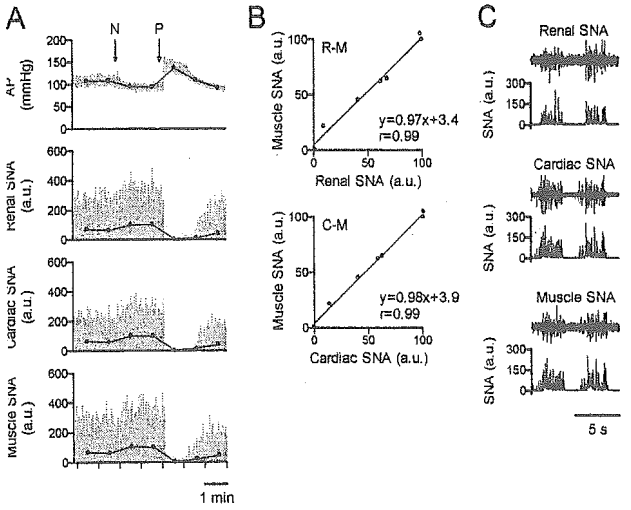

Figure 1. Experiment 1. A, Representative integrated signals of renal, cardiac, and muscle SNA during intravenous bolus injections of nitroprusside (time point N) followed by phenylephrine (time point P). Fine and bold lines indicate SNA signals resampled at 10 Hz and those averaged over 1 minute, respectively. B, Scatterplots of 1-minute muscle SNA against 1-minute renal and cardiac SNAs of same data shown in A. C, Representative original (upper panels) and integrated (lower panels) signals of 3 SNAs before pharmacological injection from 1 animal. R-M indicates renal vs muscle SNAs; C-M, cardiac vs muscle SNAs.

increases in CSP, similar to renal and cardiac SNAs (Figure 2A). All animals showed strong correlations between 1-minute muscle and renal SNAs (r=0.97±0.01; range, 0.96 to 0.99) and between 1-minute muscle and cardiac SNAs (r=0.97±0.01; range, 0.95 to 0.99). The baroreflex relation of muscle SNA against CSP was almost superimposable on that of renal or cardiac SNA in individual animals. The parameters in a reverse-sigmoid logistic function fitted in muscle SNA were similar to those in renal or cardiac SNA:

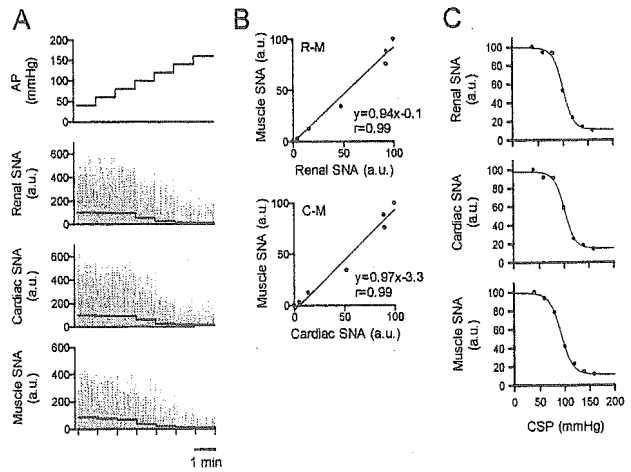

Figure 2. Experiment 2. A, Representative integrated signals of renal, cardiac, and muscle SNA during 1-minute stepwise increases in CSP from 1 animal. Fine and bold lines indicate SNAs resampled at 10 Hz and those averaged over 1 minute, respectively. B, Scatterplots of 1-minute muscle SNA against renal and cardiac SNAs. C, Sigmoidal baroreflex relation between each SNA and CSP. B and C used same data as shown in A. R-M indicates renal vs muscle SNAs; C-M, cardiac vs muscle SNAs.

P_1=99±1, 97±1, and 96±1 AU; P_2=0.11±0.02, 0.12±0.01, and 0.14±0.03 AU/mm Hg; P_3=99±4, 103±4, and 103±4 mm Hg; and P_4=3±2, 3±2, and 3±2 AU in muscle, renal, and cardiac SNAs, respectively.

Discussion

Despite accumulated data of muscle SNA as measured by microneurography in human studies, whether muscle SNA parallels other SNAs controlling cardiovascular organs remains unclear. The major new finding in this study is that 1-minute muscle SNA was correlated strongly with both renal and cardiac SNAs, with r at nearly unity, in both baroreflex closed- and open-loop conditions. This finding supports our hypothesis that muscle SNA averaged over 1 minute parallels renal and cardiac SNAs in response to baroreflex forcing. Our finding suggests that microneurographic muscle SNA is a useful proxy for renal and cardiac SNA in addressing baroreflex control of SNA.

Earlier human studies[3,4] reported that microneurographic muscle SNA was correlated with noradrenaline spillovers in the kidney (r^2=0.58) and heart (r^2=0.49) at rest, suggesting a correlation between muscle SNA and cardiac or renal SNA. However, because spillover values are affected by neurotransmitter kinetics in synapses (release and uptake) and circulating noradrenaline independent of SNA,[17] these results are not definitive. The present study complemented and extended the human studies by recording these SNAs directly and demonstrated stronger correlations (r>0.95) between muscle SNA and cardiac or renal SNA than earlier studies of spillover technique.

Previous studies reported a greater response of splenic SNA to baroceptor pressure changes than those of cardiac and renal SNAs in cats, suggesting regional differences in SNAs,[18] but those studies did not investigate muscle SNA. Additionally, these regional differences were detected in faster SNAs averaged over 4 to 8 seconds.[18,19] The present study investigated 1-minute SNA and hence did not address the relation between faster muscle SNA and renal or cardiac SNA.

The present study does not contradict earlier findings that indicated regionally different SNA responses to physiological stresses other than baroreceptor pressure changes. For example, the human cold pressor test increased muscle SNA but not heart rate.[20]

Limitations

The anesthetic, artificial respiration, and surgical procedures used in this study may affect SNAs. In addition, experiment 2 was performed under a nonphysiological condition and did not investigate baroreflex hysteresis. We bandpass filtered all SNAs at the same condition (150 to 1000 Hz) except muscle SNA in experiment 2 (480 to 5000 Hz, human study condition).[2] However, this did not affect the interpretation of data, because both experiments 1 and 2 showed strong correlations between muscle SNA and renal or cardiac SNA.

Conclusion

Muscle SNA averaged over 1 minute parallels renal and cardiac SNAs in response to a forced baroreceptor pressure change.

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