Receptor mechanisms of serotonin-induced prenodal lymphatic constriction in the canine forelimb

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Dobbins, David E. Receptor mechanisms of serotonin-induced prenodal lymphatic constriction in the canine forelimb. Am. J. Physiol. 274 (Heart Circ. Physiol. 43): H650–H654, 1998.—Numerous endogenous vasoactive agents have been shown to cause lymphatic smooth muscle contraction. In this study, we assessed the ability of serotonin (5-HT) to alter lymphatic smooth muscle activity and elucidated the receptor mechanisms of 5-HT’s actions. Both intralymphatic and intra-arterial administration of 5-HT significantly increased lymphatic smooth muscle activity in lymphatics perfused at constant flow, as indicated by an increase in lymphatic perfusion pressure. The 5-HT-induced increase in lymphatic perfusion pressure is attenuated but not blocked by the intra-arterial infusion of phentolamine, suggesting the involvement of α-adrenergic receptors and 5-HT receptors. Intralymphatic infusion of the 5-HT2-receptor-agonist 5-hydroxytryptamine significantly increased lymphatic perfusion pressure, either alone or when administered into an α-receptor blocked preparation, whereas the 5-HT1-receptor-agonist carboxamidotryptamine maleate did not affect the prenodal lymphatics. These data indicate that the lymphatic smooth muscle contraction produced by 5-HT is mediated both by lymphatic α-adrenergic receptors and 5-HT2 receptors.

lymphatic contractility; lymphatic smooth muscle; transvascular fluid flux; prenodal lymphatics; lymphatic function

THE LYMPHATIC SYSTEM is crucial to the maintenance of circulatory homeostasis in that it returns critical amounts of fluid and protein to the circulation daily. Several studies have suggested that alterations in lymphatic smooth muscle activity play a pivotal role in determining lymph flow, hence impacting lymphatic function under both normal and pathophysiological conditions (13, 14, 16, 18). We have previously shown that lymphatic smooth muscle contracts in response to the intralymphatic administration of numerous endogenous vasoactive agents, including epinephrine, norepinephrine, acetylcholine, histamine, bradykinin, prostaglandins, endothelin-1, platelet-activating factor, and neurokinin A (4, 5, 7–10). Additionally, intra-arterial infusion of many of these agents also results in significant lymphatic smooth muscle contraction.

To date, the receptor mechanisms by which endogenous vasoactive agents produce prenodal lymphatic smooth muscle contraction and relaxation in vivo have not been adequately addressed. Ascertainment of specific receptor mechanisms by which endogenous agents contract or relax lymphatic smooth muscle will help to identify pharmacological targets (receptors) through which the drainage function of the lymphatic system could be enhanced to clinically manage edema. Previous studies have shown that the receptor mechanisms involved in the mediation of lymphatic constriction can be studied by administering vasoactive agents intralymphatically before and during intra-arterial administration of appropriate receptor antagonists. By this approach, we have shown that constriction of prenodal lymphatics by either epinephrine or norepinephrine can be blocked by the intra-arterial infusion of the equipotent α1- and α2-receptor-antagonist phentolamine (6). These data indicated that epinephrine- and norepinephrine-induced lymphatic constriction is mediated through stimulation of prenodal lymphatic α-receptors. Additionally, since the specific α1-receptor-agonist prazosin attenuates but does not completely block epinephrine and norepinephrine-induced lymphatic smooth muscle activation, it appears that both α1- and α2-receptors are involved. This interpretation of the antagonist data was confirmed by the fact that both the α1-receptor-agonist phenylephrine and the α2-receptor-agonist α-methyl norepinephrine also significantly constrict prenodal lymphatics (6).

Serotonin (5-HT) has been proposed to play a significant role in both normal and pathophysiological circulatory conditions, such as ischemic heart disease (where loss of 5-HT-induced vasodilation subsequent to down-regulation of the endothelial nitric oxide system may contribute to pathogenesis), control of cerebral blood flow and changes in the permeability of the blood-brain barrier, microcirculatory adjustments in pancreatitis, migraine (where chronically low systemic 5-HT levels predispose patients to migrainous headache), and altered permeability of the hepatic sinusoids (2, 3, 11, 21). The potential impact of 5-HT on lymphatic function under either normal or pathophysiological conditions has not yet been adequately examined.

The receptor mechanisms through which 5-HT interacts with the vasculature are complex. 5-HT has been shown to interact with α- and β-adrenergic receptors as well as with 5-HT1A, 5-HT1B, 5-HT1C, and 5-HT2 receptors. The vasodilation seen in blood vessels in many beds is mediated through the interaction of 5-HT with the 5-HT2 receptor. However, controversy exists in the literature. The vasorelaxation seen in such preparations as the human or canine basilar artery has been attributed to 5-HT1B receptors by some investigators and 5-HT2 receptors by others. The receptor actions of 5-HT in the prenodal lymph vessels have not yet been determined. In this study, we report both the actions of 5-HT on prenodal lymphatic smooth muscle and the receptor mechanisms operant in 5-HT-mediated prenodal lymphatic constriction.

METHODS

Adult mongrel dogs of either sex were anesthetized with pentobarbital sodium (35 mg/kg iv and supplemented as
The experimental protocol was as follows. After the completion of all cannulations, the lymphatic vessel was perfused with control perfusate for a minimum of 15 min to ensure that all measured pressures had achieved steady-state values. In the 5-HT intralymphatic experiments (n = 7), the lymph vessel was then perfused with perfusate containing 5-HT in a concentration of $9.32 \times 10^{-9}$, $9.32 \times 10^{-8}$, $9.32 \times 10^{-7}$, and $9.32 \times 10^{-6}$ M for a minimum of 15 min at each concentration or until the peak pressure had been obtained. After the infusion of each concentration of 5-HT, the lymph vessel was perfused with control perfusate until the lymphatic perfusion pressure returned to control values before proceeding to the next highest concentration of 5-HT. In the 5-HT intra-arterial experiments (n = 7), the lymphatic was perfused continuously with control perfusate. 5-HT solutions were infused intra-arterially to obtain plasma concentrations of $6.22 \times 10^{-10}$, $6.22 \times 10^{-9}$, $6.22 \times 10^{-8}$, and $6.22 \times 10^{-7}$ M for a minimum of 15 min or until the peak change in lymphatic pressure had been obtained. Between each infusion of 5-HT, sufficient time was allowed for all measured pressures to return to control values. In the 5-HT and phentolamine experiments (n = 7), 5-HT was first given intralymphatically at a concentration of $9.32 \times 10^{-7}$ M to establish a control 5-HT response in these animals. The lymphatic was then infused with control perfusate until all pressures returned to control values. Phentolamine was then infused at 400 µg/min intra-arterially. Five minutes after beginning the phentolamine infusion, the intralymphatic infusion of 5-HT was repeated during the continued infusion of phentolamine. In the 5-HT receptor agonist studies, the 5-HT$_1$ agonist 5-carboxyamidotryptamine maleate was infused intralymphatically (n = 7) in a concentration of $7.65 \times 10^{-7}$, $7.65 \times 10^{-6}$, and $7.65 \times 10^{-5}$ M. The 5-HT$_2$-receptor-agonist α-methylserotonin was infused intralymphatically (n = 7) in a concentration of $7.34 \times 10^{-8}$, $7.34 \times 10^{-7}$, $7.34 \times 10^{-6}$, and $7.34 \times 10^{-5}$ M. In a final series of experiments, α-methylserotonin was infused intralymphatically (n = 9) in a concentration of $7.34 \times 10^{-5}$ M before and during the intra-arterial infusion of phentolamine at 400 µg/min to determine if the lymphatic constriction seen with the 5-HT$_2$ agonist was mediated in part by lymphatic α-adrenoceptors.

All data were analyzed using Student’s t-test, as modified for paired replicates. The pressures obtained during the peak of the response were compared with those obtained immediately before the administration of any drug.

**RESULTS**

The intralymphatic infusion of 5-HT (Fig. 1) significantly increased lymphatic perfusion pressure at the three highest concentrations infused. These data indi-
cate that the threshold concentration necessary to produce lymphatic constriction lies between $9.32 \times 10^{-9}$ and $9.32 \times 10^{-8}$ M. At the two highest concentrations infused, the lymphatic perfusion pressure more than doubled. The intralymphatic infusion of 5-HT had no significant effect on mean systemic, forelimb perfusion, skin small artery, skin small vein, or central venous pressures.

The intra-arterial infusion of 5-HT (Fig. 2) likewise significantly increased lymphatic perfusion pressure at the three highest concentrations infused, indicating that the threshold concentration of 5-HT necessary to produce significant lymphatic constriction when 5-HT is administered into the bloodstream was between $6.22 \times 10^{-10}$ and $6.22 \times 10^{-9}$ M.

The infusion of 5-HT intralymphatically at a concentration of $9.32 \times 10^{-7}$ M before phentolamine (Fig. 3) significantly increased lymphatic perfusion pressure from a control value of 5 mmHg to a peak value of 11.5 mmHg. The infusion of phentolamine intra-arterially did not significantly affect lymphatic perfusion pressure (data not shown), and the repetition of the same dose of 5-HT intralymphatically in the presence of $\alpha$-adrenoreceptor blockade still significantly increased lymphatic perfusion pressure; however, the increase seen was significantly less (Student's t-test as modified for paired replicates) than that seen before $\alpha$-receptor blockade.

The intralymphatic infusion of the 5-HT$_1$-receptor-agonist 5-carboxyamidotryptamine maleate at three concentrations failed to significantly alter lymphatic perfusion pressure (Fig. 4).

Intralymphatic infusion of the 5-HT$_2$-receptor agonists $\alpha$-methylserotonin at four concentrations (Fig. 5) resulted in significant increases in lymphatic perfusion pressure at the three highest concentrations infused, indicating that the threshold concentration needed to produce significant lymphatic constriction lies between $7.34 \times 10^{-8}$ and $7.34 \times 10^{-7}$ M. At the highest concen-
pressure from a control value of 5.6 mmHg to a peak pressure of 8.3 mmHg, a significant increase but less than that seen before lymphatic \( \alpha \)-receptor blockade. These data indicate the presence of 5-HT\(_2\) receptors in 5-HT-mediated lymphatic constriction. The lymphatic constriction seen to remain in the \( \alpha \)-receptor-blocked preparations subsequent to 5-HT infusion could indeed be the result of lymphatic 5-HT receptors, and the experiments with the 5-HT receptor agonists confirm this notion. Although the intralymphatic infusion of the 5-HT\(_2\)-receptor-agonist 5-carboxyamidotryptamine maleate is without effect (Fig. 4), infusion of the 5-HT\(_2\)-receptor-agonist \( \alpha \)-methylserotonin (Fig. 5) does produce significant lymphatic constriction. These data indicate the presence of 5-HT\(_2\) receptors in the prenodal lymphatic vessels. However, because it was already shown that 5-HT itself interacts with the \( \alpha \)-receptors contained within the lymphatics, it was necessary to establish that the 5-HT\(_2\)-receptor-agonist would also produce constriction in an \( \alpha \)-blocked preparation. As can be seen in Fig. 6, \( \alpha \)-methylserotonin does indeed still constrict lymphatics after the lymphatic \( \alpha \)-receptors have been blocked by phentolamine. These data then serve to corroborate that the prenodal lymphatics do contain 5-HT\(_2\) receptors and that the constriction seen with intralymphatic infusion of 5-HT is indeed likely mediated through a combination of \( \alpha \)-adrenergic receptors and 5-HT 5-HT\(_2\) receptors.

The lymphatic constriction produced by intralymphatic 5-HT is significantly attenuated by the \( \alpha \)-receptor blockade. The \( \alpha \)-receptor blockade suggests a role for lymphatic \( \alpha \)-receptors in 5-HT-mediated lymphatic constriction. The lymphatic constriction seen to remain in the \( \alpha \)-receptor-blocked preparations subsequent to 5-HT infusion could indeed be the result of lymphatic 5-HT receptors, and the experiments with the 5-HT receptor agonists confirm this notion. Although the intralymphatic infusion of the 5-HT\(_2\)-receptor-agonist 5-carboxyamidotryptamine maleate is without effect (Fig. 4), infusion of the 5-HT\(_2\)-receptor-agonist \( \alpha \)-methylserotonin (Fig. 5) does produce significant lymphatic constriction. These data indicate the presence of 5-HT\(_2\) receptors in the prenodal lymphatic vessels. However, because it was already shown that 5-HT itself interacts with the \( \alpha \)-receptors contained within the lymphatics, it was necessary to establish that the 5-HT\(_2\)-receptor-agonist would also produce constriction in an \( \alpha \)-blocked preparation. As can be seen in Fig. 6, \( \alpha \)-methylserotonin does indeed still constrict lymphatics after the lymphatic \( \alpha \)-receptors have been blocked by phentolamine. These data then serve to corroborate that the prenodal lymphatics do contain 5-HT\(_2\) receptors and that the constriction seen with intralymphatic infusion of 5-HT is indeed likely mediated through a combination of \( \alpha \)-adrenergic receptors and 5-HT 5-HT\(_2\) receptors.

The results of this study, previous studies in the canine forelimb, and other in vivo and in vitro experiments clearly demonstrate that many endogenous vaso-
active substances can alter lymphatic smooth muscle tone and hence impact lymphatic vessel function. Previous reports indicate that, while many similarities exist between the manner in which lymphatic smooth muscle and vascular smooth muscle respond to vasoactive agents, differences also exist. For example, the potent vasodilators histamine, bradykinin, and acetylcholine all constrict lymphatic vessels in the canine forelimb (9). Whether these differences are a reflection of differing receptor profiles between the two smooth muscle populations or differences in the endothelial cell/smooth muscle cell axis remains to be determined. Accumulated data on lymph vessel function and lymphatic vessel receptor populations suggest that it may be possible to develop a class of drugs that interact with the lymphatic system to enhance its function in disease states. Thus alterations in transvascular fluid flux in the numerous disease states in which it is manifest could be treated with a double-pronged therapeutic approach, both by anti-inflammatory drugs that restore microvascular permeability to macromolecules and by drugs that enhance the ability of the lymphatic system to transport fluid. Clearly, perturbations in the lymphatic system can cause or exacerbate edema formation in numerous disease states. It has been noted, for example, that lymphedema is associated with loss of vascular smooth muscle from the lymphatic collecting vessels of the affected organ (22). Further understanding of the mechanisms that cause lymph vessels to constrict and dilate are critical in evaluating the potential clinical manipulation of the system in the many disease states where increased transvascular fluid flux and edema formation are an instigating or exacerbating circumstance of the disease process.

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