Summary

**Background and purpose:** Adenosine and inosine accumulate extracellularly during hypoxia/ischemia in the brain and may act as neuroprotectants. In spinal cord, there is pharmacological evidence for increases in extracellular adenosine during hypoxia, but no direct measurements of purine release, and furthermore the efflux pathways and origin of extracellular purines are unknown. To characterize hypoxia-evoked purine accumulation, we examined the effect of acute hypoxia on the extracellular levels of adenosine and inosine in the isolated rat spinal cord.

**Experimental approach:** Extracellular adenosine and inosine concentrations were assayed in an *in vitro* preparation of the isolated spinal cord of the neonatal rat by high performance liquid chromatography (HPLC).

**Key results:** The extracellular level of inosine was about tenfold higher than that of adenosine. Acute hypoxia (10 min) caused a temperature-dependent increase in these two purines, which was inhibited by an increase in external Ca\(^{2+}\), but not by several inhibitors of efflux pathways or metabolic enzymes of adenine nucleotides. Inhibitors of adenosine deaminase or equilibrative nucleoside transporter (ENT) abolished the hypoxia-evoked increase in inosine but not adenosine. A glial metabolic inhibitor
abolished the increase of both purines evoked by hypoxia but not by oxygen-glucose deprivation, hypercapnia or an adenosine kinase inhibitor.

**Conclusions and implications:** Our data suggest that hypoxia releases adenosine itself from intracellular sources. Inosine formed intracellularly may be released through ENTs. During hypoxia, astrocytes appear to play a key role in purine release from the rat spinal cord.

**Key words:** Hypoxia, adenosine, inosine, spinal cord, fluoroacetate

**Abbreviations:** AA, arachidonic acid; ACSF, artificial cerebrospinal fluid; BBG, brilliant blue G; CBX, carbenoxolone; DPSPX, 1,3-dipropyl-8-(p-sulphophenyl)xanthine; DIP, dipyridamole; ENT, equilibrative nucleoside transporter; EHNA, erythro-9-(2-hydroxy-3-nonyl)adenine hydrochloride; FA, fluoroacetate; HPLC, high performance liquid chromatography; NBTI, S-(4-nitrobenzyl)-6-thioinosine; OGD, oxygen-glucose deprivation; PDE, phosphodiesterase; SPZ, sulfinepyrazone.
**Introduction**

Adenosine accumulates in the extracellular space during cerebral hypoxia/ischemia (Latini and Pedeta, 2001; Pearson *et al*., 2003), and it acts as a neuroprotectant under this pathological condition mainly due to the inhibition of excessive neuronal excitation by adenosine A1 receptors (Wardas, 2002; Pedata *et al*., 2007). However, the exact mechanisms responsible for adenosine accumulation are unknown. In the rat brain, oxygen-glucose deprivation (OGD) or hypercapnia was reported to release ATP (Parkinson and Xiong, 2004; Liu *et al*., 2008; Dulla *et al*., 2005), resulting in the increase in extracellular adenosine due to their degradation by a series of ecto-enzymes such as ecto-5’-nucleotidase (Matsuoka and Ohkubo, 2004; Gödecke, 2008). On the other hand, there is also evidence showing that adenosine itself is directly released by hypoxia (Martín *et al*., 2007) and OGD (Frenguelli *et al*., 2007).

In the rat hippocampal slices, Ca^{2+} inhibits adenosine release during hypoxia indicating non-exocytotic release of adenosine (Dale *et al*., 2000; Martín *et al*., 2007). A glial metabolic inhibitor is also reported to inhibit the hypoxia-evoked adenosine release, suggesting the involvement of astrocytic function (Martín *et al*., 2007).

Inosine also accumulates during hypoxia/ischemia and elicits protective effects (Haun *et al*., 1996; Litsky *et al*., 1999; Chen *et al*., 2002; Shen *et al*., 2007). In
rat hippocampal slices, most of the inosine increase occurring during hypoxia is due to the extracellular degradation of adenosine mediated by ecto-adenosine deaminase (Frenguelli et al., 2003). On the other hand, the increase in inosine during OGD is due to the formation of inosine intracellularly and its subsequent release by equilibrative nucleoside transporters (ENTs) in cultured rat cortical neurons and astrocytes (Parkinson and Xiong, 2004). The mechanism of adenosine and inosine accumulation in the extracellular space appears to depend on the experimental conditions and/or the region of CNS involved.

Various diseases or surgical procedures cause hypoxic/ischemic conditions in the spinal cord that impair spinal function (Cheshire et al., 1996; Tator et al., 1997; Rowland et al., 2008). It has been reported that acute hypoxia depresses spinal synaptic transmission which is reversed by adenosine A₁ receptor antagonists (Lloyd et al., 1988; 1989; Czéh and Somjen, 1990, Park et al., 2002). However, there is no direct evidence showing the extracellular adenosine level during hypoxia, and efflux pathways and origin of extracellular adenosine in response to hypoxia are unknown in the spinal cord. In addition, the extracellular concentration of inosine is also expected to show a considerable change because adenosine deaminase plays a significant role in adenosine metabolism in the rat spinal cord (Golembiowska et al., 1995; 1996).
To investigate the effect of brief exposure to hypoxia on the accumulation of adenosine and inosine in the spinal cord, we measured the extracellular concentration of purines in isolated neonatal rat spinal cord preparations in which acute hypoxia immediately resulted in adenosine A₁ receptor-sensitive synaptic depression (Lloyd et al., 1989).

Methods

Preparations

All experiments were approved by the Animal Care and Use Committee of the Graduate School of Veterinary Medicine, Hokkaido University. All efforts were made to minimize animal suffering and to reduce the number of animals used. Both male and female neonatal rats (Wistar, 0-7 days old) were used.

Neonatal rats were killed by decapitation, and the spinal cords were isolated. The composition of artificial cerebrospinal fluid (ACSF) was as follows (mM): NaCl 138; NaHCO₃ 21; NaH₂PO₄ 0.6; CaCl₂ 1.25; KCl 3.5; MgCl₂ 2.0; glucose 10; gassed with 95% O₂ and 5% CO₂; pH~7.3. Hypoxic ACSF was gassed with 95% N₂ and 5% CO₂ (pH~7.3) at least 1 h before the experiments were started. The partial pressures of O₂ (pO₂), measured with a dissolved oxygen meter (ISO₂, World Precision Instruments,
USA), were 65.8±1.4 % (n=3) and 5.0±0.9 % (n=3) in normal and hypoxic ACSF, respectively. Hypercapnic ACSF was prepared by gassing with 80% O₂ and 20% CO₂ (pH~6.7). For OGD, glucose was substituted by equimolar sucrose in the hypoxic ACSF. For Ca²⁺-free ACSF, CaCl₂ was removed and 1 mM EGTA was added.

Experimental protocols

The isolated spinal cord was cut into several pieces and equilibrated in ACSF for 1 h at 35°C. Then solution (1 ml) was changed every 10 min and the sample solution was collected. In some experiments, tissues were treated with ACSF containing fluoroacetate for 30 min or other drugs for 20 min before exposure to hypoxia or other stimulants. The purine level in the presence of drugs was compared with that in its absence in preparations obtained from littermates.

Measurement of purine concentration

Collected sample solutions (500 µl) were immediately chilled on ice, and 180 µl of 0.1 M citrate-phosphate buffer (pH 4.0) and 50 µl solution of 4 µM α,β-methylene ADP (internal standard) were added. Then a 365 µl aliquot of the mixture was separated and 10 µl of 45% chloroacetaldehyde was added to it for the measurement of adenosine
and adenine nucleotides. The remainder of the mixture was used for the measurement of inosine. The concentration of adenosine and adenine nucleotides was determined by HPLC with a fluorescence detector according to the method of Kawamoto et al. (1998) with some modifications as previously described (Otsuguro et al., 2009). The inosine concentration was determined according to the method described by Ferraris et al. (1991) with the following modifications: the samples were separated by reverse-phase HPLC with an ODS column (Cosmosil 5C18-MS, 4.6 × 150 mm, Nacalai Tesque Inc., Kyoto, Japan) and monitored at 254 nm wavelength with a UV detector (UV-2075, JASCO, Tokyo, Japan). The mobile phase buffer consisted of 100 mM KH$_2$PO$_4$ and 2.0% CH$_3$CN (pH 3.3 with H$_3$PO$_4$). The flow rate was 1.0 ml min$^{-1}$. The calibration curves for adenine nucleotides, adenosine and inosine were constructed by plotting the peak height ratio of standard mixture to that of the internal standard after the same treatment as that for sample solutions. Representative chromatograms of a standard mixture are shown in Figure 1A and B. The amount of purines in a sample was quantified by direct comparison of the peak height to that of the internal standard. The detection limit for all purines was about 20 fmol. The concentration of cAMP was assayed using a commercially available enzyme immunoassay kit (cAMP EIA, non-acetylation, RPN2251, GE Healthcare Japan, Tokyo, Japan). The amount of
purines accumulated in 10 min was expressed as the extracellular amount per milligram of tissue wet weight (pmol mg$^{-1}$). The increments of adenosine and inosine in response to the stimulants (i.e. hypoxia, OGD, hypercapnia or ABT-702) were estimated by subtracting the resting release for preceding 10 min incubation without stimulants from the stimulants-evoked release for 10 min, and were expressed as $\Delta$adenosine and $\Delta$inosine, respectively.

**Data analysis**

Results are expressed as mean±SEM (n=number of observations). Statistical comparisons between two samples from the same preparation and between those from littermates were performed by the paired and unpaired Student’s $t$-test, respectively. For multiple comparisons, ANOVA following Dunnett’s test was used. A $P$ value of less than 0.05 was considered significant.

**Drugs**

ABT-702 dihydrochloride, arachidonic acid sodium salt (AA), brilliant blue G (BBG), carbenoxolone disodium salt (CBX), guanosine 3’5’-cyclic monophosphate sodium salt (cGMP), ARL 67156 trisodium salt, 1,3-dipropyl-8-(p-sulphophenyl)xanthine
(DPSPX), diprydamole (DIP), S-(4-nitrobenzyl)-6-thioinosine (NBTI), α,β-methylene ADP sodium salt, rolipram and (±)-sulfinepyrazone (SPZ) were purchased from Sigma Chemical Co. (St. Louis, MO, USA). Erythro-9-(2-Hydroxy-3-nonyl) adenine hydrochloride (EHNA) was from Tocris (Bristol, UK). Sodium fluoroacetate (FA) was from Wako Pure Chemical Ind. (Osaka, Japan). All drugs were mixed in ACSF and applied to preparations. Drug/molecular target nomenclature follows that recommended by Alexander et al. (2009).

Results

The isolated spinal cord was incubated with normal ACSF under normoxic conditions and the extracellular amounts of adenine nucleotides (ATP, ADP, AMP), adenosine and inosine in the ACSF were measured using HPLC (Figure 1C and D). ATP and ADP could not be detected. The level of inosine was approximately ten or more times higher than the levels of adenosine and AMP. Brief (10 min) exposure of the isolated spinal cord to hypoxic ACSF evoked a significant increase in the concentration of adenosine and inosine but not AMP. ATP and ADP were not detected during hypoxia (Figure 2A). The effect of oxygen-glucose deprivation (OGD) on the rat spinal cord was examined because OGD has been reported to release adenine nucleotides in the rat cultured
forebrain astrocytes (Parkinson and Xiong, 2004) and hippocampal slices (Frenguelli et al., 2007). OGD (10 min) evoked significant increases in adenosine and inosine but not AMP in the rat spinal cord. ATP and ADP were not detected during OGD (Figure 2B). The effect of OGD (10 min) on the increase in purines was reversible for adenosine (pre: 0.43±0.12 pmol mg⁻¹, OGD: 1.28±0.18 pmol mg⁻¹, P<0.01, post: 0.70±0.07 pmol mg⁻¹, n=4) and inosine level (pre: 5.30±0.57 pmol mg⁻¹, OGD: 17.69±2.73 pmol mg⁻¹, P<0.01, post: 6.55±1.46 pmol mg⁻¹, n=4) (P<0.01 versus pre, Dunnett’s test).

The adenosine and inosine appearing in the ACSF in response to longer exposure times of the spinal cord to hypoxic ACSF were also examined. The increases in adenosine and inosine during hypoxia gradually declined, but they were significantly larger than control throughout the exposure for 30 min (Figure 3). After return to normoxia, the levels of these purines returned to baseline within 10 min.

We next examined the dependency of the extracellular adenosine and inosine increase on temperature and external Ca²⁺ concentration. The basal level of adenosine in the ACSF at 25°C (0.17±0.01 pmol mg⁻¹, n=8, P<0.05, unpaired Student’s t-test) was significantly lower than that at 35°C (0.35±0.05 pmol mg⁻¹, n=8), while there was no significant difference in the basal level of inosine between 25°C (5.13±1.20 pmol mg⁻¹,
n=8) and 35°C (6.39±0.54 pmol mg⁻¹, n=8). The increase in adenosine and inosine in response to hypoxic ACSF (10 min) was markedly lower at 25°C than at 35°C (Figures 4A and B). The hypoxia-evoked increases in adenosine and inosine were suppressed by extracellular Ca²⁺ in a concentration-dependent manner and abolished by 2.5 mM Ca²⁺ (Figures 4C and D). The extracellular Ca²⁺ concentration used did not significantly affect the basal levels of adenosine (0 mM Ca²⁺: 0.59±0.17 pmol mg⁻¹, 1.25 mM Ca²⁺: 0.38±0.06 pmol mg⁻¹, 2.5 mM Ca²⁺: 0.46±0.07 pmol mg⁻¹, n=6) and inosine (0 mM Ca²⁺: 12.29±2.65 pmol mg⁻¹, 1.25 mM Ca²⁺: 15.95±1.51 pmol mg⁻¹, 2.5 mM Ca²⁺: 12.07±1.33 pmol mg⁻¹, n=6).

The contribution of the purine metabolic pathways to the hypoxia-evoked increase in adenosine and inosine was investigated by using several inhibitors of enzymes involved in these pathways. EHNA (10 μM), an inhibitor of adenosine deaminase that prevents the conversion of adenosine to inosine, significantly increased the basal adenosine level (control: 0.79±0.12 pmol mg⁻¹ versus EHNA: 1.71±0.26 pmol mg⁻¹, n=6, P<0.01, unpaired Student’s t-test) and decreased the basal inosine level (EHNA: 6.66±1.06 pmol mg⁻¹ versus control: 13.88±3.29 pmol mg⁻¹, n=6, P<0.05, unpaired Student’s t-test). In the presence of EHNA, the hypoxia (10 min)-evoked adenosine increase was significantly enhanced, while hypoxia failed to
increase inosine levels (Figures 5A and B), indicating that the increase in inosine was largely due to the metabolism of adenosine by adenosine deaminase.

Extracellular adenosine is formed through the degradation of extracellular ATP by a series of ecto-nucleotidases, including ecto-ATPase and ecto-alkaline phosphatase. ARL67156 (100 µM) and levamisole (1 mM), respective inhibitors of ecto-ATPase and alkaline phosphatase, did not affect the basal levels of adenosine (ARL67156: 0.40±0.14 pmol mg\(^{-1}\) versus control: 0.37±0.09 pmol mg\(^{-1}\), n=6, levamisole: 0.33±0.06 pmol mg\(^{-1}\) versus control: 0.42±0.05 pmol mg\(^{-1}\), n=5) and inosine (ARL67156: 3.73±0.64 pmol mg\(^{-1}\) versus control: 4.47±1.12 pmol mg\(^{-1}\), n=6, levamisole: 5.12±1.23 pmol mg\(^{-1}\) versus control: 5.37±1.51 pmol mg\(^{-1}\), n=5) or their hypoxia (10 min)-evoked increase (Figures 5A and B). Extracellular adenosine is also produced from extracellular cAMP degradation, which is initiated by ecto-phosphodiesterase (PDE). PDE4 is a cAMP-specific and major PDE subtype in the CNS (Jin et al., 1999; Nikulina et al., 2004). However, the PDE4 inhibitor rolipram (100 µM), and the ecto-PDE inhibitors DPSPX (1 mM) and cGMP (1 mM), did not show any significant effect on the hypoxia (10 min)-evoked increase in adenosine and inosine (Figures 5C and D). To confirm the contribution of cAMP to purine accumulation, we measured the extracellular level of cAMP. The level of cAMP was
very low and there was no significant difference in the cAMP level between normoxic (4.16±0.41 fmol mg⁻¹, n=4) and hypoxic (4.13±0.56 fmol mg⁻¹, n=4) conditions for 10 min. These results suggest that extracellular degradation of ATP and cAMP does not contribute to the accumulation of adenosine and inosine during hypoxia. Rolipram, DPSPX and cGMP did not significantly affect the basal levels of adenosine (rolipram: 0.48±0.10 pmol mg⁻¹ versus control: 0.52±0.11 pmol mg⁻¹, n=8, DPSPX: 0.51±0.01 pmol mg⁻¹ versus control: 0.63 pmol mg⁻¹, n=6, cGMP: 0.33±0.04 pmol mg⁻¹ versus control: 0.39±0.05 pmol mg⁻¹, n=6) and inosine (rolipram: 12.72±2.64 pmol mg⁻¹ versus 14.47±1.94 pmol mg⁻¹, n=8, DPSPX: 11.50±4.84 pmol mg⁻¹ versus control: 11.94±3.33 pmol mg⁻¹, n=6. cGMP: 8.24±1.58 pmol mg⁻¹ versus control: 10.67±2.63 pmol mg⁻¹, n=6). We also examined the effect of homocysteine thiolactone on the accumulation of adenosine and inosine during hypoxia because it had been reported to reduce the adenosine accumulation during OGD by trapping intracellular adenosine in the rat hippocampus (Lloyd et al., 1993, Frenguelli et al., 2007). However, homocysteine thiolactone had no effect on the hypoxia-evoked purine increase in the spinal cord (data not shown).

To determine the possible pathways for the transport of purines across the plasma membrane, the effects of inhibitors of several pathways were assessed. A
mixture of ENT inhibitors NBTI (5 µM) and DIP (10 µM), significantly increased the 
basal level of adenosine (NBTI + DIP: 0.92±0.19 pmol mg⁻¹ versus control: 0.72±0.18 
µmol mg⁻¹, n=8, P<0.05, unpaired Student’s t-test) but not that of inosine (NBTI + 
DIP: 16.06±3.56 pmol mg⁻¹ versus control: 15.20±2.73 pmol mg⁻¹, n=8). On the other 
hand, ENT inhibitors significantly suppressed the hypoxia (10 min)-evoked increase in 
inosine but not adenosine (Figure 6). These results indicate that ENTs play important 
roles in regulating extracellular adenosine concentration during normoxia and in the 
efflux pathway of inosine during hypoxia, but not normoxia. As cAMP transporters and 
channels with large conductance, such as gap junction channels, P2X7 receptors and 
maxi-anion channels, are possible efflux pathways for adenine nucleotides (Darby et 
al., 2003; Dutta et al., 2004; Suadicani et al., 2006; Kang et al., 2008; Liu et al., 2008; 
Lin et al., 2008; El-Sheikh et al., 2008; Russel et al., 2008), the inhibitors of these 
transporters and channels were examined. SPZ (2 mM), a cAMP transporter inhibitor, 
CBX (100 µM), a gap junction channel inhibitor, BBG (5 µM), a P2X7 receptor 
antagonist and AA (20 µM), a maxi-anion channel inhibitor, had no effect on the basal 
levels of adenosine (SPZ: 0.70±0.06 pmol mg⁻¹ versus control: 0.89±0.16 pmol mg⁻¹, 
n=6, CBX: 0.82±0.31 pmol mg⁻¹ versus control: 0.89±0.28 pmol mg⁻¹, n=6, BBG: 
1.14±0.63 pmol mg⁻¹ versus control: 0.93±0.54 pmol mg⁻¹, n=6, AA: 0.28±0.09 pmol
mg⁻¹ versus control: 0.29±0.09 pmol mg⁻¹, n=6) and inosine (SPZ: 7.07±1.58 pmol mg⁻¹ versus control: 10.51±0.90 pmol mg⁻¹, n=6, CBX: 4.91±0.65 pmol mg⁻¹ versus control: 6.58±2.17 pmol mg⁻¹, n=6, BBG: 5.29±1.23 pmol mg⁻¹ versus 4.59±1.14 pmol mg⁻¹, n=6, AA: 9.92±2.95 pmol mg⁻¹ versus control: 10.78±3.60 pmol mg⁻¹, n=6) or on hypoxia (10 min)-evoked increases in these purines (Figure 6).

In rat cultured cortical astrocytes, the hypoxia-evoked adenosine release is suppressed in the presence of a glial metabolic inhibitor (Martín et al., 2007). We investigated the effect of FA, a glial metabolic inhibitor, on the hypoxia-evoked increase in adenosine and inosine in the rat spinal cord. Although the application of FA (5 mM) for 30 min did not affect the basal levels of adenosine and inosine, the significant increase in adenosine and inosine during hypoxia disappeared in the presence of FA (Figure 7). The increase in inosine seemed to be more sensitive to FA than that of adenosine.

To confirm the effect of FA, the isolated spinal cords were pre-incubated with 5 mM FA for 30 min and then exposed to hypoxia or other stimulants for 10 min in the presence of FA. The hypoxia-evoked increases in adenosine and inosine were significantly suppressed by FA (Figure 8). OGD is reported to cause adenosine and inosine release from both astrocytes and neurons (Parkinson and Xiong, 2004).
However, the exposure of OGD for 10 min increased the levels of adenosine and inosine regardless of the presence or absence of FA. We have previously reported that hypercapnia causes the release of adenosine by inhibiting the activity of adenosine kinase in the rat spinal cord (Otsuguro et al., 2006; 2009). In the present study, we found that the extracellular level of inosine was also increased by the exposure (10 min) of hypercapnia (20% CO₂). ABT-702 (10 µM), an adenosine kinase inhibitor, also evoked increase in adenosine and inosine (Figure 8). After the pre-incubation (30 min), FA failed to suppress these purine increases in response to hypercapnia or ABT-702.

As ABT-702 increased not only adenosine but also inosine, the effect of EHNA on the ABT-702-evoked increase in these purines was examined. EHNA (10 µM) markedly enhanced the ABT-702 (10 µM)-evoked increase in adenosine, but abolished that in inosine (Figure 9).

**Discussion and conclusions**

In the present experiments, the accumulation of purines in the extracellular space during hypoxia was studied in the rat spinal cord. Our results suggest that the increase in extracellular adenosine concentration during hypoxia occurs through the release of intracellular adenosine, and that astrocytes play a key role in the release of purines
from the rat spinal cord.

Extracellular ATP and cAMP can be sources of adenosine because of the activity of ecto-enzymes such as ecto-ATPase, ecto-alkaline phosphatase and ecto-PDE (Matsuoka and Ohkubo, 2004; Gödecke, 2008). However, brief exposure (<30 min) to hypoxia and oxygen-glucose deprivation (OGD) have been shown to release adenosine itself from rat cultured cortical astrocytes (Martín et al., 2007) and the hippocampus (Frenguelli et al., 2007), respectively. Our data also suggest that hypoxia directly releases adenosine itself in the rat spinal cord for the following reasons. Firstly, increases in extracellular ATP and cAMP did not occur during hypoxia. Secondly, the increase in adenosine was insensitive to the inhibitors of ecto-metabolic enzymes. In cultured rat forebrain astrocytes, it has been reported that a 60 min exposure to OGD releases adenine nucleotides into extracellular spaces, where they were then converted to adenosine (Parkinson and Xiong, 2004). In the rat hippocampus, the ATP release need longer exposures (>10 min) of OGD in the young animals (11-15 days old) than the older ones (Frenguelli et al., 2007). It may be a reason why ATP release is not observed in our experiments of neonatal rats (0-7 days old).

Our data show an inosine/adenosine ratio that is larger than the ratios previously reported in the rat brain (Frenguelli et al., 2003; Parkinson and Xiong,
EHNA, an adenosine deaminase inhibitor, enhanced both the basal and hypoxia-evoked adenosine increase, while it decreased the basal inosine level and abolished the evoked inosine increase. These results indicate that inosine is formed from adenosine during hypoxia through the activity of adenosine deaminase. ABT-702, an adenosine kinase inhibitor, increased not only adenosine but also inosine to the same extent as hypoxia did. In addition, EHNA markedly enhances the ABT-702-evoked increase in adenosine, while it abolished that in inosine, indicating the rapid conversion from adenosine to inosine by adenosine deaminase. In the rat hippocampus, the intracellular adenosine increase induced by energy depletion is mainly regulated by adenosine deaminase (Lloyd and Fredholm, 1995). In the rat spinal cord, it has been reported that coadministration of adenosine kinase and adenosine deaminase inhibitors evoked a marked synergic release of adenosine, suggesting that only a modest inhibition of adenosine kinase is required to recruit the involvement of adenosine deaminase (Golembiowska et al., 1995). In the rat spinal cord, it is likely that the activity of adenosine deaminase is high enough to play a key role in regulating intracellular adenosine concentration, especially when adenosine formation is increased.

The extracellular increases in adenosine and inosine during hypoxia were both 2004).
temperature dependent. In the rat hippocampus, a rise in temperature causes an increase in intracellular adenosine concentration, and thus adenosine efflux from tissues (Masino et al., 2001). The large increase in extracellular adenosine observed at 35°C in the present study could accelerate the formation of inosine. At 25°C, hypoxia had little effect on adenosine and inosine accumulation, implying the involvement of enzymatic processes in the release of purines and/or reduced demand for oxygen in tissues at lower temperature.

The Ca^{2+} concentration in cerebrospinal fluid is approximately 1.25 mM (Hunter and Smith, 1960), which was the Ca^{2+} concentration of the ACSF used in the present study. The hypoxia-evoked adenosine and inosine increases were enhanced by the removal of external Ca^{2+} and greatly inhibited by a high concentration (2.5 mM) of Ca^{2+}, indicating the involvement of non-exocytotic mechanisms. Similar phenomena also occur in rat hippocampal slices (Dale et al., 2000) and cultured cortical astrocytes (Martin et al., 2007). In addition, hypercapnia-evoked adenosine release is also inhibited by Ca^{2+} (Otsuguro et al., 2006; 2009). These data emphasize the importance of Ca^{2+} in the control of purine concentration under pathological conditions. Ca^{2+} probably acts by inhibiting the formation and/or release of purines in the CNS including the spinal cord.
The ENT inhibitors blocked the hypoxia-evoked increase in inosine but not adenosine, suggesting that ENT is a main pathway for inosine release during hypoxia. FA, a glial metabolic inhibitor, abolished the increase in adenosine and inosine induced by hypoxia, but not to suppress the increase in these purines by hypercapnia or ABT-702. In the rat brain, fluorocitrate (FC), another glial metabolic inhibitor, also abolished the hypoxia-evoked adenosine release (Martín et al., 2007). It seems likely that adenosine is released by astrocytes. Alternatively, astrocytic activity may affect purine release from other cells such as neurons, since astrocytes control neuronal function under physiological and pathological conditions (Hansson and Rönnbäck, 2003; Hydon and Carmignoto, 2006; Rossi et al., 2007). On the other hand, it has been reported that both astrocytes and neurons release adenosine during OGD (Parkinson and Xiong, 2004). In our study, unlike hypoxia, OGD increased the purine level in presence of FA. Therefore, OGD might recruit different mechanisms for purine release triggered by hypoxia. Astrocytes have been also proposed to regulate basal adenosine level (Pascual et al., 2005). However, the treatment of 5 mM FA for 30 min suppressed the hypoxia-evoked release but not the basal level of purines. In the cultured astrocytes, FC (1 mM, 1h) was shown to reduce the basal adenosine level (Martín et al. 2007). On the other hand, the prolong treatment (>1h) of high concentration (20 mM) of FA has
been reported to increase adenosine release by itself (Canals et al., 2008). The effects of glial metabolic inhibitors such as FA and FC on the basal purine release appear to depend on the experimental conditions.

In conclusion, hypoxia induces the release of adenosine itself, which is negatively modulated by Ca\(^{2+}\). Hypoxia also releases inosine, which is mainly produced intracellularly and released through the activity of ENTs (Figure 10). The concentration of extracellular inosine was markedly higher than that of adenosine during normoxia and hypoxia. Astrocytic function plays an important role in purine accumulation during hypoxia, but not during hypercapnia or OGD in the rat spinal cord.

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Conflict of interest
None.

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Figure legends

**Figure 1** Chromatograms of purines obtained by reverse-phase HPLC. A standard mixture (2.0 pmol) of ATP, ADP, AMP and adenosine was injected with IS (internal standard) after ethenopurine derivation and monitored with fluorescence detector (A). A standard solution of inosine (2.0 pmol) was injected with IS and monitored with UV detector (B). Sample solutions collected 10 min after incubation of isolated spinal cord with normoxic or hypoxic ACSF were injected and monitored with fluorescence detector (C) and UV detector (D). Superimposed chromatograms in normoxia and hypoxia were normalized to the peak amplitude of IS.

**Figure 2** Amount of extracellular purine during normoxia, hypoxia and oxygen-glucose deprivation (OGD) in the rat spinal cord. The isolated spinal cords were incubated in normal ACSF and then in hypoxic (A) or OGD ACSF (B) for 10 min each. Each column and error bar represents the mean±SEM. (n=10-11). **P < 0.01 versus normoxia (paired Student’s t-test).

**Figure 3** Time course of adenosine (A) and inosine increase (B) evoked by
hypoxia. ACSF was changed every 10 min. The isolated spinal cords were exposed to hypoxic ACSF for 30 min (filled circle). Spinal cord preparations isolated from littermates were used as controls without hypoxic exposure (open circle). Each column and error bar represents the mean±SEM. (n=5-9) *P < 0.05 versus control at same time point (unpaired Student’s t-test).

Figure 4  Effects of temperature and extracellular Ca\(^{2+}\) on adenosine and inosine levels. The hypoxia-evoked increment in adenosine (A) and inosine (B) were measured at 25 and 35°C. Each column and error bar represents the mean±SEM. (n=8) **P < 0.01 versus at 25°C (unpaired Student’s t-test). The hypoxia-evoked increment in adenosine (C) and inosine (D) in 0, 1.25 and 2.5 mM extracellular Ca\(^{2+}\) was measured. Each symbol and error bar represents the mean±SEM. (n=6).

Figure 5  Effect of inhibitors of purine metabolic enzymes. The hypoxia-evoked increment in adenosine (A and C) and inosine (B and D) was measured in the presence (black columns) and absence (gray columns) of 10 µM \textit{erythro}-9-(2-hydroxy-3-nonyl)adenine (EHNA, n=6), 100 µM ARL67156 (n=6), 1 mM levamisole (n=5), 100 µM rolipram (n=8), 1 mM
1,3-dipropyl-8-(p-sulphophenyl)xanthine (DPSPX, n=6) and 1 mM cGMP (n=6). Each column and error bar represents the mean±SEM. *P < 0.05, **P < 0.01 versus in the absence of inhibitors (unpaired Student’s t-test).

Figure 6 Effect of inhibitors of the purine efflux pathway. The hypoxia-evoked increment in adenosine (A) and inosine (B) was measured in the presence (black columns) and absence (gray columns) of 5 µM S-(4-nitrobenzyl)-6-thioinosine (NBTI) + 10 µM dipyridamole (DIP, n=8), 2 mM sulfinepyrazone (SPZ, n=6), 100 µM carbenoxolone (CBX, n=6), 5 µM brilliant blue G (BBG, n=6) and 20 µM arachidonic acid (AA, n=6). Each column and error bar represents the mean±SEM. *P < 0.05, **P < 0.01 versus in the absence of inhibitors (unpaired Student’s t-test).

Figure 7 Effect of a glial metabolic inhibitor on the amount of extracellular adenosine (A) and inosine (B). ACSF was changed every 10 min and samples were collected. The preparations were exposed to hypoxic ACSF for 40 min (filled circle). Control preparations obtained from littermates were incubated in normal ACSF for 50 min (open circle). Fluoroacetate (FA, 5 mM) was applied to all preparations for 30 min. Each column and error bar represents the mean±SEM. (n=4-8) *P < 0.05 versus
control at the same time point (unpaired Student’s $t$-test).

**Figure 8** Effect of a glial metabolic inhibitor on the adenosine (A) and inosine (B) increase caused by different stimulants. Preparations were pre-incubated with fluoroacetate (FA) for 30 min. Then, in the presence (black columns) and absence (grey columns) of FA, purine accumulation was induced by hypoxia ($n=7$-$8$), oxygen-glucose deprivation (OGD, $n=6$), hypercapnia ($n=8$) or 10 µM ABT-702 ($n=7$). Each column and error bar represents the mean±SEM. *$P < 0.05$ versus in the absence of FA (unpaired Student’s $t$-test).

**Figure 9** Effect of EHNA on purine accumulation by ABT-702. The ABT-702 (10 µM)-evoked increment in adenosine (A) and inosine (B) was measured in the presence (black columns) and absence (gray columns) of 10 µM *erythro*-9-(2-hydroxy-3-nonyl)adenine (EHNA). Each column and error bar represents the mean±SEM. *$P < 0.05$ versus in the absence of EHNA (unpaired Student’s $t$-test).

**Figure 10** Schematic representation of adenosine and inosine production and release in rat spinal cords. Hypoxia increases intracellular adenosine, which is released
via unknown pathways or converted to inosine by adenosine deaminase (ADA).

Inosine is released via equilibrative nucleoside transporters (ENTs) which are blocked by S-(4-nitrobenzyl)-6-thioinosine (NBTI) and dipyridamole (DIP). ABT-702 inhibits adenosine kinase (AK), resulting in increase in intracellular adenosine.
Fig. 1

(A) Graph showing the levels of ATP, ADP, and AMP over time (min) with a peak at 0.1 mV.

(B) Graph showing the levels of IS and inosine over time (min) with a peak at 0.01 mV.

(C) Graph comparing the levels of IS, AMP, adenosine, hypoxia, and normoxia over time (min).

(D) Graph comparing inosine and normoxia over time (min).
**Fig. 2**

A

- ATP: Not Detected
- ADP: Not Detected
- AMP
- Adenosine
- Inosine

B

- ATP: Not Detected
- ADP: Not Detected
- AMP
- Adenosine
- Inosine
Fig. 3

A

Adenosine (pmol mg\(^{-1}\))

- ○ normoxia
- ● hypoxia

B

Inosine (pmol mg\(^{-1}\))

- ○ normoxia
- ● hypoxia
Fig. 4

A

$\Delta$ adenosine (hypoxia) (pmol mg$^{-1}$)

25°C 35°C

B

$\Delta$ inosine (hypoxia) (pmol/mg)

25°C 35°C

C

$\Delta$ adenosine (hypoxia) (pmol mg$^{-1}$)

[Ca$^{2+}$]$_o$ (mM)

D

$\Delta$ inosine (hypoxia) (pmol/mg)

[Ca$^{2+}$]$_o$ (mM)
Fig. 5

**A**

<table>
<thead>
<tr>
<th></th>
<th>EHNA</th>
<th>ARL67156</th>
<th>levamisole</th>
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</thead>
<tbody>
<tr>
<td>Δadenosine (hypoxia) (pmol mg⁻¹)</td>
<td>0.4 ± 0.1</td>
<td>1.2 ± 0.2</td>
<td>0.4 ± 0.1</td>
</tr>
<tr>
<td></td>
<td>*</td>
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</tbody>
</table>

**B**

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<th>EHNA</th>
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<tbody>
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<td>Δinosine (hypoxia) (pmol mg⁻¹)</td>
<td>2.0 ± 0.5</td>
<td>4.0 ± 0.5</td>
<td>1.0 ± 0.2</td>
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**C**

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<th>rolipram</th>
<th>DPSPX</th>
<th>cGMP</th>
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<td>Δadenosine (hypoxia) (pmol mg⁻¹)</td>
<td>0.4 ± 0.1</td>
<td>0.6 ± 0.2</td>
<td>0.4 ± 0.1</td>
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**D**

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<tr>
<th></th>
<th>rolipram</th>
<th>DPSPX</th>
<th>cGMP</th>
</tr>
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<tbody>
<tr>
<td>Δinosine (hypoxia) (pmol mg⁻¹)</td>
<td>2.0 ± 0.5</td>
<td>4.0 ± 0.5</td>
<td>1.0 ± 0.2</td>
</tr>
</tbody>
</table>

Legend:
- **control**
- **inhibitor**
Fig. 6

A

\[ \text{\Delta adenosine (hypoxia)} \text{ (pmol mg}^{-1}\text{)} \]

B

\[ \text{\Delta inosine (hypoxia)} \text{ (pmol mg}^{-1}\text{)} \]

- NBTI + DIP
- SPZ
- CBX
- BBG
- AA

control
inhibitor

*
Fig. 7

A

hypoxia

FA

Adenosine (pmol mg\(^{-1}\))

Inosine (pmol mg\(^{-1}\))

time (min)

*B

B

hypoxia

FA

Inosine (pmol mg\(^{-1}\))

Adenosine (pmol mg\(^{-1}\))

time (min)

*
Fig. 9

\[
\begin{align*}
\Delta \text{adenosine (pmol mg}^{-1}\text{)} & \quad \Delta \text{inosine (pmol mg}^{-1}\text{)} \\
\text{ABT-702} & \quad \text{ABT-702 + EHNA} \\
\text{ABT-702 + EHNA} & \quad \text{ABT-702 + EHNA}
\end{align*}
\]
Fig. 10

Adenosine → Inosine

- ABT-702
- AMP
- AK
- ADA
- EHNA
- hypoxia
- ENTs
- NBTI + DIP