We have developed a fundus camera that can record reflectance changes (RCs) of the retina in response to both light and electrical stimulation, and we have shown that local electrical stimulation by a platinum wire electrode attached to the sclera can elicit RCs at the corresponding retinal locus. The gray-scale values (GSVs) of the RCs are correlated with the amplitude of the electrical evoked potentials (EEPs) recorded at the optic chiasma (OX).[11] These findings suggest that retinal RCs elicited by electrical stimulation may be related to the activation of RGCs. However, it is still not clear which layer of the retina is principally activated by electrical stimulation.

Electrical stimulation of the OX activates RGCs directly, and an intravitreal injection of tetrodotoxin (TTX) blocks the RCs elicited by TES. Because TTX inhibits the voltage-gated sodium channels of the RGCs and of some cells in the inner nuclear layer of the retina, blockage of RCs by TTX indicates that the RGCs are involved in the RCs.

The purpose of this study was to compare the retinal RCs elicited by TES to those elicited by electrical stimulation of the OX in cats. We also examined the differences in the RCs before and after an intravitreal injection of TTX to determine whether the RGCs contributed to the RCs.

Methods

Animals

Two cats were initially injected intraperitoneally with atropine sulfate (0.1 mg/kg), and then anesthetized with an intramuscular injection of ketamine hydrochloride (25 mg/kg). The anesthesia was maintained by an intravenous infusion of pentobarbital sodium (1 mg/kg per hour), and the cats were paralyzed with pancuronium bromide (0.2 mg/kg per hour) mixed with Ringer's solution and glucose (0.1 g/kg per hour).

The animals were artificially ventilated with a mixture of N_2O:O_2 (1:1), and the end-tidal CO_2 concentration was controlled at 3.5%–5.0% by altering the frequency and tidal volume of the ventilation. The intratracheal pressure and electrocardiogram were also monitored. The body temperature was maintained with a heating pad at 38°C.

All experiments were performed in accordance with the ARVO Statement for the Use of Animals in Ophthalmic and Visual Research, and the procedures were approved by the Animal Research Committee, Osaka University Medical School.

Surgical Procedures

To prevent eye movement and secure the TES electrode, a stainless steel ring was sutured to the sclerocorneal limbus and fixed to the stereotaxic head holder. The pupil was dilated with 5% phenylephrine hydrochloride, 0.5% tropicamide, and 1% atropine sulfate. To protect the corneal surface, a hard contact lens (polymethylmethacrylate; base curve, 8.50 mm; diameter, 13.5 mm; power, +1.5 diopters) was placed on the cornea.

To record the potentials evoked by light and electrical stimulation of the retina from the OX, a pair of stainless steel electrodes were placed around the OX stereotaxically.

Optical Imaging of Reflective Changes of the Retina

The ocular fundus was monitored with a fundus camera (TRC-50LX, Topcon, Tokyo, Japan) equipped with a digital CCD (C8484, Hamamatsu Photonics, Hamamatsu, Japan). 2
The resolution of the camera was 1280 × 1024 pixels, but use of the binning mode of the camera to obtain maximum light sensitivity reduced the resolution to 320 × 256 pixels (12-bit gray scale). A 12-bit digitizer was used, and a 4096 gray-scale level was obtained for each pixel. The exposure time of the CCD imaging was 20 ms.

A halogen lamp was used to illuminate the posterior fundus, and a band-pass filter was inserted in the illumination optical path to limit the wavelength of the fundus monitoring light to 800–880 nm (Fig. 1). The power of the monitor light was 250 nW, much lower than the safe exposure limit of the American National Standards Institute.

Fundus images were obtained every 25 ms for 26 s, at 2 s before, 4 s during, and 20 s after stimulation. To improve the signal-to-noise ratio, ten images of ten consecutive experiments were averaged. The interval between sessions was 1 min. A two-dimensional image of the optical signal was obtained by subtracting the images recorded before the stimulation from those recorded after the stimulation.

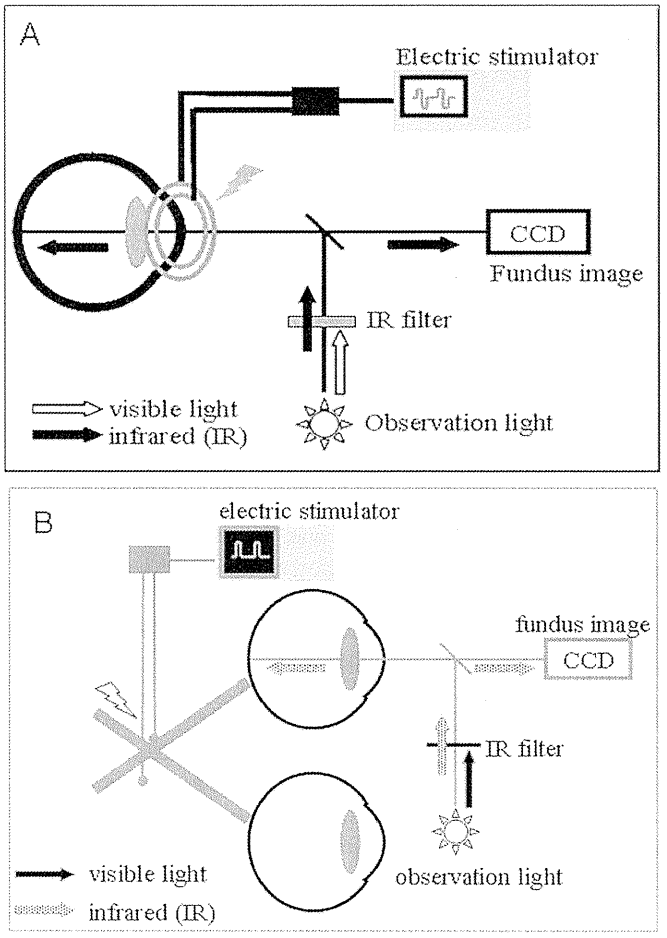
To reduce background fluctuations, a stabilized power supply (PS-150UE-DC, Hayashi Watch Works, Tateyama, Japan) was used. All experiments were performed in a dark room after 30 min of dark adaptation. 3

Electrophysiological Recordings from the Optic Chiasma

Light-evoked responses were recorded from each electrode to be certain that the electrodes were placed in the OX. EEPs were also recorded from the OX after TES. The signals were monitored on an oscilloscope and on an audio speaker in real time.

Electrical Stimulation of the Retina by Transcorneal Electrical Stimulation

TES was applied from a ring electrode set at the sclerocorneal limbus with a rectangular train of 20 paired biphasic (anodic first) pulses of 5 ms duration and a frequency of 20 Hz. All pulses were generated by a pulse generator (SEN7203, Nihon Koden, Tokyo, Japan) and delivered to the electrodes through a linear stimulus isolation unit (BSI-950, Dagan, Minneapolis, MN, USA). The reference electrode was set under the skin of the head (Fig. 1A). To examine the relationship between the stimulus current and the intensity of the RCs, the stimulating current was



14 **Figure 1A, B.** Diagram of the experimental set-up of transcorneal electrical stimulation (**A**) and retrograde electrical stimulation at optic chiasma (**B**). **A** The retina was activated by electric currents passed between the ring electrode set at the sclerocorneal limbus and the reference electrode set under the skin of the head. Biphasic pulses of 0.5 ms duration were applied for 4 s at a frequency of 20 Hz. Fundus images, observed with near-infrared light (800–880 nm), were obtained every 20 ms for 26 s between 2 s before and 20 s after stimulation. **B** The retinal ganglion cells were retrogradely activated by delivering electrical currents between two electrodes placed around the optic chiasma. Monophasic pulses of 0.05 ms duration were applied for 4 s at a frequency of 100 Hz.

increased systematically between the threshold current to the maximum current (≤1 mA)

Electrical Stimulation of the Optic Chiasma

A pair of electrodes was inserted into the OX to stimulate the optic axons of the RGCs. Monophasic pulse trains at 100 Hz with a pulse duration of 50 μs were used, and the duration of the stimulation was 4 s (Fig. 1B). To examine the relationship between the stimulus current and the intensity of the RCs, the stimulating current was increased systematically between a threshold current and the maximum current (≤1 mA).

Intravitreal Injection of TTX

Reflectance changes elicited by TES were measured before and 2 h after a single injection of tetrodotoxin citrate (TTX; 206-11071, Wako Pure Chemical Industries, Osaka, Japan), dissolved in saline. The 20-μl solution was injected into the middle of the vitreal chamber with a 26-gauge Hamilton microsyringe through the pars plana, approximately 3 mm posterior to the temporal limbus. The final vitreal concentration of TTX was estimated to be 27 μM, assuming a complete mixture with no leakage and a vitreal volume of 3.7 ml. We confirmed that the injected TTX blocked the activity of the RGCs 2 h after injection, indicated by the light-evoked responses at the OX being completely extinguished. 4

Data Analyses

The amplitude of the EEPs evoked by TES was measured between the first negative peak (N1, latency about 20 ms) to the first positive peak (P2, latency about 25 ms). Twenty 5 records were averaged to determine the amplitude for a particular stimulus current. To evaluate the intensity of the RCs, the GSV of each spot in the area of interest was averaged. The averaged GSV of each spot after the onset of electrical stimulation was subtracted from that before the electrical stimulation to obtain the differential image. We evaluated the intensity of the RCs on the optic disc (OD), a retinal artery (RA), and a retinal vein (RV).

Statistical Analyses

A regression analysis between the stimulus current and the intensity of RCs was performed with the SPSS statistical package.

Results

Our evaluation of the intensity of the RCs was focused on small regions of the OD, RA, and RV, indicated by the white marks in Fig. 2A. Examination of a two-dimensional map of the RCs after either TES or OX stimulation showed transient and localized decreases of the reflectances. The RCs were visualized as a darkening of the OD and retinal blood vessels (Fig. 2B). 6

RCs Elicited by TES

Time Course of RCs Elicited by TES

The GSV of the reflectance at the OD in cat 1 began to decrease about 1 s after the onset of stimulation (3 s after the onset of recording), and continued to decrease linearly to a deep trough at 5.5–6 s after the onset of stimulation. The reflectance then gradually returned to the baseline

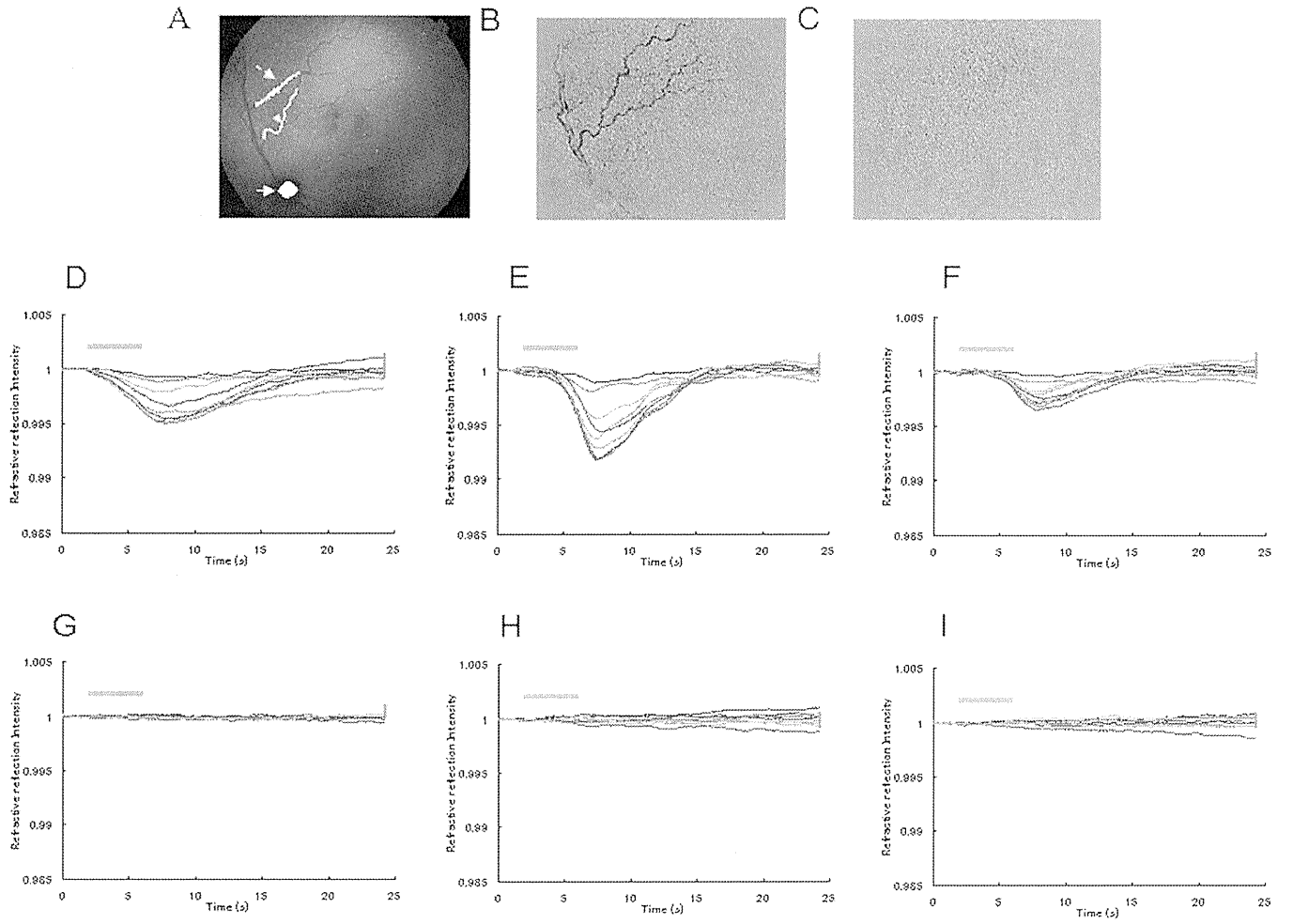


Figure 2A–I. Two-dimensional maps of retinal reflectance changes (RCs) and time courses of the RCs at the optic disc (OD), retinal artery (RA), and retinal vein (RV) before and after tetrodotoxin (TTX) injection. The RCs were elicited by transcorneal electrical stimulation (TES) of different current intensities in cat 1. **A** The areas measured for the RCs of the RA (*arrowhead*), OD (*solid arrow*), and RV (*dashed arrow*). Two-dimensional map of RCs 5.5 s after the onset of TES (**B**), and after the onset of TES with intravitreal injection of TTX (**C**). **D** Time course of the RCs at the OD (**D**), the RA (**E**), and the RV (**F**). Time course of the RCs at the OD after an intravitreal injection of TTX (**G**), at the RA after intravitreal injection of TTX (**H**), **I** at the RV after intravitreal injection of TTX (**I**). **D–I** Line color indicates the stimulus current: —, 0.06 mA; —, 0.09 mA; —, 0.12 mA; —, 0.18 mA; —, 0.25 mA; —, 0.36 mA; —, 0.5 mA; —, 0.7 mA; and —, 1 mA. —, duration of the TES (2–6 s after the onset of measurement); —, standard deviation of the reflectance change at 26 s with a current of 1.0 mA.

value (Fig. 2D). The GSV of the reflectance at the RA began to decrease about 2 s after the stimulus onset and continued to decrease linearly to a deep trough at 6 s (Fig. 2E). The GSV of the RC at the RV began to decrease about 3–4 s after the stimulus onset; it continued to decrease linearly to a deep trough at about 7–9 s and then returned gradually to the baseline value (Fig. 2F).

In cat 2, the time courses of the GSV of the RCs at the OD and RA were similar to those of cat 1. The GSV of the RC at the RV began to increase 1 s after the stimulus onset, peaked about 2 s later, and then decreased.

Stimulus-Intensity Dependence of RCs Elicited by TES

The decrease in the GSV of the reflectance at the OD as a function of the TES current in cat 1 was approximately linear up to 0.4 mA and then it became saturated (Fig. 3A). At the RA and RV, the reflectance also decreased linearly with an increase in the stimulating current until the saturation current was reached (Fig. 3B, C). In cat 2, the relationship between GSV of RC and the stimulating current at the OD and RA also showed that the RCs decreased almost linearly with the stimulus current up to 0.5 mA and then

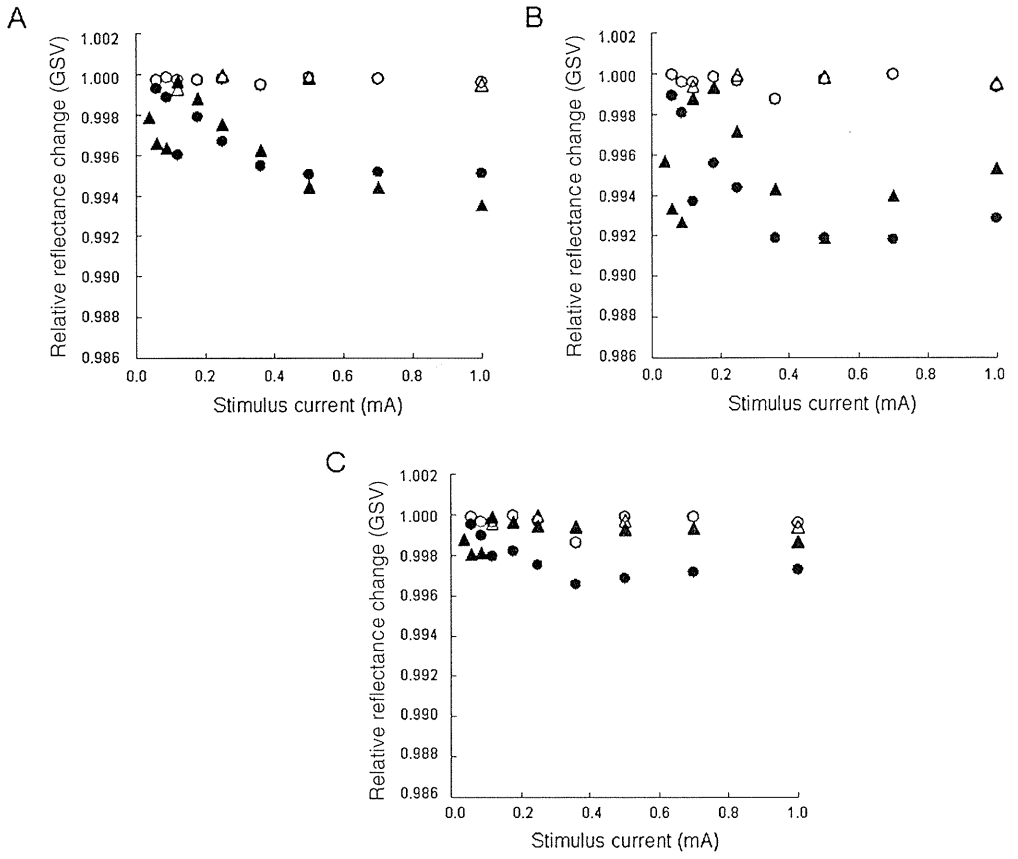


Figure 3A–C. Relationship between RCs elicited by TES at the OD (**A**), RA (**B**), and RV (**C**) before and after TTX injection in cat 1 (○) and cat 2 (△): ● *and* ▲, RCs before TTX injection; ○ *and* △, RCs after TTX injection. *GSV*, gray-scale value.

became saturated, except when the stimulus current was <0.1 mA (Fig. 3A, B). The RCs at the RV in cat 2 were very small, but the relationship between the RCs and the stimulating current showed a similar trend (Fig. 3C).

RCs Elicited by Stimulation of the OX

Time courses of RCs elicited by OX stimulation

Examination of a two-dimensional map of the RCs after OX stimulation in cat 1 showed that, as after TES, the reflectance decreased at the OD, RA, and RV (Fig. 4A). The reflectance at the OD began to decrease about 1 s after the stimulus onset, and it continued to decrease linearly to a minimum at about 6–7 s, then returned gradually to the baseline value (Fig. 4D). The reflectance of the RA began to decrease about 2 s after the stimulus onset and continued to decrease linearly until about 6–7 s. Thereafter, the reflectance of the RA gradually returned to the baseline value, resulting in a trough at a time similar to that seen for the OD (Fig. 4E). On the other hand, the RCs of the RV were slightly delayed and weaker. They began to decrease about 3–4 s after the stimulus onset, and continued to decrease linearly to a deep trough at about 7–9 s. The reflectance then gradually returned to the baseline value (Fig. 4F).

In cat 2, the time courses at the OD, RA, and RV were similar to those in cat 1, except that the early positive peak for the RV was not seen. 7

Stimulus-Intensity Dependence of RCs Elicited by OX Stimulation

The GSV of the reflectance at the OD decreased linearly with an increase of current intensity in cat 1 (Fig. 5A). The RCs of the RA decreased with an increase of current intensity (Fig. 5B). The RCs at the RV were weaker than those at the RA or the OD and tended to decrease with increasing current intensity (Fig. 5C).

The GSV of the RCs at the OD and the RA in cat 2 decreased with an increase of the current intensity up to 0.5 mA and then became saturated (Fig. 5A). The RCs of the RA decreased concomitantly with the increase in current intensity (Fig. 5B). The RCs at the RV were weaker than those at the RA or OD and tended to decrease concomitantly with the increase in current intensity (Fig. 5C). 8 9

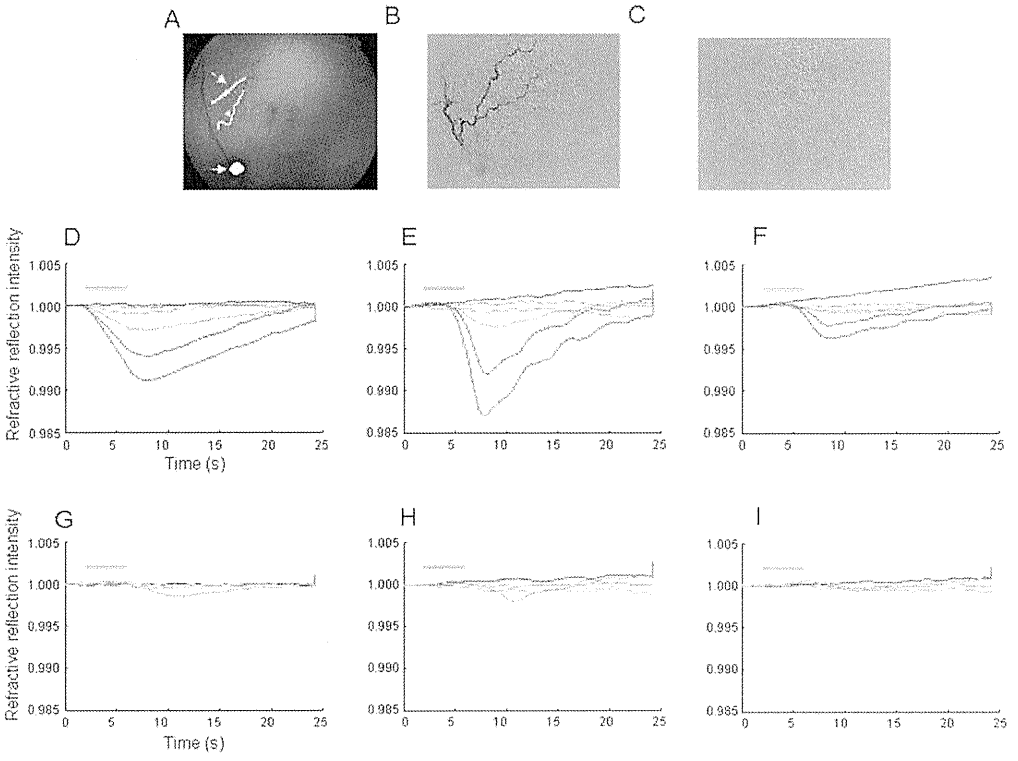


Figure 4A–I. Two-dimensional maps of the RCs and time courses of the RCs at the OD, RA, and RV. The RCs were elicited by optical chiasma (OX) stimulation of different current intensities in cat 1. **A** The areas measured for the RCs of the RA (*arrowhead*), OD (*solid arrow*), RV (*dashed arrow*). **B** Two-dimensional map of the RCs 5.5 s after the onset of OX stimulation (**B**), **C** and after the onset of OX stimulation with intravitreal injection of TTX (**C**). **D** Time course of the RCs at the OD (**D**), at the RA (E), and at the RV (**F**). **G** Time course of the RCs at the OD after intravitreal injection of TTX (**G**), at the RA after intravitreal injection of TTX (**H**), and at the RV after intravitreal injection of TTX (**I**). **D–I** Line color represents the stimulus current. **D–F:** —, 0.18 mA; —, 0.25 mA; —, 0.36 mA; —, 0.5 mA; —, 0.7 mA; and —, 1.0 mA. **G–I:** —, 0.36 mA; —, 0.5 mA; —, 0.7 mA; and —, 1.0 mA. **D–I** —, duration of the TES (2 to 6 s after the onset of measurement); —, the standard deviation of the reflectance change at 26 s with a current of 1.0 mA.

Effect of TTX Injection on RCs Elicited by TES or OX Stimulation

To block the activation of RGCs by TES or OX stimulation, TTX was injected intravitreally. Two hours after the injection, visually evoked potentials could not be recorded from the OX as they could be before the TTX injection. The RCs at the OD, RA, and RV evoked by TES or OX stimulation were almost extinguished (Figs. 2C, 4C). The time courses of RCs at the OD, RA, and RV showed almost no change even with maximal stimulation (Figs. 2, 4G–I).

Electrophysiological Recordings from the OX Following TES

The N1–P2 amplitude of the EEP recorded in the OX increased linearly with an increase of stimulus current up to 0.4 mA and then became saturated in cat 1 (Fig. 6). The relationship between the EEP amplitude and the GSV of RCs at the OD was assessed in both cats. A linear regression analysis yielded an R^2 value of 0.649 ($P = 0.009$) in cat 1 and 0.502 ($P = 0.033$) in cat 2, suggesting that RCs increased linearly with the EEPs at the OX elicited by electrical stimulation of the retina by TES (Fig. 6C). 10

Discussion

We examined two-dimensional maps of the intrinsic signals of the retina, the RCs, during and after TES and OX stimulation in cats. Under both stimulus conditions, RCs were detected on the OD, RA, and RV but not around the foveal area of the retina (Fig. 2B). No RCs were detected at area centralis possibly because the signals elicited by electrical stimulation were weak.[11] The changes in the intrinsic signals elicited by diffuse electrical stimulation using DTL electrodes are also very weak in the foveal area,[12] consistent with our findings.

The RCs reached a deep trough at about 6–7 s at the OD and RA after both TES and OX stimulation (Figs. 2, 4), which suggests that the RCs at the OD are caused by an increase in either blood volume or blood flow. The onset of the RCs was slightly earlier at the OD than at the RA after both TES and OX stimulation (Figs. 2, 4), suggesting that the changes of either blood volume or flow induced by

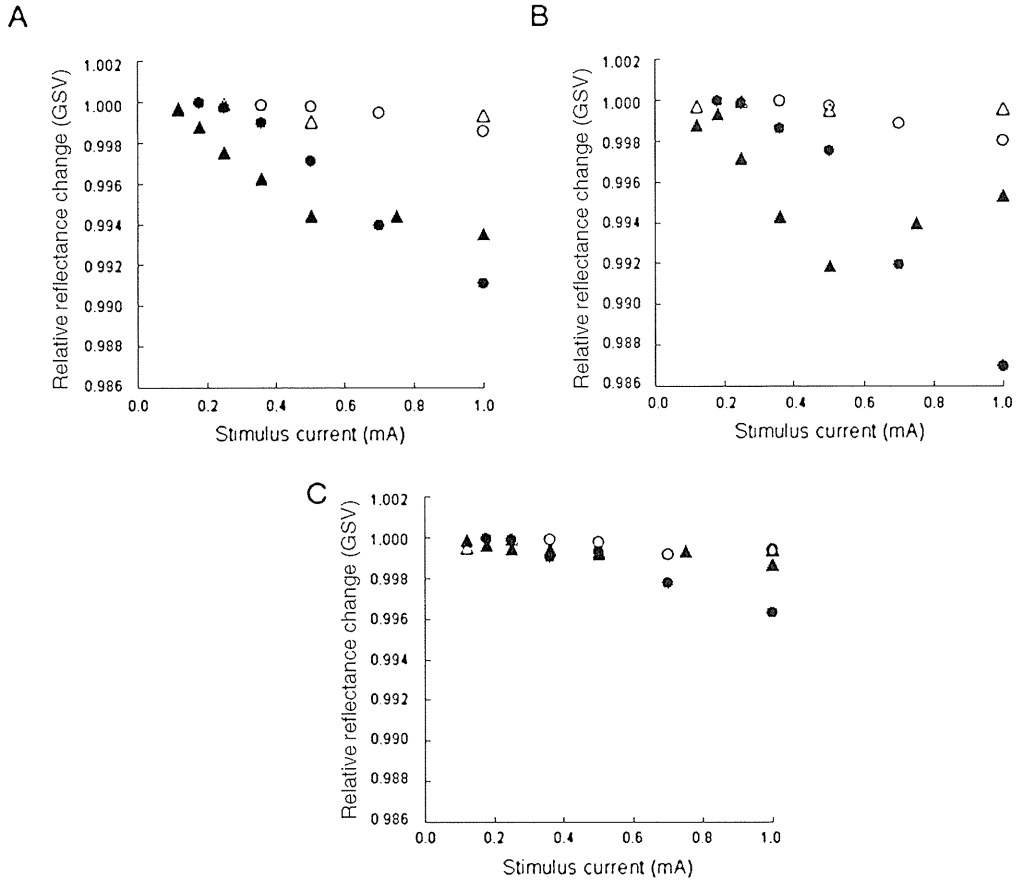


Figure 5A–C. Relationship between the RCs by OX stimulation at the OD (**A**), the RA (**B**), and the RV (**C**) before and after TTX injection in cat 1 (○) and cat 2 (△): ● *and* ▲, RCs before TTX injection; ○ *and* △, RCs after injection.

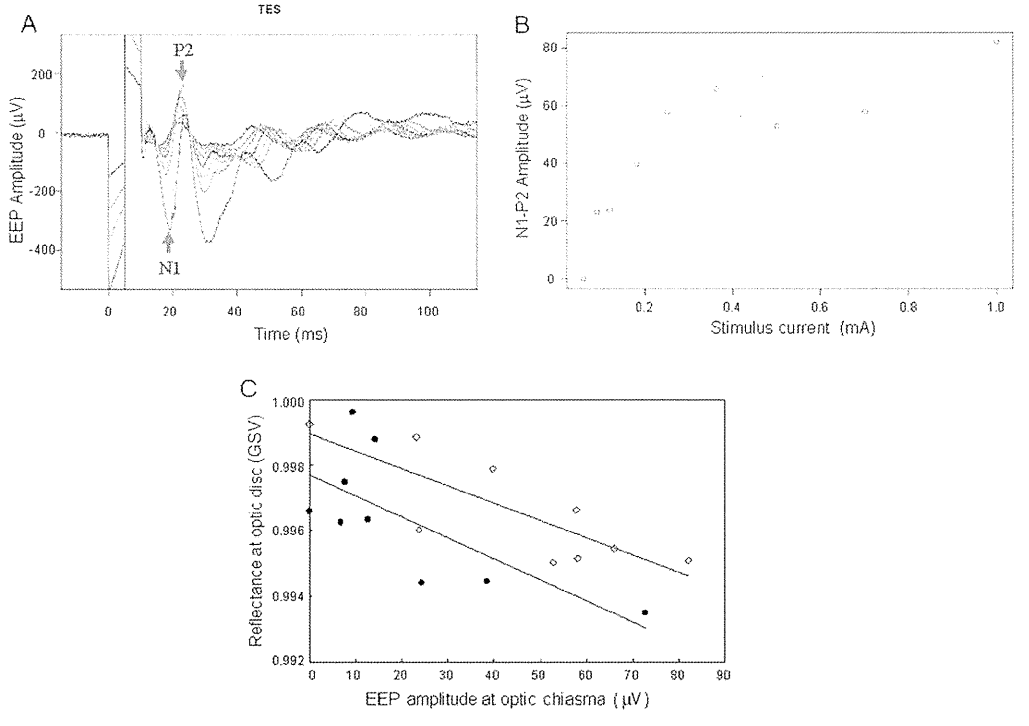


Figure 6. A Electrically evoked potentials (*EEPs*) recorded from the OX in response to TES in cat 1; **B** the relationship between the EEP amplitude and the stimulating electrical current; and **C** the relationship between the RCs at the optic disc and EEP amplitude at the OX by TES. The EEP amplitude was measured between the first negative peak (*N1*) and the second positive peak (*P2*). **A** Line color indicates the stimulus current: —, 0.06 mA; ┈, 0.09 mA; ┈, 0.12 mA; —, 0.18 mA; ┈, 0.25 mA; ┈, 0.36 mA; , 0.5 mA; , 0.7 mA; and ┈, 1 mA. **C** ○, data from cat 1; ●, data from cat 2.

either TES or OX stimulation occurred at the OD first and that the oxygenated blood flow reached the RA subsequently.

The onset of RCs was about 1–2 s later at the RV than at the RA after both TES and OX stimulation (Figs. 2, 4), which indicates that the RCs at the RV were caused by the activation of the RGCs and the change of blood flow in the RA.

After TES, the GSVs of the RCs at the OD were correlated with the EEP amplitude at the OX (Fig. 6C), suggesting that the RCs at the OD were related to the degree of RGC activation. The RCs elicited by TES tended to saturate with an increase of stimulus current (Fig. 4), and saturation was also observed in the amplitude of the EEP elicited by OX stimulation (Fig. 6B), suggesting that a TES current larger than a certain value does not effectively stimulate any RGCs.

Two hours after TTX injection, the light-evoked responses at the OX were extinguished, indicating that the action potentials of the RGCs were completely blocked. Under these conditions, the RCs at the OD, RA, and RV elicited by both TES and OX stimulation were also abolished (Figs. 2, 4). These results suggest that the RCs after either TES or OX stimulation were caused by activation of the RGCs, which was followed by blood volume or flow changes.

Schallek et al.[13] reported that the inhibition of action potentials of RGCs by TTX did not induce significant changes in the retinal intrinsic signals elicited by light stimulation. Bizheva et al.[14] used functional optical coherence tomography to study RCs in the different retinal layers and found that the photoreceptor layer was mainly activated but activation was also observed in the inner plexiform layers. The results of these experiments indicate that light stimulation elicits RCs predominantly in the photoreceptor layer but that the reflectance of the inner retinal layers is also changed.

The difference between TES and OX stimulation is that TES may stimulate all of the layers of the retina whereas OX stimulation activates mainly the RGCs, because the bipolar and amacrine cells cannot be activated by retrograde trans-synaptic signals. Therefore, the RCs in the retina elicited by OX stimulation can be attributed to RGC activation and subsequent changes in the blood volume or flow. The RCs in the retina elicited by TES and OX stimulation were not significantly different even after TTX injection, suggesting that TES activates mainly the RGCs, and blood flow is recruited after the RGCs are activated.

In conclusion, TES activates principally the RGCs, and the change in the blood flow is recruited thereafter.

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Optimal parameters of transcorneal electrical stimulation (TES) to be neuroprotective of axotomized RGCs in adult rats

Takeshi Morimoto [a], Tomomitsu Miyoshi [b], Hajime Sawai [b], Takashi Fujikado [c,*]

[a] Department of Ophthalmology, Osaka University Graduate School of Medicine, Japan
[b] Department of Integrative Physiology, Osaka University Graduate School of Medicine, Japan
[c] Department of Applied Visual Science, Osaka University Graduate School of Medicine, 2-2 Yamadaoka, Suita City, Osaka 565-0871, Japan

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ABSTRACT

We previously showed that transcorneal electrical stimulation (TES) promoted the survival of axotomized retinal ganglion cells (RGCs) of rats. However the relationship between the parameters of TES and the neuroprotective effect of TES on axotomized RGCs was unclear. In the present study, we determined whether the neuroprotective effect of TES is affected by the parameters of TES. Adult male Wistar rats received TES just after transection of the left optic nerve (ON). The pulse duration, current intensity, frequency, waveform, and numbers of sessions of the TES were changed systematically. The alterations of the retina were examined histologically seven days or fourteen days after the ON transection. The optimal neuroprotective parameters were pulse duration of 1 and 2 ms/phase ($P < 0.001$, each), current intensity of 100 and 200 μA ($P < 0.05$, each), and stimulation frequency of 1, 5, and 20 Hz ($P < 0.001$, respectively). More than 30 min of TES was necessary to have a neuroprotective effect ($P < 0.001$). Symmetric pulses without an inter-pulse interval were most effective ($P < 0.001$). Repeated TES was more neuroprotective than a single TES at 14 days after ON transection ($P < 0.001$). Our results indicate that there is a range of optimal neuroprotective parameters of TES for axotomized RGCs of rats. These values will provide a guideline for the use of TES in patients with different retinal and optic nerve diseases.

1. Introduction

Neuronal activity has a neurotrophic effect on neurons (Linden, 1994; Mennerick and Zorumski, 2000). *In vivo* and *in vitro* studies have shown that electrical stimulation (ES) or neuronal activity promotes the survival and/or neurite outgrowth of different types of neurons (Fields et al., 1990; Grumbacher-Reinert and Nicholls, 1992; Al-Majed et al., 2000a,b).

In the visual system, it has been shown *in vitro* study that ES or depolarization by KCl promotes the survival and/or neurite outgrowth of cultured retinal ganglion cells (RGCs) (Meyer-Franke et al., 1998; Shen et al., 1999; Goldberg et al., 2002). Our laboratory has shown that direct ES of a transected optic nerve (ON) in adult rats promoted the survival of the axotomized RGCs in adult rats (Morimoto et al., 2002). We also showed that transcorneal electrical stimulation (TES), which is less invasive than ES of the transected ON (ON-ES), also promoted the survival of axotomized RGCs in adult rats (Morimoto et al., 2005), and In addition, promoted the survival of photoreceptors in Royal College Surgeons rats (Morimoto et al., 2007). Miyake et al. (2007) have reported that TES immediately after crushing the ON lessened the degree of visual impairment in adult rats. In the clinic, TES has been demonstrated to improve visual function in patients with nonarteritic anterior ischemic optic neuropathy, traumatic optic neuropathy (Fujikado et al., 2006), and retinal artery occlusion (Inomata et al., 2007).

In spite of these studies, the optimal TES parameters which will result in the best neuroprotective effect and safety of the retina in the clinical situation have not been determined. There are different parameters of the TES that need to be considered, e.g., pulse duration, current intensity, frequency, duration of stimulation, waveform, and number of sessions. Different combinations of these parameters also need to be considered. There are several studies on the effect of the electrical stimulation parameters on tissue damage (Yuen et al., 1981; McCreery et al., 1990; Harnack et al., 2004; Nakauchi et al., 2007), but reports on the relationship between the ES parameters and their neuroprotective effects on injured neurons are limited (Okazaki et al., 2008).

Therefore, the purpose of this study was to determine the optimal ES parameters for the neuroprotection of axotomized RGCs. To accomplish this, we cut the ON of adult rats and stimulated the eyes with electrical pulses of different duration, current intensity,

* Corresponding author. Tel.: +81 6 6879 3940; fax: +81 6 6879 3948.
E-mail address: fujikado@ophthal.med.osaka-u.ac.jp (T. Fujikado).

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frequency, duration of stimulation time, waveform, and number of TES sessions. The retinas were examined histologically to determine the effectiveness of the TES in protecting the retinal neurons.

2. Materials and methods

2.1. Experimental animals

Adult male Wistar rats (230–270 g) were obtained from SLC Japan, Inc. (Shizuoka, Japan). All experimental procedures were performed in accordance with the ARVO Statement for the Use of Animals in Ophthalmic and Vision Research and were approved by the Animal Research Committee, Osaka University Graduate School of Medicine. The animals were anesthetized with intraperitoneal pentobarbital (50 mg/kg body weight) for all surgical procedures.

2.2. Retrograde labeling of RGCs

To identify the RGCs from other retinal cells, the RGCs were retrogradely labeled with Fluorogold (FG; Fluorochrome Inc., Englewood, CO), a fluorescent tracer, before the ON transection. The anesthetized animals were held on a surgical frame with a nose clamp. Craniotomy was performed on the posterior parietal bones to expose the occipital cortex. The occipital cortex was carefully aspirated to expose the dorsal surface of the bilateral superior colliculi (SC), avoiding damage to the superior sagittal sinus and SC. A small sponge soaked in 2% FG (in 0.9% NaCl containing 10% dimethyl sulfoxide) was placed on the surface of both superior colliculi (Morimoto et al., 2002, 2005; Okazaki et al., 2008).

2.3. ON transection

Seven days after the retrograde labeling of the RGCs, the left ON was transected as described in detail elsewhere (Morimoto et al., 2002, 2005; Okazaki et al., 2008). Briefly, a skin incision was made through the left eyelid close to the superior orbital rim, and the incision was retracted to expose the globe. The superior extraocular muscles were spread apart, the ON was exposed by a longitudinal incision of the orbital retractor muscle and perineurium. The ON was transected approximately 3 mm from the posterior pole of the eye with care taken not to damage the retinal blood vessels.

2.4. Transcorneal electrical stimulation

A bipolar contact lens electrode with an inner and outer ring (Kyoto Contact, Kyoto, Japan) was used as the stimulating electrodes. The corneal surface was anesthetized by 0.4% oxybuprocaine HCl in addition to systemic anesthesia, and the contact lens electrode was placed on the cornea of the eye with the transected ON. Hydroxyethylcellulose gel (1.3%) was used to protect the cornea and for making electrical contact with the cornea.

2.5. Stimulation parameters

TES was delivered with anodic first (cornea positive) biphasic square pulses from a constant current stimulator (SEN-7203; Nihonkoden, Tokyo, Japan; Isolator, A395R; World Precision Instruments, Sarasota, FL) (Morimoto et al., 2005, 2007). The stimulus parameters were: pulse durations of 0.5, 1, 2, 3, and 5 ms/phase with 100 μA, 20 Hz, and for 60 min; current intensities of 50, 100, 200, 300 and 500 μA with 1 ms/phase, 20 Hz and for 60 min; frequencies of 0.5, 1, 5, 20, 50, and 100 Hz at 100 μA, 1 ms/phase, and for 60 min; stimulation duration of 15, 30, and 60 min at 100 μA, 1 ms/phase, and 20 Hz (Table 1).

The waveform of the TES was also changed from symmetrical, asymmetrical, and symmetrical with an inter-pulse interval of 0.5 ms or 1 ms at 100 μA, 1 ms/phase, 20 Hz, and for 60 min. In addition the effect of repeated sessions of TES of 100 μA, 1 ms/phase, 20 Hz, for 60 min on days 0, 4, 7, and 10 after the ON transection was compared with a single session of TES with the same parameters of stimulation was investigated 14 days after ON transection.

Table 1
Stimulation parameters tested in this study.

Experiment	Current intensity (μA)	Pulse duration (ms/phase)	Frequency (Hz)	Stimulation duration [min]
Pulse duration	100	0.5–5	20	60
Current intensity	50–500	1	20	60
Frequency	100	1	1–100	60
Stimulation duration	100	1	20	15–60

2.6. Quantification of RGC density

Seven or 14 days after the ON transection and TES, the animals were deeply anesthetized and perfused with 4% paraformaldehyde (PFA) in 0.1 M phosphate buffer (PB, pH 7.4). Both eyes were enucleated and small incisions were made at the dorsal pole of the eyes for retinal orientation. The eyes were stored in 4% PFA in 0.1 M PB overnight at 4 °C. The retinas were dissected from the eyes, and four radial cuts were made to flatten the retinas on a glass microscope slide.

To calculate the density of the surviving RGCs, the number of FG-labeled RGCs was counted using a fluorescence microscope (Axioskop, Carl Zeiss, Oberkochen, Germany) with UV excitation at 365 nm. The RGCs in three areas of 0.5 × 0.5 mm^2 along the naso-temporal and dorso-ventral axes (nasal, temporal, dorsal and ventral) at 1, 2 and 3 mm from the optic disc were counted using a microscanner (Sapporo Beer, Saitama, Japan). The mean density of RGCs was calculated from the number of surviving RGCs counted in the 12 areas of every retina (Morimoto et al., 2002, 2005; Okazaki et al., 2008).

2.7. Statistical analyses

Data are presented as the mean ± standard deviations (SDs) and the data were statistically analyzed using a commercial software (SigmaStat, version 3.11; Systat Software, Inc). Comparisons among the groups were made by one-way analysis of variance (ANOVA), when the equal variance test passed, and was followed by the Tukey test or by Kruskal–Wallis one-way ANOVA on ranks, when the equal variance test failed, followed by the Dunn's method. Comparisons between two groups were made by Student's t tests. The level of statistical significance was set as $P < 0.05$.

3. Results

3.1. Effect of pulse duration on neuroprotection of axotomized RGCs

The somas of the RGCs in the intact control retinas were round with the fine dots of FG in the perinuclear cytoplasm and proximal dendrites (Fig. 1A). The mean RGC density in the intact control retinas was 2357 ± 150 cells/mm^2 (mean ± SD; $n = 12$; Fig. 2A). Seven days after the ON transection and without TES, the number of FG-labeled RGCs were markedly reduced to 1290 ± 96 cells/mm^2 ($n = 8$) which is 54.7% of that of intact retinas. The RGCs were irregularly shaped and debris of dead RGCs were present (Fig. 1B). The mean RGC density in the retinas with sham electrical stimulation 7 days after ON transection, was 1221 ± 176 cells/mm^2 ($n = 6$) which was 51.8% of intact retinas. This density was not significantly different from that in the retinas with ON transection without TES, and was used as the control value to evaluate the neuroprotective effect of TES.

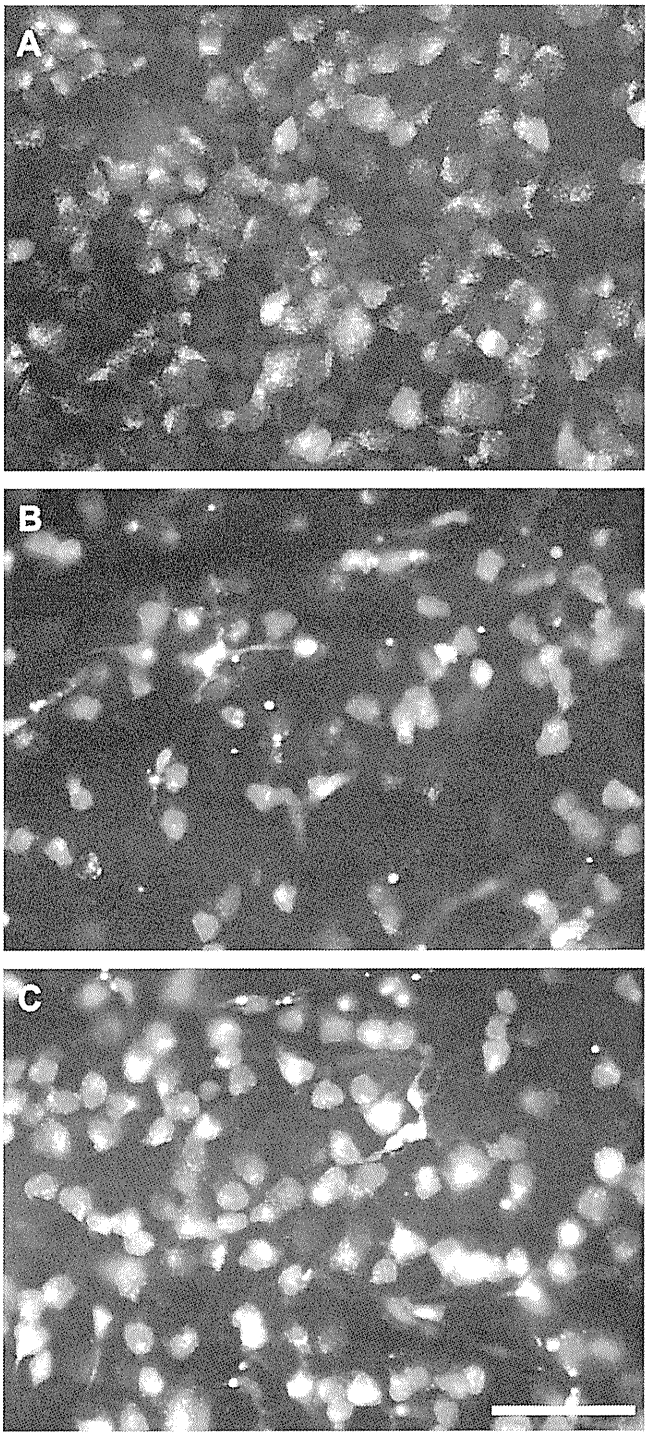

Fig. 1. Representative photographs of Fluorogold (FG)-labeled RGCs in flat-mounted retinas: intact (A), 7 days after ON transection without TES (B), ON transection with TES (C). All images were obtained from an approximately 1 mm temporal to the optic disk in each retina. A: In an intact retina, FG-labeled RGCs can be seen to have round-shaped soma with punctuate fluorescence of FG in their cytoplasm. B: In the retina 7 days after ON transection, the number of FG-labeled RGCs is markedly lower than that of RGCs in the intact retina, and debris of dead cells can be seen. C: In the retina 7 days after ON transection with TES (100 μA, 1 ms/phase, 20 Hz, 60 min), the number of surviving RGCs is strongly enhanced by TES, and many FG-labeled RGCs appeared to be similar to those in intact retinas. Scale bar = 100 μm.

Our overall results showed that TES promoted the survival of axotomized RGCs and the degree of neuroprotection depended on the pulse durations. Examination of the retinas following ON transection and TES showed many RGCs, whose shapes resembled those of the RGCs in intact retinas, had survived (Fig. 1C). The mean density of RGCs following TES of 0.5 ms/phase duration was significantly increased to 1639 ± 215 cells/mm^2 which was 69.5% of intact retinas ($P < 0.001$ vs sham stimulation; $n = 6$; Fig. 2A). TES of 1, 2 and 3 ms/phase pulse durations further increased the density up to 85.4%, 85.3% and 81.6%, respectively, of the intact retinas ($P < 0.001$; $n = 6$ each; Fig. 2A). Although TES of 5 ms/phase duration significantly increased the density of RGCs to 72.3% ($n = 6$) of that in sham stimulation, the neuroprotective effect was significantly lower than the maximum effect of 1 ms/phase ($P = 0.002$; $n = 6$; Fig. 2A).

3.2. Effect of current intensity on neuroprotection of axotomized RGCs

The mean RGC density in the retinas following TES at a current intensity of 50 μA was 1624 ± 55 cells/mm^2 ($n = 6$) which is 68.9% of intact retinas. This density was not significantly different from that in the sham stimulated retinas (Fig. 2B). However when the TES was increased to 100 μA and 200 μA, there was a significant increase in the density to 85.4% and 80.0%, respectively, of intact retinas ($P < 0.05$; $n = 6$ each). An increase of TES to 300 μA and 500 μA resulted in a decrease in the mean RGC densities to 70.0% and 64.5%, respectively, of intact retinas. These values were not significantly different from that of the sham stimulated eyes (Fig. 2B).

3.3. Effect of electric charge (intensity × duration) on neuroprotection of axotomized RGCs

The magnitude of the electric charge/phase, i.e., current intensity × pulse duration in coulombs has been identified as one of the factors that determine the effectiveness of ES in being neuroprotective in neural tissues. We compared the difference in the neuroprotective ability between increases of pulse duration to increases of current intensity. An increase in the current intensity decreased the number of RGCs more than an increase of pulse duration (Fig. 2C). There were significant differences in the number of RGCs between the survival effect with increases of current intensity and increases of pulse duration at more than 300 μC/phase ($^*P = 0.006$, $^{**}P = 0.002$; Fig. 2C).

3.4. Effect of frequency of stimulation on neuroprotection of axotomized RGCs

The mean RGC densities seven days after ON transection with sham stimulation and TES at 5 different frequencies are shown in Fig. 3. At 20 Hz, the mean RGC density was 85.0% of intact retinas which was significantly higher than that in the sham stimulated retinas ($P < 0.001$; $n = 6$). At 50 and 100 Hz, the mean RGC densities decreased to 73.1% and 68.5% respectively ($n = 6$ each), but these values were also significantly higher than that of sham stimulation. At 100 Hz the percentage of RGCs surviving after TES was significantly lower than that after 20 Hz TES ($P = 0.004$). Thus the optimal TES frequency was 20 Hz. The survival rates after TES of 5 Hz and 1 Hz were not significantly different from that at 20 Hz, 80.0% and 84.3%, respectively, of intact retinas ($n = 6$ each, $P < 0.001$ vs Sham stimulation). On the other hand, TES at 0.5 Hz did not have a significant protection, 60.8% (Fig. 3; $n = 6$).

3.5. Effect of waveform on neuroprotection of axotomized RGCs

The neuroprotective effects of the three types of waveforms with equal charge-balance were different (Fig. 4A). TES with Type II, symmetric waveforms led to a significantly increased survival of 85% compared to the sham stimulation, while asymmetrical

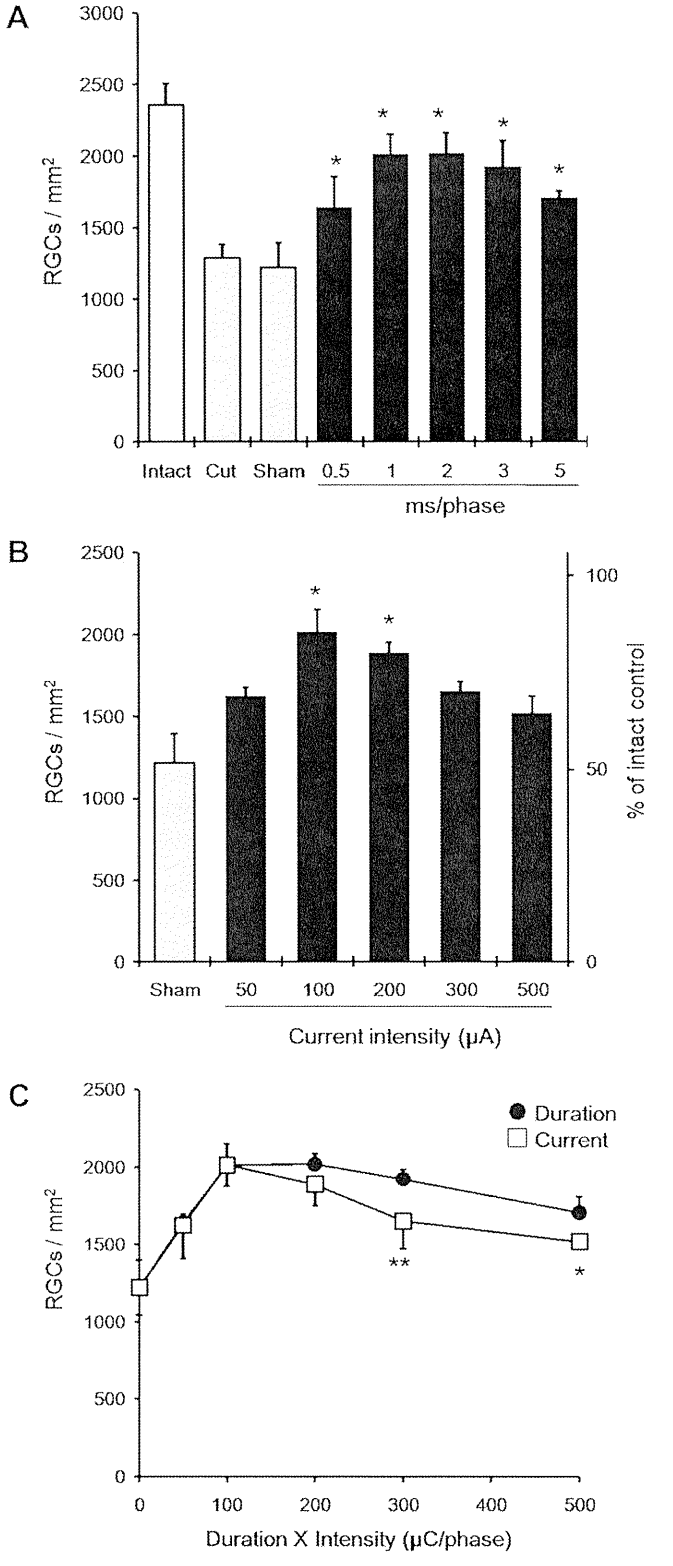

Fig. 2. Effects of pulse duration and current intensity of TES on the survival of axotomized RGCs 7 days after ON transection. A: Pulse duration-dependent neuroprotective effect of TES on RGC survival. TES (current intensity: 100 μA; frequency: 20 Hz) for 1 h was applied immediately after the ON was transected. The density of the FG-labeled RGCs/mm^2 is presented as the means ± SDs. Seven days after ON transection, the density of the RGCs is reduced to 54% of the control (Cut group). In the sham-treated animals (no electrical stimulation after ON transection), the density decreased to 53% of that of the intact control retina (Sham group). The RGC density in all five groups with TES (0.5, 1, 2, 3, and 5 ms/phase pulse duration) was significantly higher than in the sham group. Statistical analysis was made by one-way ANOVA followed by Tukey test ($P < 0.001$, $^*P < 0.001$ compared with sham). B: Current intensity-dependent neuroprotective effect of TES on RGC survival 7 days after ON transection. TES (pulse duration: 1 ms/phase; frequency: 20 Hz) for 1 h was applied immediately after ON transection. TES at 100 μA and 200 μA significantly increased the mean RGC densities compared with sham stimulation. Statistical analysis was made by Kruskal–Wallis One-Way Analysis of Variance on Ranks followed by Dunn's method ($P < 0.001$, $^*P < 0.05$ compared with sham). C. Comparison of neuroprotective effect of TES with pulse duration change and that with current intensity change 7 days after ON transection. The survival effect by current intensity significantly decreases as compared with that by pulse duration (more than 300 μC/phase) (t test, $^{**}P = 0.002$, $^*P = 0.006$).

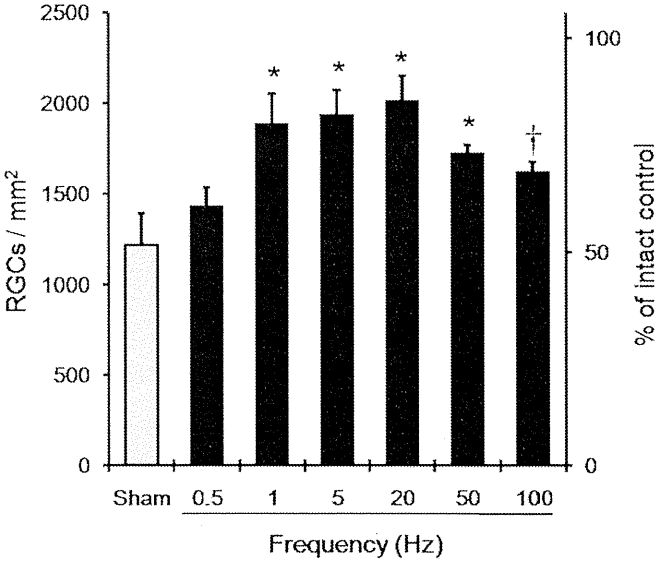

Fig. 3. Frequency-dependent neuroprotective effect of TES on axotomized RGCs 7 days after ON transection. TES (current intensity 100 μA; pulse duration 1 ms/phase) for 1 h was applied immediately after ON transection. TES at 1–20 Hz exerted the most significant effect on RGC survival; the mean densities of RGCs at 1–20 Hz exerted the most significant effect on RGC survival; the mean densities of RGCs at 1–20 Hz was significantly higher than the sham stimulation group ($P < 0.005$). Statistical analysis between the sham stimulation and ES groups was performed using one-way ANOVA followed by Tukey test ($P < 0.01$, $^*P < 0.005$, $\dagger P < 0.001$ compared with sham).

waveforms of Type I led to a survival of 68.7% and Type III to 68.3% of intact retinas ($P < 0.001$; $n = 6$ each; Fig. 4B).

Next we examined the effect of the addition of inter-pulse interval to symmetrical pulses on the survival-promoting effect on RGCs (Fig. 4C). As the inter-pulse interval was increased, the survival rate of RGCs significantly decreased from 85% to 62% ($P < 0.001$; $n = 6$ each; Fig. 4D).

3.6. Stimulation duration on neuroprotection of axotomized RGCs

TES for 30 min significantly increased the survival of RGCs to 1802 ± 111 cells/mm^2 ($n = 6$) which is 76.8% of intact retinas ($P < 0.001$ vs sham stimulation). On the other hand, after TES for 10 min, the mean RGC density was 1398 ± 124 cells/mm^2 ($n = 6$, 59.3% of intact retinas), which was not significantly different than that of the sham stimulated retinas (Fig. 5).

3.7. Effect of repeated TES on neuroprotection of axotomized RGCs

The mean RGC density in retinas 14 days after ON transection with sham stimulation was 350 ± 216 cells/mm^2 ($n = 6$), which was 13.9% of intact retinas ($n = 6$; Fig. 6A,D). On the other hand, a single TES session (1× TES) significantly enhanced the survival of RGCs to 22.9% of intact retinas ($P < 0.001$ vs sham; $n = 6$; Fig. 6B,D). Four TES sessions (4× TES on days 0, 4, 7 and 10 after ON transection) further increased the number of RGCs to 47.1% of intact retinas ($P = 0.024$ vs 1× TES; $n = 6$; Fig. 6C,D).

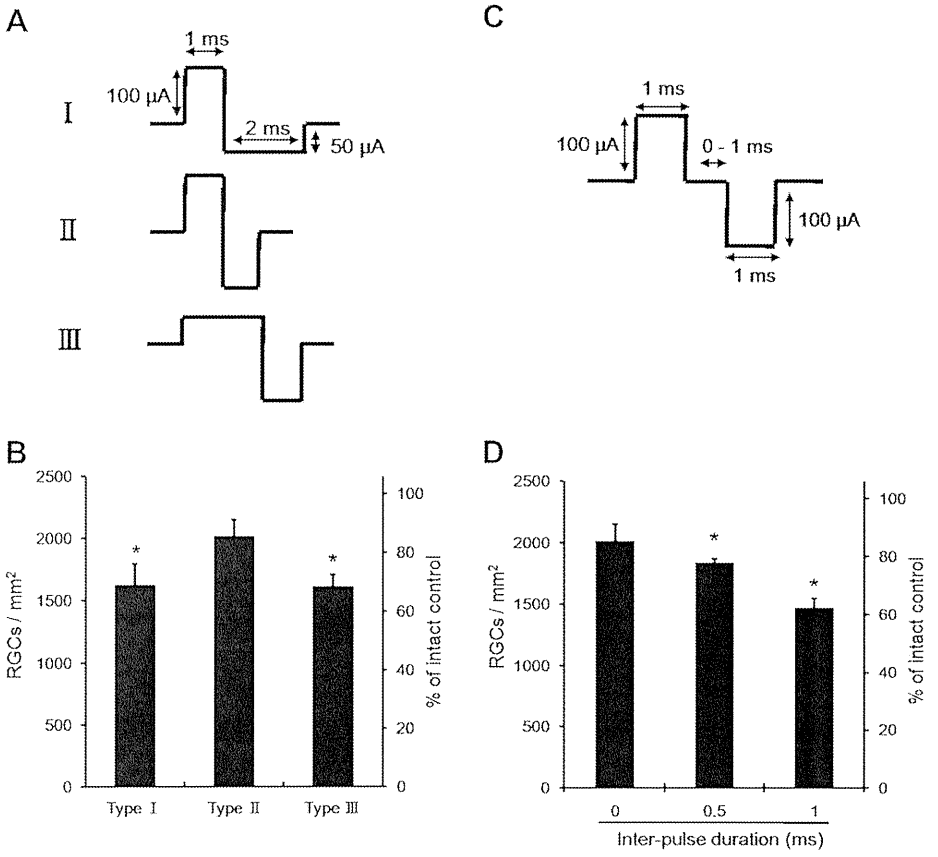

Fig. 4. Effects of waveforms of TES on the survival of axotomized RGCs 7 days after ON transection. A: Waveforms of the biphasic stimuli used in this study. Type I: Asymmetric rectangular pulse waveform (anodic first wave 100 μA, 1 ms/phase and cathodic second wave 50 μA, 2 ms/phase), Type II: Symmetric rectangular pulse waveform (100 μA, 1 ms/phase), Type III: Asymmetric rectangular pulse waveform (anodic first wave 50 μA, 2 ms/phase and cathodic second wave 100 μA, 1 ms/phase). All waves were charge-balanced. B: Neuroprotective effect of each waveform on axotomized RGCs 7 days after ON transection. TES with symmetric waveform (Type II) significantly increased the survival of RGCs more than asymmetric waveforms (Type I and Type III). Statistical analysis was performed using one-way ANOVA followed by Tukey test ($P < 0.001$, $^*P < 0.001$ compared with Type II). C: Waveform of a symmetric waveform with inter-pulse interval. D: Effect of inter-pulse interval on axotomized RGCs. The neuroprotective effect of TES on RGCs significantly decreased depending on the length of inter-pulse interval. Statistical analysis was performed using one-way ANOVA followed by Tukey test ($P < 0.001$, $^*P < 0.001$ compared with Type II without inter-pulse interval).

4. Discussion

Our results showed that the neuroprotective effect of TES on axotomized RGCs was dependent on the pulse duration, current intensity, frequency, stimulation duration, waveform, and the number of stimulation sessions.

4.1. Current charge (pulse duration × intensity)

The neuroprotective effect of TES was dependent on both the pulse duration and current intensity. There was a range of optimal pulse durations and current intensities, and an increase of the pulse duration or current intensity over the optimal range decreased the survival-promoting effect. On the other hand, the density of the electric charge, which is the production of current intensity and pulse duration, determined the extent of neural tissue damage (Yuen et al., 1981; McCreery et al., 1990; Harnack et al., 2004; Nakauchi et al., 2007). We found that there was a significant difference in neuroprotective effect of pulse duration and current intensity, on the basis of the same amount of electric charges (more than 300 μC/phase). In a retinal prosthesis study using supra-choroidal–transretinal stimulation (STS), the threshold of electric charge for the retinal safety was lower with shorter pulse durations even with the same amount of electric charge (Nakauchi et al., 2007). This is similar to our present results. Because the electric charge rate within an unit time became larger with an increase of

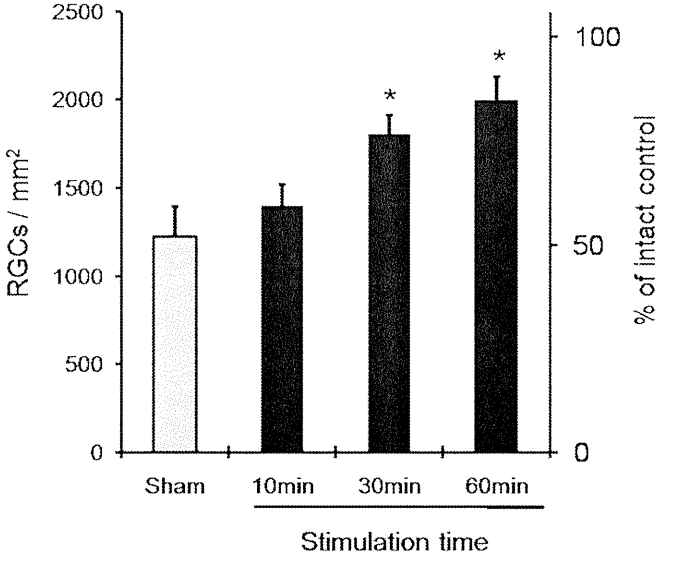

Fig. 5. Effect of stimulation duration on neuroprotection of axotomized RGCs. TES (current intensity: 100 μA; pulse duration: 1 ms/phase; frequency: 20 Hz) was applied immediately after ON transection. In the 10 min ES group, the mean density of RGCs was not significantly different from that in the sham group. In the 30 and 60 min groups, the mean density was significantly higher than that in the sham group ($P < 0.001$; each $n = 6$). Statistical analysis among the groups was performed using one-way ANOVA ($P < 0.001$) followed by Tukey test ($^*P < 0.001$ compared with the sham group).

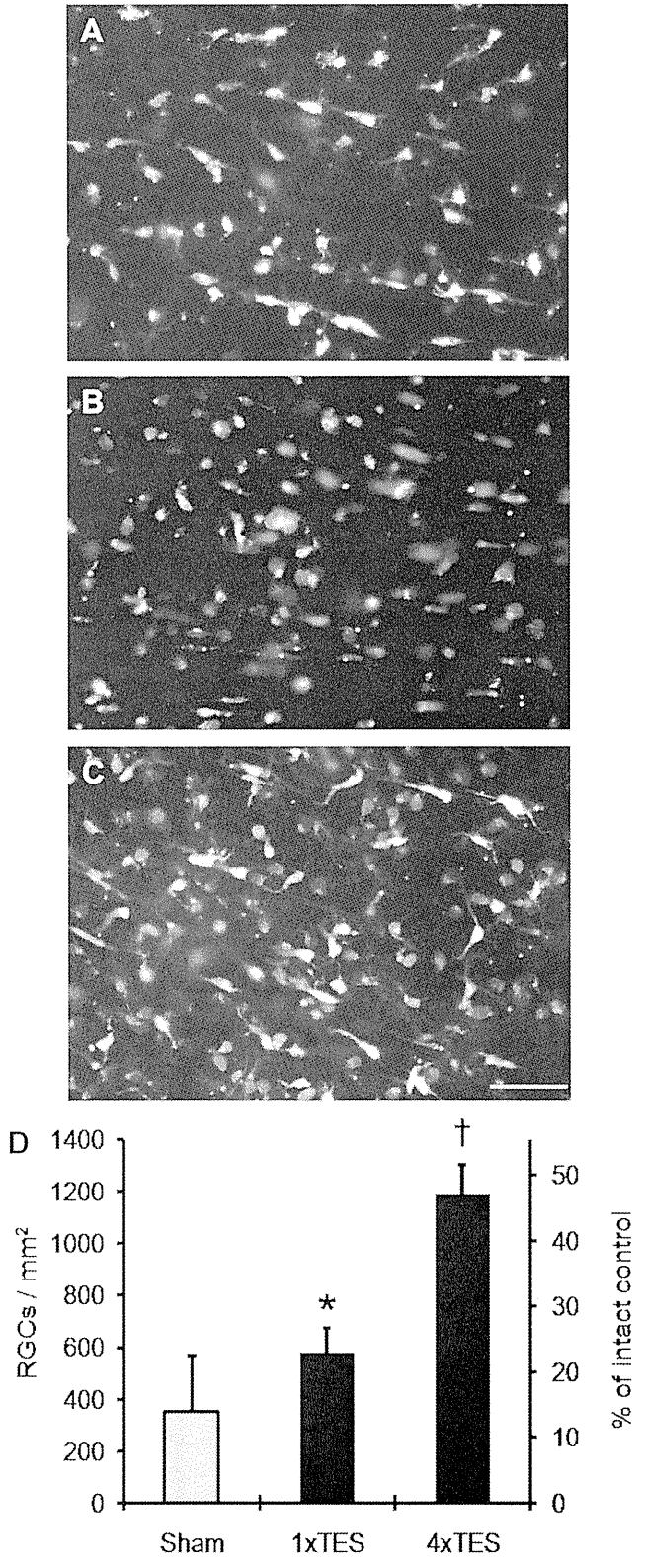

Fig. 6. Effect of repeated TES on the survival of RGCs 14 days after ON transection. Fluorescence photomicrographs of retinas 14 days after ON transection with sham TES (A), with single TES (B) and 4 times TES (C). Only a few FG-labeled RGCs are present 14 days after ON transection with sham stimulation (A). On the other hand single TES increased the viable RGCs (B), and 4× TES further increased the viable RGCs than 1× TES (C), Scale bar = 100 μm. Mean density of RGCs 14 days after ON transection with sham TES was much lower than that in the retina 7 days after ON transection. Although the mean density of RGCs 14 days after ON transection with 1× TES was also lower than that of RGCs 7 days after ON transection with TES, the density remained significantly higher than that with sham TES 14 days after ON transection ($P = 0.02$). Moreover 4× TES significantly increased the surviving RGCs more than single TES 14 days after ON transection ($P < 0.001$). One-way ANOVA: $P < 0.001$, followed by Tukey test: $^{*}P = 0.02$, $^{\dagger}P < 0.001$ comparing with sham group (D).

current intensity than with an increase of pulse duration, the increase of electric current may cause greater tissue damage even if the same amount of electric charge/phase is given. Therefore the neuroprotective effect may be lower with an increase of current intensity than that of pulse duration.

4.2. Frequency-dependent effect of TES on RGC survival

TES of 1–20 Hz frequency had the greatest neuroprotection on RGCs. On the other hand, when the ON stump is stimulated thus stimulating the axons of the RGCs, 20 Hz of ES was the most optimal frequency (Okazaki et al., 2008). It is possible that TES stimulates not only RGCs but also other retinal cells such as the Müller cells to exert its neuroprotective effects. In fact, our earlier study showed that 20 Hz TES increased the expression of IGF-1 in Müller cells *in vivo* (Morimoto et al., 2005) and direct 20 Hz ES to the cultured Müller cells also increased the expression of insulin-like growth factor-1 (IGF-1), brain derived neurotrophic factor (BDNF) and fibroblast growth factor 2 (FGF2) in these cells (Sato et al., 2008a,b,c). Therefore TES might have the wider range of optimal frequencies than the direct stimulation of the ON stump.

In other neural tissues, different frequencies were reported to be optimal. For example, after crushing the spinal cord *in vivo*, ES at 20 Hz also promoted axonal regeneration of the motoneurons (Al-Majed et al., 2000a,b). On the other hand, for cochlear implants high frequency (300 pps) of ES promoted a greater survival of ototoxic spiral ganglion cells (SGCs) than low frequency (30 pps) of ES *in vivo* (Leake et al., 2008). *In vitro* study, not low frequency (20 Hz) but high frequency (50 or 100 Hz) of ES promoted the secretion of BDNF from hippocampal neurons or primary sensory neurons (Balkowiec and Katz, 2000, 2002). ES of dorsal root ganglion (DRG) axons at 20 Hz promoted greater axonal regeneration than 200 Hz (Udina et al., 2008). Thus the optimal frequency of ES to have neuroprotective effects differs for different types of neurons and nervous systems. Because neurons and glial cells have various voltage-sensitive ion channels for each cells, the activation of ion channels may depend on the frequency of ES. For example, Müller cells have voltage-sensitive L-type Ca channel (Xu et al., 2002). We have demonstrated that 20 Hz ES activates voltage-sensitive L-type Ca channels to increase the expression of the mRNAs of IGF-1 and BDNF in cultured Müller cells (Sato et al., 2008a,b). In hippocampal neurons, 100 Hz ES activates the N-type Ca channels to make hippocampal neurons release BDNF (Brosenitsch and Katz, 2001). Another possibility is that high frequency of ES induces greater tissue damage. In the cat's sciatic nerve, ES at 100 Hz and 50 Hz cause the severe neural damage, although ES at 20 Hz induces little or no neural damage (McCreery et al., 1995). Thus it is important to select the suitable frequency of ES applied for each type of neuron.

4.3. Effect of waveforms on the TES-induced neuroprotective effect

TES with symmetric pulse waves increased the number of surviving RGCs more than TES with asymmetric pulse waves, although both pulse waves were charge-balanced. Moreover, longer inter-pulse intervals resulted in less surviving RGCs than TES with no inter-pulse intervals. It is possible that the electric charge might not be balanced well by asymmetrical pulses to cause the tissue damage. Or it is possible that the increase in the inter-pulse interval than the safety limit, might cause the tissue damage. In cochlear

implants, the threshold of auditory nerve response evoked by ES with asymmetric pulse waves is lower than that by ES with symmetric pulse waves and the threshold of auditory nerve response evoked by long inter-pulse intervals is lower than that by the ES without inter-pulse intervals (Macherey et al., 2006). The effects of asymmetrical or symmetrical pulses with long inter-pulse intervals were similar to monophasic pulses (Macherey et al., 2006). These pulses might lead to neural damage with the lower electric charge than the symmetric pulses.

4.4. Stimulation time-dependent effect of TES on RGC survival

TES for 10 min immediately after ON transection did not increase the number of surviving RGCs, but that for 30 min did. This result is similar to that following ES of the transected ON stump (Okazaki et al., 2008). These results indicate that ES to RGCs may influence the intrinsic survival signal or the death signal. It may take more than 30 min of intervention to obtain some survival signals. Further investigation is needed to determine what kind of signals are being induced.

4.5. Single TES vs repeated TES for long-lasting neuroprotection

Fourteen days after ON transection, the densities of surviving RGCs in the retinas with single TES (1× TES) were still higher than in the control retinas without TES. And repetitive TES (4× TES) increased the number of surviving RGCs more than 1× TES. These results indicate that repeated TES has cumulative neurotrophic effects on the long term survival of RGCs. In fact we have demonstrated that TES up-regulates the expression of the mRNA and protein of IGF-1 to rescue axotomized RGCs (Morimoto et al., 2005). Our results suggest that IGF-1 induced by TES might be cumulative and have neuroprotective effects of RGCs continuously for 2 weeks. The mechanism of repetitive TES on the longer term survival of RGCs should be investigated in the future.

5. Conclusions

We performed a systematic analysis of the neuroprotective effect of different stimulus parameters of TES on axotomized RGCs. We concluded that the optimal parameter of TES on the neuroprotection of RGCs are: current intensity of 100–200 μA, pulse duration of 1–3 ms/phase, frequency of 1–20 Hz, stimulation duration of 30–60 min, symmetrical pulse waves without inter-pulse intervals, and repeated stimulations. It is important that stimulation with these optimal parameters with low electric power, is applied for the overall period to maintain long term survival of RGCs. These findings should serve as guideline for ES in humans.

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Efficacy of Suprachoroidal–Transretinal Stimulation in a Rabbit Model of Retinal Degeneration

Kentaro Nishida,[1] *Motohiro Kamei,*[1] *Mineo Kondo,*[2] *Hirokazu Sakaguchi,*[1] *Mihoko Suzuki,*[1] *Takashi Fujikado,*[1] *and Yasuo Tano*[1]

Purpose. To develop a middle-sized animal model of outer retinal degeneration and to evaluate the effectiveness of suprachoroidal-transretinal stimulation (STS) in eliciting cortical potentials from this model.

Methods. Twelve rabbits were intravenously injected with 0.47 mg/kg verteporfin and the retinas were irradiated with a red light for 90 minutes. Fluorescein angiography and full-field and focal electroretinography (ERG) were performed at 7 and 28 days after the irradiation. Electrically evoked potentials (EEPs) were elicited by electrical stimulation, with the STS electrode implanted over the irradiated region, 1 month and 1 year after the irradiation. EEPs were also recorded from three rabbits before and after retinotomy of the normal retina surrounding the degenerated area, to eliminate the influence of stray currents. The retina beneath the site of the STS electrode was examined histologically at 1 month (group 1) and 1 year (group 2) after the irradiation.

Results. An extensive area of degeneration was detected histologically, mainly in the outer retina after the irradiation. Focal ERGs were not recorded when the stimulus was confined to the irradiated area; however, EEPs were successfully elicited by STS of the same area 1 month and 1 year after the irradiation. The 360° retinectomy did not significantly alter the amplitudes, the implicit times, or the thresholds of EEPs evoked by STS.

Conclusions. Verteporfin with light irradiation induces degeneration predominantly in the outer retinal layers in rabbits. The elicitation of EEPs by STS from the degenerated area suggests that the STS system may be useful in patients with retinitis pigmentosa. (*Invest Ophthalmol Vis Sci.* 2010;51:2263–2268) DOI:10.1167/iovs.09-4120

Despite extensive attempts by genetic manipulation and artificial prosthetic devices, a practical solution for the visual decrease in patients with retinitis pigmentosa (RP) has not been obtained. Because some of the inner retinal neurons are somewhat preserved in RP patients,[1,2] several research groups are investigating whether an intraocular retinal prosthesis can restore vision in these patients by activating the functioning neurons.[3–7]

We have developed a new method of stimulating the retina called suprachoroidal-transretinal stimulation (STS),[8] and experiments on normal rabbits[9,10] and RCS rats[11] have shown that electrically evoked potentials (EEPs) can be elicited by stimulating the retina by STS. However, a middle-sized animal model with damage predominantly in the outer retinal layer, as is observed in eyes of RP patients, is needed to evaluate the effectiveness of the STS system more completely. RCS rats, S334ter rats, and P23H rats are established animal models Steinberg RH, et al. *IOVS* 1996;37:ARVO Abstract 3190)[12,13] of degeneration of the outer retinal layers, including the photoreceptors. Unfortunately, a rat eye is relatively small, which makes it difficult to implant an STS system that might be used in humans. A larger size eye model is necessary, because a safe and effective current level has not been determined in eyes of a size comparable to that of humans.

Several dog models of retinal degeneration have been identified,[14–16] but investigating a group of dogs is difficult because of the cost and labor. Thus, the purpose of this study was to develop a middle-sized animal model with predominant degeneration of the outer retinal layer which is easily available, not expensive, and easy to handle. We selected the commonly used laboratory rabbit, and induced degeneration of the outer retinal layers including the photoreceptors by photochemical damage with verteporfin. We then evaluated the efficacy of the STS system in this model.

Materials and Methods

Animals

Twelve eyes of 12 Dutch-belted rabbits (weighing 2.0–2.3 kg; Biotech, Saga, Japan) were used. All procedures conformed to the ARVO Statement for the Use of Animals in Ophthalmic and Vision Research. Every effort was made to minimize animal discomfort and to limit the number of animals to that necessary to obtain statistical significance. Nine rabbits were used for developing the retinal degeneration and the functional evaluation of the STS system; five rabbits (group 1) were used for the evaluation at 1 month, and four rabbits (group 2) were used for the evaluation at 1 year. An additional three rabbits (group 3) were used to test the validity of the model.

Light Irradiation with Verteporfin

Rabbits were anesthetized with an intramuscular injection of ketamine (33 mg/kg) and xylazine (8.5 mg/kg), and the pupils were dilated with 0.5% tropicamide and 0.5% phenylephrine hydrochloride. Verteporfin (Visudyne; Novartis, Basel, Switzerland) was injected through an ear vein at a dose of 0.47 mg/kg. This dose was determined from the results of a study of photodynamic therapy (PDT) in monkeys[17] and the results of our pilot study with 0.24, 0.47, and 0.96 mg/kg of verteporfin in rabbits. Verteporfin was reconstituted as recommended by the manufacturer.

Light irradiation was applied 5 minutes after the verteporfin infusion. A red light-emitting diode (LED; MCEP-CR8; Moritex, Tokyo, Japan) with peak emission at 630 nm was placed next to the surface of the diffuser contact lens (illuminance was 8.0×10^4 lux). The retina was irradiated from three directions—the center, nasal, and temporal

From the [1]Department of Ophthalmology, Osaka University Graduate School of Medicine, Suita, Japan; and the [2]Department of Ophthalmology, Nagoya University Graduate School of Medicine, Nagoya, Japan.

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Corresponding author: Motohiro Kamei, Department of Ophthalmology, Osaka University Graduate School of Medicine, 2-2 Yamadaoka, E7, Suita, 565-0871, Japan; mkamei@ophthal.med.osaka-u.ac.jp.

to the visual streak—with an irradiation duration of 30 minutes in each direction, which resulted in a total irradiation time of 90 minutes.

Fundus Photography and Fluorescein Angiography

Fundus photography and FA were performed with a fundus camera (TRC-50IX; Topcon, Tokyo, Japan), with the animals under general anesthesia before and at 1 month (group 1) and 1 year (group 2) after the irradiation with verteporfin. For FA, 0.075 mL/kg of 10% sodium fluorescein was injected intravenously.

Full-Field ERGs

Dark-adapted, full-field ERGs were recorded in all group 1 rabbits, 1 month after the light exposure. After 20 minutes of dark adaptation and pupil dilation, the rabbits were anesthetized with an intramuscular injection of ketamine (40 mg/kg) and xylazine (4 mg/kg), and the ERGs were picked up with a corneal Burian-Allen bipolar electrode (Hansen Ophthalmic Development Laboratories, Iowa City, IA). The rabbits were placed in a Ganzfeld bowl and stimulated with stroboscopic stimuli of 1.7 log cd-s/m^2 (photopic units). Ten responses were averaged with a stimulus interval of 10 seconds. The a-wave amplitude was measured from the baseline to the first negative trough, the b-wave from the negative trough to the positive peak.

Focal ERGs

Focal ERGs were recorded from all group 1 rabbits, 1 week and 1 month after irradiation. The techniques used for eliciting and recording focal ERGs have been described in detail.[18,19] Briefly, focal ERGs were elicited by placing the stimulus spot on the visual streak. The position of the spot on the fundus was monitored during the recording with a modified infrared fundus camera. The same Burian-Allen bipolar contact lens electrode was used to record the focal ERGs. The luminances of the stimulus and the background were 30.0 and 3.0 cd/m^2, respectively. A 5- or 30-Hz rectangular stimulus (50% on and 50% off) was used, and a 15° stimulus spot was placed on the visual streak. A total of 512 responses were averaged by a signal processor, and the time constant was 0.03 second with a 300-Hz high-cut filter.

Electrical Stimulation and Recording of EEPs at the Visual Cortex

Cortical Electrodes. With the animal under deep general anesthesia, the top of the skull was exposed and 1-mm holes were drilled through the skull 8 mm anterior to the lambdoid suture and 7 mm to the right and left of the midline. Then, screw-type stainless steel recording electrodes coated with silver, were screwed into the skull to make electrical contact with the dura mater. The reference electrode was then screwed into the skull at the bregma.

Stimulating Electrode. A single stimulating electrode was used. The wire (90% platinum, 10% iridium; diameter, 60 μm) was insulated with silicon and embedded in a 2-mm horizontal × 5.5-mm vertical × 0.1-mm-thick parylene plate. The tip of the wire was connected to a 500-μm-diameter single stimulating platinum electrode (see Fig. 3A). The inferior surface of the sclera was exposed by cutting the inferior rectus and the inferior oblique muscles. A scleral pocket (3 × 5 mm) was created just over the irradiated area on the visual streak. The electrode plate was then implanted into the scleral pocket and sutured with 5-0 Dacron onto the sclera just above the pocket. The insulated strand lead from the electrode was sutured at the limbus with 5-0 Dacron. The implanted electrode was confirmed to be located just under the damaged area of the visual streak by binocular ophthalmoscopy.

An electronic stimulator (SEN-7203; Nihon Kohden, Shinjyuku, Japan) was connected through a stimulus isolation unit (A-395R; World Precision Instruments, Sarasota, FL) to the STS electrode. The reference electrode was a platinum wire coated with polyurethane resin, and approximately 3 mm of the tip was exposed. The wire was inserted into the vitreous cavity and was fixed 1 mm posterior to the limbus with 8-0 Vicryl.

Eliciting EEPs

EEPs were recorded 1 month (groups 1 and 3) and 1 year (group 2) after irradiation. The electrical stimulating current was change from 50 to 1000 μA, and biphasic pulses were used for the electrical stimulation. The biphasic pulses consisted of current flowing from the vitreal electrode to the STS electrode in one phase and with current flowing from the STS electrode to the vitreal electrode. The duration of both phases was 0.5 ms. The threshold current for eliciting an EEP was determined by decreasing the electric current in steps. The minimum electric current that elicited the first or second positive peak of the EEP (P1 or P2) was defined as the threshold current. The EEP amplitude was measured from the baseline to the first positive trough.

Assessing Validity of This Model

To investigate the influence of stray current beyond the degenerative area where the STS stimulating electrode was placed, we removed 360° of the normal retina surrounding the degenerated area by vitrectomy and retinectomy. EEPs were recorded from the degenerated retina immediately after the retinectomy by stimulating with the STS electrode in three irradiated eyes (group 3; Figs. 3C1, 3C2). Then, EEPs were recorded before and again immediately after retinectomy in those eyes that had only the degenerated retina and optic nerve.

Histologic Study

Histologic studies were performed in the areas where the electrode was placed 1 month (group 1) and 1 year (group 2) after, to ensure that the outer retina was degenerated. After the EEPs were recorded, the stimulating electrode was removed from the eye, and the rabbits were euthanatized with a 5-mL intravenous injection of pentobarbital (50 mg/mL). The eyes were enucleated, fixed with 4% paraformaldehyde, dissected, and embedded in optimal cutting temperature compound (Tissue-Tek; Sakura Finetechnical Co. Ltd. Tokyo, Japan). Cryosections of 7-μm thickness were cut and stained with hematoxylin and eosin. The sections were examined under a light microscope and photographed with a CCD camera (AxioCam; Carl Zeiss Japan, Tokyo, Japan). The images were then analyzed (AxioVision 2.0 software for Windows; Carl Zeiss Japan). The numbers of nuclei in the outer nuclear layer (ONL), inner nuclear layer (INL), and ganglion cell layer (GCL) were counted at ×40 magnification in all eyes from groups 1 and 2. Three sections from each eye were counted; at the center of the stimulating electrode, and at ±500 μm away from the electrode. Sections were oriented along the visual streak.

Statistical Analyses

The Mann-Whitney test was used to calculate the significance of the differences in the full-field ERGs, EEPs, and cell counts between control and irradiated eyes. Paired *t*-tests were used to calculate the significance of the differences in the EEPs before and after retinectomy in group 3. $P < 0.05$ was considered statistically significant (all analyses: SigmaStat, ver.2.0; Systat, San Jose, CA).

Results

Retinal Degeneration Model

A well-defined chorioretinal atrophy was observed in all eyes by indirect ophthalmoscopy at 1 month after the irradiation. In addition, a hypofluorescent area, that corresponded to the area of the chorioretinal atrophy was seen by FA. The lesion and the hypofluorescent area remained unchanged for 1 year, whereas the area of occluded choriocapillaris increased (Figs. 1A–F).

Histologic Examination of the Retina beneath the Electrode

Photoreceptors and nuclei in the ONL were almost completely absent beneath the area where the electrode array was placed. The relative number of cells (experimental eye/control eye)

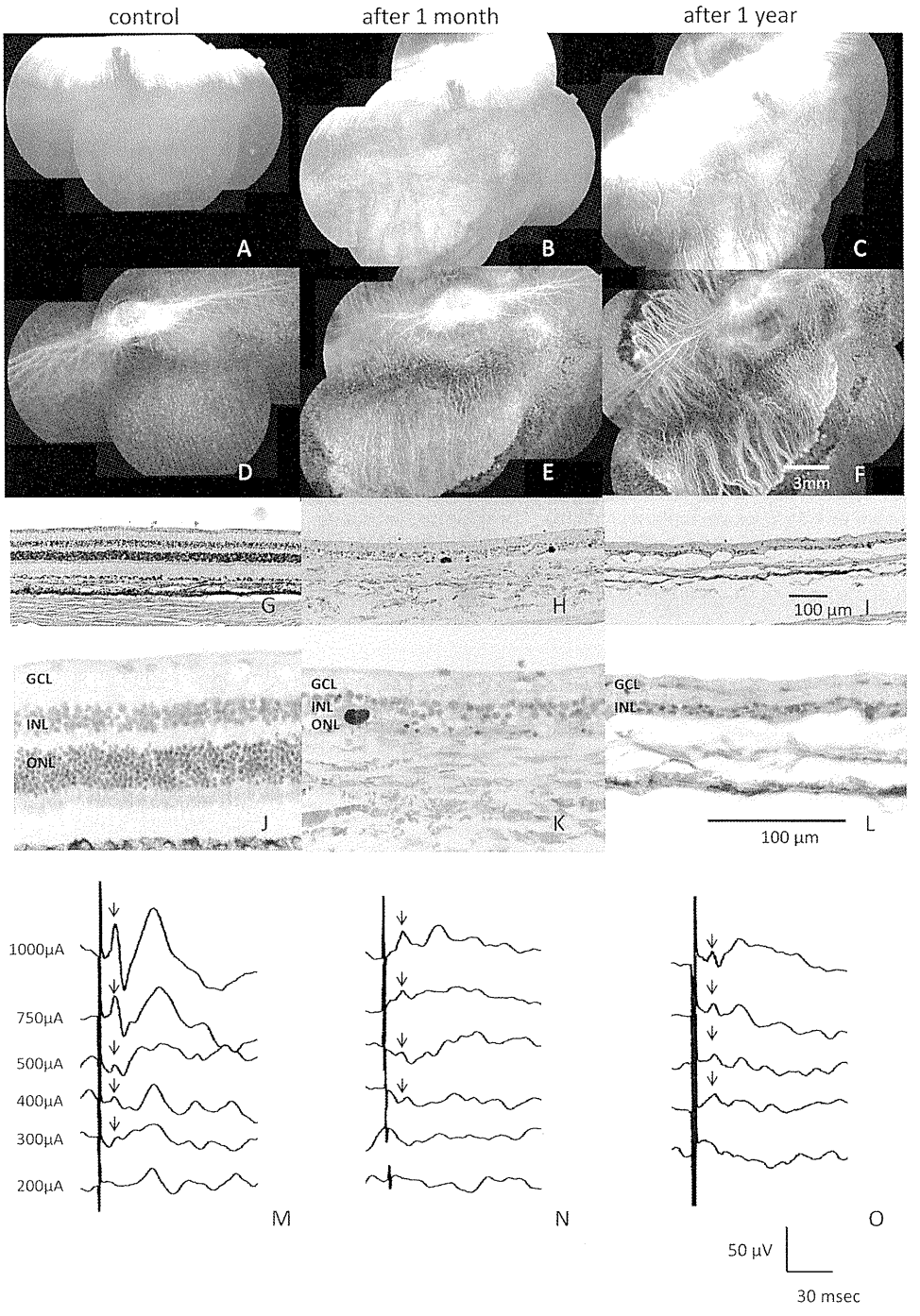


FIGURE 1. Representative fundus photographs (**A–C**), fluorescein angiograms (**D–F**), photomicrographs of the area where the electrode was placed (**G–L**), and EEPs (**M–O**) of the control and irradiated eyes at 1 month and 1 year after the irradiation with a red LED after intravenous verteporfin. (**B**, **C**, **E**, **F**) Atrophy of RPE and choriocapillaris can be seen. The occlusion of the choriocapillaris continued to be present at 1 year (**F**). Histopathology of the control eye (**G**, **J**) showed that the ONL and outer layers were fibrotic (**H**, **I**, **K**, **L**). At 1 year, the atrophy of the choroid had progressed, and the number of cells in the INL had decreased but the GCL was preserved (**I**, **L**). Scale, 100 μm. The EEPs (*arrows*) recorded after biphasic electrical pulses from the STS electrodes implanted in the control eye and degenerated eyes at 1 month and 1 year after irradiation.

was reduced to 1.5% ($P = 0.003$) in the ONL, to 56.8% ($P = 0.006$) in the INL, and to 84.5% ($P = 0.317$) in the GCL (Figs. 1G–L; Table 1). At 1 year after irradiation, the cell counts in the INL were reduced to 66% ($P = 0.004$) of the control, but those in the GCL were not significantly reduced ($P = 0.903$).

Full-Field and Focal ERGs

Representative waveforms of the dark-adapted, full-field ERGs are shown in Figure 2A, and the means ± SDs of the amplitude and implicit times of the a- and b-waves are shown in Figure 2B. We found that the amplitudes of both the a- and b-waves were reduced to about one half of the control ERGs ($P < 0.05$) at 1 month after irradiation (group 1). There was no significant difference in the implicit times of the a- and b-waves before and after the irradiation ($P = 0.548$ and $P = 0.095$).

We then recorded focal ERGs to examine the retinal function in the irradiated area. We could not record any responses with the stimulus spot placed on the irradiated area from all the eyes. The amplitudes of focal ERGs were less than the noise level (0.3 μV) for all rabbits (Fig. 2C), whereas focal ERGs with both 5- and 30-Hz stimuli from all the control eyes were recorded.

Evaluation of STS

EEPs were successfully elicited by STS from all eyes in all groups (Figs. 1M–O, 3D, 3E). The mean threshold current evoking the EEP in the irradiated eyes at 1 month after irradiation was 431.3 ± 143.8 μA and that of the control eyes was 360.0 ± 114.0 μA. This difference was not significant ($P = 0.262$). The average current density was 20.5 and 16.4 $\mu C/cm^2$

TABLE 1. Cell Counts in the Control and Irradiated Eyes

	ONL	INL	GCL
Control	475.8 ± 84.9	186.0 ± 31.2	14.8 ± 3.9
1 Month after irradiation	7.0 ± 10.3	105.6 ± 31.1	12.5 ± 3.8
P^*	**0.003**	**0.006**	0.317
1 Year after irradiation	0	69.3 ± 32.4	14.4 ± 3.3
P^*	**0.004**	**0.004**	0.903

Data are expressed as the mean ± SD.

* Mann-Whitney Rank Sum Test with significant differences in bold.

for the irradiated and control eyes, respectively ($P = 0.262$). The implicit times of the first positive waves of the EEPs in the irradiated eyes and in the control eyes were 13.4 ± 8.7 and 17.1 ± 12.4 ms, respectively ($P = 0.662$). The mean threshold current of the irradiated eyes 1 year after irradiation was 300.0 ± 141.4 μA (group 2) and was 233.3 ± 115.5 μA in the control eyes. None of these differences was significant ($P = 0.400$). The averaged electrical density was 13.6 and 10.6 $\mu C/cm^2$ for the irradiated and the control eyes, respectively ($P = 0.400$). The implicit times of the first positive waves of the EEPs in irradiated eyes and in control eyes were 17.9 ± 4.7 and 13.9 ± 5.9 ms ($P = 0.229$).

There was no significant difference in the threshold current of the irradiated eyes at 1 month (431.3 ± 143.8 μA) and 1 year (300.0 ± 141.4 μA) after the irradiation ($P = 0.413$).

Influence of Stray Current

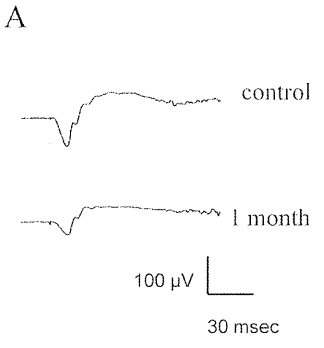
The threshold current for evoking the EEPs in group 3 was 400 ± 0 μA before the retinectomy and 400 ± 0 μA after the retinectomy. The means ± SDs of the amplitude and implicit times of EEPs elicited by 1000, 750, 500, and 400 μA are shown in Figures 3F1 and 3F2. There was no significant difference in the amplitude and the implicit times of EEPs before and after retinectomy ($P = 0.058$–0.716). Thus, removing the nonirradiated retina from the degenerated retina and optic nerve did not reduce the EEPs.

DISCUSSION

In a pilot study, we irradiated eyes with stronger light and for longer durations (24 hours) without verteporfin and failed to damage large areas of the outer retinal layer. We, therefore, used verteporfin according to a report on the predominant damage of the outer retinal layer by repeated PDT.[17] We also chose a red LED for the light source because the LED light does not generate heat as easily as do other light sources, and 630 nm is the peak excitation wavelength of verteporfin.[20,21]

We then conducted another pilot study to develop a retinal degeneration model with verteporfin and a red LED. We changed the dose of verteporfin (0.24, 0.47, and 0.96 mg/kg), total irradiation time (45 and 90 minutes), irradiation direction (1 and 3 directions) and distance (0 and 15 mm), and finally succeeded in creating substantial damage to the outer retinal layers with a dose of 0.47 mg/kg verteporfin and irradiation from 3 directions for 30 minutes, each when the red LED was placed just in front of the diffuser contact lens. These conditions induced retinal degeneration in which the outer retinal layers were preferentially damaged and the inner retinal layers were relatively well preserved. In addition, the damage was extensive and uniform. We conclude that our technique of photochemical damage with verteporfin and a red LED light can produce retinal degeneration resembling the histologic characteristics of eyes of patients with RP.

The amplitudes of the full-field ERGs remained about one half that of the controls (Figs. 2A, 2B) because the degenerated region did not cover the entire retina (Figs. 1A–F). In contrast, focal ERGs were not elicited when the stimulus spot was placed on the degenerated area (Fig. 2C). This result corresponded with the histologic findings that the outer retinal layers were almost completely absent in the irradiated area (Figs. 1G–L). However, the inner retinal layers were somewhat intact in the damaged region, which is known to be characteristic of the end stage of human RP.[2] These results demonstrated that the damaged region of this model resembled the



B

	Control	Post-1M	*P* Value
Amplitude(μV)			
a-wave	68.8±24.7	33.6 ±8.8	***P**=0.016*
b-wave	203.8 ±85.2	108.7±24.1	***P**=0.008*
Implicit time(ms)			
a-wave	11.2±0.6	10.7±1.2	*P*=0.548
b-wave	39.4 ±4.4	34.2±6.0	*P*=0.095

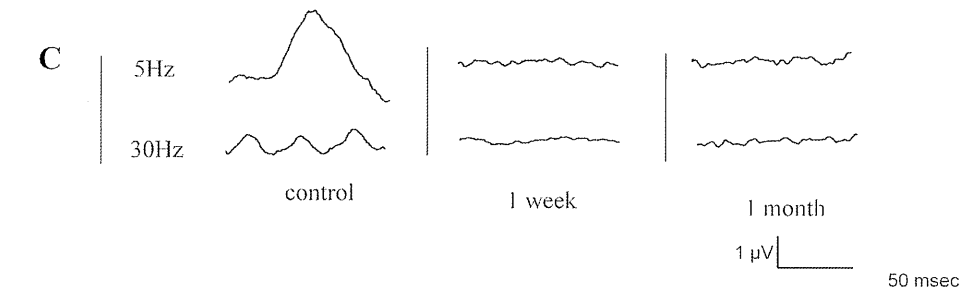
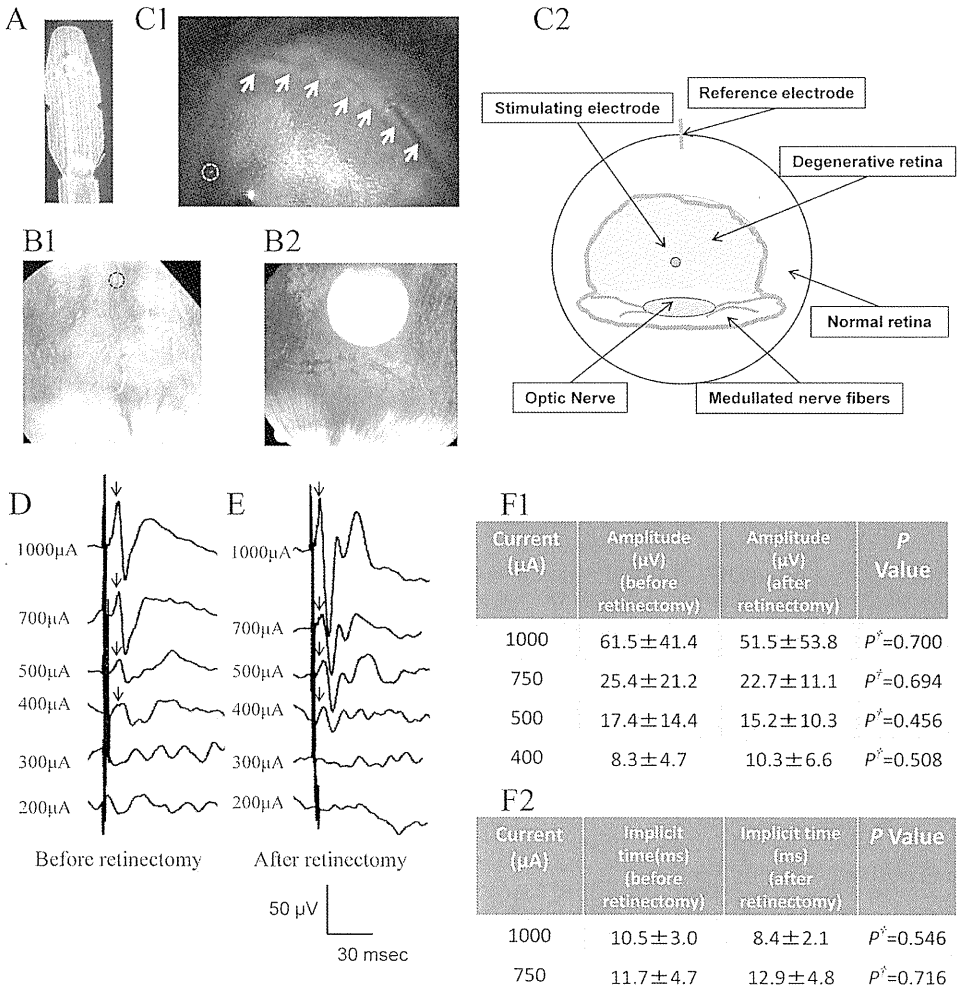


FIGURE 2. Representative full-field (A) and focal (C) ERGs at 1 month after irradiation. The amplitudes of the a- and b-waves at 1 month were reduced to one half of the control value (B). Data are shown as the means ± SD. *Mann-Whitney rank sum test with significant differences in *bold*.



F1

Current (μA)	Amplitude (μV) (before retinectomy)	Amplitude (μV) (after retinectomy)	*P* Value
1000	61.5±41.4	51.5±53.8	*P*†=0.700
750	25.4±21.2	22.7±11.1	*P*†=0.694
500	17.4±14.4	15.2±10.3	*P*†=0.456
400	8.3±4.7	10.3±6.6	*P*†=0.508

F2

Current (μA)	Implicit time(ms) (before retinectomy)	Implicit time (ms) (after retinectomy)	*P* Value
1000	10.5±3.0	8.4±2.1	*P*†=0.546
750	11.7±4.7	12.9±4.8	*P*†=0.716
500	12.2±5.1	11.0±5.8	*P*†=0.339
400	14.0±5.8	11.4±6.0	*P*†=0.058

FIGURE 3. Inserted STS electrode and isolated degenerated retina and representative EEPs. (**A**) STS electrode (diameter 500 μm) inserted in the degenerated area (**B1**, *dotted black outline*) was apparently smaller than the photic stimuli for focal ERGs (**B2**). Retinectomy was performed (**C1**, *white arrows*) along the border of the degenerative retina and normal retina (**C2**, *red line*); inserted STS electrode (**C1**, *dotted white outline*) and representative EEPs (*black arrows*) before (**D**) and after retinectomy (**E**). The amplitudes (**F1**) and the implicit times (**F2**) of the EEPs after retinectomy were not significantly different from those before the retinectomy. Data are the mean ± SD. †Paired *t*-tests.

histologic and physiological characteristics of eyes of patients with RP.

Despite the absence of focal ERGs when the stimulus was placed on the damaged area (Fig. 2C), EEPs could still be elicited by the STS electrode placed beneath the irradiated area (Figs. 1N, 3B1, 3B2). These results indicate that the STS electrode can stimulate the inner retina in the area that has been damaged by the irradiation to evoke EEPs. One year after irradiation, the ONL had entirely disappeared, and even the INL was significantly decreased but partially remained as shown in the histologic sections (Fig. 1L, Table 1).

Because the EEPs are evoked from ganglion cells and partly from bipolar cells, even though the ONL was completely absent, the EEPs at 1 year after the irradiation were not significantly different from those recorded 1 month after the irradiation.

However, the EEPs may have been evoked by stray currents that stimulated functioning neurons some distance from the irradiated area. To eliminate this possibility, we removed the normal retina surrounding the degenerated area by retinectomy. Our findings showed that EEPs of the same amplitude and thresholds could still be elicited. Thus, we conclude that the EEPs were not elicited by stray currents (Figs. 3C–F). In addition, these findings demonstrate that the degenerated area with our parameters of photocoagulation was large enough to evaluate the effect of the STS system.

The shapes of the EEPs in our rabbits were different from those of RCD1,[22,23] which may be because of the differences in retinal prosthesis, the number of stimulating electrodes, and the current densities.

Earlier studies[24–33] reported that an intravenous administration of either monoiodoacetic acid (IAA) or sodium iodate ($NaIO_3$) can damage the retina. IAA is well known to be retinotoxic and to damage the photoreceptors selectively,[25–27] and the damage of the inner retinal layer is much less severe than that of the outer retinal layers.[24,28] However, the effect of this toxin is uneven among individuals and occasionally even between the eyes of the same animal.[28] Liang et al.[28] injected IAA intravenously at a dose of 20 mg/kg into 23 rabbits and found a uniformly decreased ONL in only 3 eyes, partial damage of the ONL in 9 eyes, and no change in 11 (48%) eyes. Because a dose of 20 mg/kg IAA is relatively high and results in a high mortality (20%),[29] increasing the dose of this drug to damage the ONL more uniformly is not practical. Our method has the advantages that a predominant outer retinal degeneration can be created with almost 100% certainty.

There are many reports[30–33] on the $NaIO_3$-induced retinal degeneration. Sorsby[31] injected different concentrations of $NaIO_3$ (10–60 mg/kg) into rabbits intravenously and concluded that an incidence of 100% of retinal lesions was attained at a dose of 25 mg/kg. But he did not evaluate the size of the lesions. In another study[32] an injection of $NaIO_3$ at a dose of 25