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Transcerebral Exchange Kinetics of Nitrite and Calcitonin Gene-Related Peptide in Acute Mountain Sickness
Evidence Against Trigeminovascular Activation?

Damian M. Bailey, PhD, FRSC; Sarah Taudorf, MD; Ronan M.G. Berg, MD; Lars T. Jensen, MD, DMSc; Carsten Lundby, PhD; Kevin A. Evans, MSc; Philip E. James, PhD; Bente K. Pedersen, MD, DMSc; Kirsten Moller, MD, PhD, DMSc

Background and Purpose—High-altitude headache is the primary symptom associated with acute mountain sickness, which may be caused by nitric oxide-mediated activation of the trigeminovascular system. Therefore, the present study examined the effects of inspiratory hypoxia on the transcerebral exchange kinetics of the vasoactive molecules, nitrite (NO₂), and calcitonin gene-related peptide (CGRP).

Methods—Ten males were examined in normoxia and after 9-hour exposure to hypoxia (12.9% O₂). Global cerebral blood flow was measured by the Kety-Schmidt technique with paired samples obtained from the radial artery and jugular venous bulb. Plasma CGRP and NO₂ were analyzed via radioimmunoassay and ozone-based chemiluminescence. Net cerebral exchange was calculated by the Fick principle and acute mountain sickness/headache scores assessed via clinically validated questionnaires.

Results—Hypoxia increased cerebral blood flow with a corresponding increase in acute mountain sickness and headache scores (P<0.05 vs normoxia). Hypoxia blunted the cerebral uptake of NO₂, whereas CGRP exchange remained unaltered. No relationships were observed between the change (hypoxia–normoxia) in cerebral NO₂ or CGRP exchange and acute mountain sickness/headache scores (P>0.05).

Conclusion—These findings argue against sustained trigeminovascular system activation as a significant event in acute mountain sickness. (Stroke, 2009;40:2205-2208.)

Key Words: acute mountain sickness ■ brain ■ calcitonin gene-related peptide ■ hypoxia ■ gene-related peptide ■ nitrite

High-altitude headache is the most common central nervous system complication that occurs in response to the inspiratory hypoxia of high altitude. Recent evidence suggests that it is not directly attributable to mild high-altitude cerebral edema defined by vasogenic edematous brain swelling or intracranial hypertension. The prophylactic benefits of sumatriptan suggests that activation of the trigeminal vascular system may prove an alternative mechanism.

To explore this in more detail, the present study examined the effects of hypoxia on the cerebral metabolism of nitrite (NO₂), an important intravascular reserve of nitric oxide (NO), and calcitonin gene-related peptide (CGRP). These vasoactive molecules act synergistically to promote neurogenic vasodilatation and trigeminal vascular system activation, which is considered the primary mechanism responsible for vascular headaches at sea level. We hypothesized that if NO-mediated trigeminal vascular system activation is implicated in the pathophysiology of acute mountain sickness (AMS), hypoxia would result in a cerebral uptake or consumption of NO₂, thus increasing the bioavailable pool of NO. We further reasoned that this would stimulate the synthesis and net cerebral output of CGRP that would be positively related to corresponding symptom scores.

Materials and Methods

Subjects and Design

Ten healthy males aged 27 (mean)±4 (SD) years without any history of headache, migraine, or AMS provided written informed consent following approval by the Scientific Ethics Committee of Copenhagen and Frederiksberg Municipalities (Denmark). Catheters were placed under local anesthesia in the radial artery and the right internal jugular vein via ultrasound guidance with the tip pointing cranially. After 30 minutes of supine rest, measurements were obtained in normoxia (21% O₂), and measurements were obtained after 9 hours of passive exposure to normobaric hypoxia (12.9% O₂).
Table 1. Cerebral Hemodynamics

<table>
<thead>
<tr>
<th>Condition Sample Site</th>
<th>Normoxia</th>
<th>Hypoxia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Arterial</td>
<td>Venous</td>
</tr>
<tr>
<td>PO2 (mm Hg)</td>
<td>107±6</td>
<td>38±2*</td>
</tr>
<tr>
<td>SO2 (%)</td>
<td>99±1</td>
<td>66±2</td>
</tr>
<tr>
<td>PCO2 (mm Hg)</td>
<td>43±2</td>
<td>53±2*</td>
</tr>
</tbody>
</table>

Note: CPF/CFP indicates global cerebral blood/plasma flow expressed in absolute values and adjusted for changes in PaCO2; PO2/PCO2, partial pressure of oxygen/carbon dioxide; SO2, oxyhemoglobin saturation.

Bonferroni-corrected paired post hoc tests confirmed distribution normality. Data were presented as mean±SD.

Results

Cerebral Hemodynamics

Hypoxia resulted in marked arterial hypoxemia as reflected by a reduction (P<0.05 vs normoxia) in PaO2, SaO2, and Paco2 (Table 1). Global CBF (absolute and Paco2-adjusted values) and corresponding CPF tended to increase, thus preserving cerebral O2 delivery.

Cerebral Metabolic Exchange

Normoxia was associated with a positive a-v difference and, hence, net cerebral influx or uptake of NO2 (Figure, A and B), whereas CGRP exchange was unremarkable (Figure, C and D). Hypoxia blunted the cerebral uptake of NO2 primarily to a decrease in arterial delivery, whereas no changes were observed in systemic or cerebral CGRP metabolism.

Cephalalgia

Hypoxia increased the severity of AMS and corresponding headache scores (Table 2), although these were unrelated to any of the changes observed in CBF (r=0.26–0.44; P>0.05) or cerebral exchange of NO2 (r=0.42–0.14, P>0.05) and CGRP (r=−0.13–0.08; P>0.05).

Discussion

These findings fail to support our original hypothesis and contrast with some of the observations reported in the migraine (without aura) literature, a complication of the central nervous system that shares phenotypic characteristics that are virtually indistinguishable from those encountered in AMS. Goadsby et al14 were the first to document increased CGRP levels in the external jugular venous blood of patients during migraine attack, a finding that has since been replicated in cubital venous15 and internal jugular venous16 blood. Furthermore, CGRP infusion causes migraine-like head-
ache,\(^{17}\) and antagonism with BIBN 4096 BS provides effective prophylaxis.\(^{18}\) However, these findings have not been consistently reproduced caused, in part, by weak experimental design using historic control subjects and technical deficiencies associated with the accurate measurement of CGRP. Using an intrapatient comparative design and a more sensitive radioimmunoassay, a recent study failed to confirm any difference in CGRP levels from cubital and external jugular venous blood of patients during and outside of migraine attack without aura.\(^{11}\) This agrees with our current findings that adopted a similar experimental approach specifically designed to minimize the considerable interindividual variation associated with resting levels of CGRP. Incorporation of a homogenous group of apparently healthy males in the resting state excluded the potential confounding influence and interpretive complications associated with differences in sex, age, arterial hypertension, pregnancy, contraceptive pill use, and exercise on resting CGRP levels.\(^{11}\) Thus, we remain confident that the lack of CGRP output across the brain reflects the true physiological response to hypoxia and is not an artifact caused by methodological limitations.

However, because the half-life of CGRP has been estimated at only a few minutes,\(^{19}\) we cannot exclude acute release from trigeminal perivascular nerve fibers, the site of migraine nociception, during the initial early phase of hypoxia. It is conceivable that the decreased arterial delivery of NO\(^2\) may reflect an increase in the systemic rate of NO\(^2\) reduction by deoxyhemoglobin to increase the intravascular pool of bioavailable NO\(^2\) (Hb-Fe\(^2^+\)+NO\(^2\)-H\(^+-\)→Hb-Fe\(^3^+\)+NO+OH\(^–\)). The increase in NO may not only serve as a countermeasure to effect cerebral vasodilatation to preserve oxidative metabolism in the face of prevailing hypoxemia but may have also stimulated focal CGRP synthesis and release resulting in neurogenic vasodilatation, inflammation, hyperalgesia, and allodynia.\(^{20}\) Alternatively, the blood–brain barrier, which we have shown to remain mostly intact during hypoxia,\(^{13}\) may have also prevented intrathecally formed CGRP from entering the extracranial circulation in sufficient amounts to permit molecular detection.

However, what is apparent from the current findings is that the lack of CGRP exchange at 9 hours excludes sustained steady-state release of CGRP as the primary cause of AMS. Because accumulating evidence suggests that CGRP is considered a biological marker of peripheral trigeminal vascular system activation,\(^{6}\) our findings suggest that alternative mechanisms are likely responsible for the high-altitude headache observed in AMS.

Table 2. Cephalalgia

<table>
<thead>
<tr>
<th>Condition</th>
<th>Normoxia</th>
<th>Hypoxia</th>
</tr>
</thead>
<tbody>
<tr>
<td>LL (points)</td>
<td>0±0</td>
<td>3±2(^*)</td>
</tr>
<tr>
<td>ESQ-C (AU)</td>
<td>0.000±0.000</td>
<td>0.803±0.674(^*)</td>
</tr>
<tr>
<td>VAS (mm)</td>
<td>0±0</td>
<td>29±23(^*)</td>
</tr>
</tbody>
</table>

LL indicates Lake Louise; ESQ-C, Environmental Symptoms Questionnaire-Cerebral Symptoms; VAS, Visual Analogue Scale scores.
\(^*\)Different vs normoxia (\(P<0.05\)).
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Disclosure
None.

References