Improved Adductor Function After Canine Recurrent Laryngeal Nerve Injury and Repair Using Muscle Progenitor Cells

Randal C. Paniello, MD, PhD; Sarah Brookes, DVM; Neel K. Bhatt, MD; Khadijeh Bijangi-Vishehsaraei, PhD; Hongji Zhang, PhD; Stacey Halum, MD

**Objective:** Muscle progenitor cells (MPCs) can be isolated from muscle samples and grown to a critical mass in culture. They have been shown to survive and integrate when implanted into rat laryngeal muscles. In this study, the ability of MPC implants to enhance adductor function of reinnervated thyroarytenoid muscles was tested in a canine model.

**Study Design:** Animal study.

**Methods:** Sternocleidomastoid muscle samples were harvested from three canines. Muscle progenitor cells were isolated and cultured to 10^7 cells over 4 to 5 weeks, then implanted into right thyroarytenoid muscles after ipsilateral recurrent laryngeal nerve transection and repair. The left sides underwent the same nerve injury, but no cells were implanted. Laryngeal adductor force was measured pretreatment and again 6 months later, and the muscles were harvested for histology.

**Results:** Muscle progenitor cells were successfully cultured from all dogs. Laryngeal adductor force measurements averaged 60% of their baseline pretreatment values in nonimplanted controls, 98% after implantation with MPCs, and 128% after implantation with motor endplate-enhanced MPCs. Histology confirmed that the implanted MPCs survived, became integrated into thyroarytenoid muscle fibers, and were in close contact with nerve endings, suggesting functional innervation.

**Conclusion:** Muscle progenitor cells were shown to significantly enhance adductor function in this pilot canine study. Patient-specific MPC implantation could potentially be used to improve laryngeal function in patients with vocal fold paresis/paralysis, atrophy, and other conditions. Further experiments are planned.

**Key Words:** Larynx, recurrent laryngeal nerve, stem cells, paralysis, innervation.

**Level of Evidence:** NA.

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**INTRODUCTION**

Restoration of movement of the paralyzed vocal fold has long been a goal of laryngologists treating vocal fold paralysis, but reports of successful restoration of vocal fold mobility have been quite limited. Purposeful vocal fold abduction\(^1\) and adduction\(^2\) have been achieved with reinnervation methods, but these procedures have not gained wide acceptance due to technical difficulty or donor site morbidity. The ideal procedure would restore mobility and laryngeal muscle mass in a high percentage of cases while being technically within the skillset of most otolaryngologists. Restoration of abductor movement would be particularly valuable for patients with bilateral vocal fold immobility, who often need a tracheostomy or other procedure for adequate airway.

Muscle progenitor cells (MPCs) (also called **muscle stem cells**) consist of satellite cells and myoblasts, and have the potential to increase muscle mass and provide the stimulus for functional reinnervation when implanted into denervated muscles.\(^3\)–\(^5\) Muscle progenitor cells can be derived from small samples of a patient’s own tissue and thus are not rejected by the immune system. They can be implanted into the laryngeal muscle by a simple injection, making this approach an attractive option for treating laryngeal paralysis.

Several investigators have found that implanted MPCs improve cardiac function and muscle mass following myocardial infarction.\(^6\)–\(^8\) Plowman et al. reported attenuation of atrophy, increased myofiber diameter, and increased maximal contraction force after implantation of MPCs into partially denervated sheep tongues.\(^9\) Halum et al. have successfully cultured MPCs from rat skeletal muscle and implanted them into denervated thyroarytenoid muscles. They found the injected MPCs survived in their new muscle, attenuated atrophy, fused with the native myofibers, and enhanced reinnervation when programmed to express neurotrophic factor.\(^10\)–\(^12\)
The strength of the MPC-treated thyroarytenoid muscles could not be assessed in this rat model, however.

We wished to extend this study to a larger animal model, one more similar to the human larynx, so that functional measures of motor strength could be assessed after MPCs are therapeutically introduced into denervated adductor muscles. In this study, the Paniello lab (experience in measuring laryngeal function in the canine model)\textsuperscript{13,14} collaborated with the Halum lab (experience in cultivating MPCs as outlined above). We hypothesized that, in a canine model of vocal fold paralysis, MPCs implanted into the denervated thyroarytenoid muscle would enhance adductor function as measured by laryngeal adductor pressure (LAP) and glottic closing force (GCF).\textsuperscript{13}

**MATERIALS AND METHODS**

Three purpose-bred mongrel hounds, each weighing about 20 kg, were obtained and housed in a facility approved by the American Association for Accreditation of Laboratory Animal Care. The study was performed in accordance with the Public Health Service Policy on Humane Care and Use of Laboratory Animals, the National Institutes of Health Guide for the Care and Use of Laboratory Animals, and the Animal Welfare Act (7 U.S.C. et seq.). The animal-use protocol was approved by the Institutional Animal Care and Use Committee of Washington University School of Medicine.

**Initial Procedure: Baseline Data and Muscle Harvest**

Under general anesthesia, a midline incision exposed the larynx and trachea. A tracheostomy was made between rings 8 to 12, as previously described.\textsuperscript{15} Both recurrent laryngeal nerves (RLNs) were dissected, fitted with Harvard electrodes, and connected to a custom constant-current laryngeal nerve stimulator.

Pretreatment baseline laryngeal adductor function was measured in two ways.\textsuperscript{15} First, LAPs were determined as previously described. Briefly, the cuff of an endotracheal tube is connected to a pressure transducer, and the tube is passed between the vocal folds while the RLN is stimulated at supramaximal current. Pressure measurements are made at each frequency from 20 to 100 Hz at 10 Hz intervals, and the unstimulated baseline pressure is subtracted. Laryngeal adductor muscles reach tetany at higher frequencies (70–100 Hz). Second, GCF was measured as previously described. Briefly, a suture is passed through a lateral minithyrotomy, through the ventricle, and connected to a custom constant-current laryngeal nerve stimulator.

Under an operating microscope, each RLN was transected 5 cm inferior to the cricothyroid joint and then immediately repaired using 9-0 nylon sutures for epineural anastomosis. A 3 to 4 gm portion of sternocleidomastoid muscle was harvested and placed in initial myogenic culture medium (F-10 medium, Gibco; 11550–043), 10% fetal bovine serum (HyClone Laboratories; SH30070.03), 1% penicillin/streptomycin (HyClone Laboratories; J110381)), and 1% penicillin/streptomycin (HyClone Laboratories; J110381)).

Cells were labeled for subsequent identification in one of two ways: For dog 1, MPCs were transduced with green fluorescent protein (GFP)-expressing lentiviral vector at passage 2 in the presence of 8 μg/mL protamine sulfate (Sigma-Aldrich, St. Louis, MO; P4020). For dogs 2 and 3, the MPCs were incubated with the fluorescent marker QTracker 565 (Molecular Probes, Thermo Fisher Scientific; Q25001MP) for 60 minutes at 37°C. After incubation, the cells were washed twice with complete growth medium. Label uptake was confirmed with fluorescent microscopy.

To induce motor endplate expression (dog 3), acetylcholine chloride (40 nmol/L, Tocris Bioscience, Bristol, England; 2809), agrin (10 nmol/L, R&D Systems, Minneapolis, Minnesota; 550-AO), and neuregulin (2 nmol/L; R&D Systems; 378-SM) were added to culture medium, and the culture continued for 7 days. These MPCs are referred to as motor endplate-enhanced cells (MEEs).

When the cultures reached approximately 10\textsuperscript{6} cells (within 4–5 weeks), they were shipped on ice back to the canine laryngeal physiology lab at Washington University.

**Second Procedure: Muscle Progenitor Cell Implantation**

The MPCs were washed several times in phosphate-buffered saline (PBS), then spun gently into a pellet with a volume of 0.5 cc. The dog was placed under general anesthesia, intubated using the permanent stoma. Direct laryngoscopy was performed, and the scope was suspended. An 18 G angiocatheter was passed through the skin, through the cricothyroid membrane, and into the thyroarytenoid and possibly the lateral cricoarytenoid muscles. The MPC syringe was attached and the cells were implanted, followed by a 0.5 cc flush of normal saline. The dog was awakened and recovered.

**Third Procedure: Final Data Collection**

The first experiment (dog 1) was carried out only to confirm success of the process and viability of the transferred MPCs; the dog was euthanized 2 weeks following MPC implantation; and the larynx was harvested for histologic study. Functional data was not collected.

Long-term functional experiments were carried out for dogs 2 and 3. Six months after nerve transaction and repair (5 months post-MPC implantation), the awake dog was examined for spontaneous vocal fold motion by inserting a scope through the tracheostomy and visualizing the vocal folds from below.
Vocal fold movement was induced by introducing a few ccs of water into the mouth from a syringe, causing the dog to swallow. Movement was scored on a scale of 0 (no movement) to 4 (complete adduction).

Next, the dog was anesthetized, and the neck was opened in the midline. Each RLN was dissected, and an electrode placed 10 cm inferior to the cricothyroid joint (dogs 2 and 3). Direct laryngoscopy was performed, and the stimulated motion of the vocal folds was observed, videorecorded, and scored on the same 0 to 4 scale. Laryngeal adductor pressure and GCF were measured as described above. The larynx was then harvested, placed in 4% paraformaldehyde, and shipped to the Halum lab.

Histological and Immunohistochemical Analysis

Larynges were fixed with 4% paraformaldehyde in PBS for 24 hours, then changed to 30% sucrose in PBS solution until tissues sank to the bottom. Cryo-embedded sections were cut at a thickness of 12 to 14 μm with the cryotome. Standard hematoxylin and eosin staining was performed. For GFP analysis, unstained frozen sections were evaluated under fluorescent microscopy to evaluate for areas of green fluorescence, and immunohistochemistry (IHC) was performed with anti-GFP antibody to ensure the green fluorescence represented GFP (not nonspecific fluorescence).
For additional analysis of the motor endplates (staining with beta-III tubulin) with neuronal contact (staining with alpha-bungarotoxin), sections were permeabilized with Triton X-100 (Sigma-Aldrich) for 20 minutes at room temperature and then blocked with 1% bovine serum albumin for 1 hour. Sections were then incubated with Alexa Fluor 493 (Thermo Fisher Scientific)-conjugated beta-III tubulin antibody (1:10) and Alexa-Fluor 647 (Thermo Fisher Scientific)-conjugated alpha-bungarotoxin (1:1000) overnight at 4°C, and then examined by fluorescent microscopy.

RESULTS

Muscle progenitor cells were successfully isolated and cultured from all three dogs. Dogs 1 and 2 were implanted with $10^7$ MPCs; dog 3 received $12 \times 10^6$ MEEs.

Histology and Immunohistochemistry

The GFP and QTracker 545 (Molecular Probes, Thermo Fisher Scientific) fluorescent markers labels were present throughout the cultured cells, as seen on fluorescent microscopy (Fig. 1), suggesting effective cell labelling. In the harvested thyroarytenoid muscles, the fluorescent labels showed good survival of the implanted MPCs, with no label seen in the noninjected control muscles (Figs. (2 and 3)). The muscle fibers that had MPCs incorporated tended to have larger diameters than the nonlabeled fibers in all three dogs. The animal receiving the MEEs demonstrated areas of dense motor endplate expression with complexes of motor endplates, which were fully innervated based on neuronal contact (Fig. 3). These areas of dense motor endplate expression corresponded well with the areas of fluorescent label (cell tracker), suggesting the changes occurred secondary to survival of the MEEs in those areas. Because of the large size of the canine adductor complex, targeted sectioning was performed through the anterior and mid-body of the tibialis anterior muscle (the site of MPC injection). Although most of the sections demonstrated areas of fluorescence (cell survival), the size of the muscles prohibited accurate quantification.

Functional Measures (Dogs 2 and 3)

Spontaneous adduction during swallow was seen in the right (MPC-injected) vocal fold of both dogs but not on the left (control) side. When the RLNs were stimulated with supramaximal constant current, movement was seen in both vocal folds but with a significantly more normal range of motion on the MPC side (Table I). The measures of vocal fold adductor strength, LAP and GCF, both showed significantly more recovery in the MPC-injected side than the control side (Fig. 4). The MPCs implanted in dog 2 led to a recovery of adductor strength to normal (pretreatment) levels by both measures; the saline control had typical recovery for the transection-repair nerve injury model. Dog 3 received motor endplate-enhanced cells and recovered adductor strength to 28% higher than normal (by LAP); the GCF measure was even higher. These results are summarized in Table I.

DISCUSSION

In this limited pilot study, implantation of autologous-derived muscle progenitor cells into denervated thyroarytenoid and possibly lateral cricoarytenoid muscles resulted in greater functional reinnervation.

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<th>TABLE I. Functional Measurements From Dogs 2 and 3.</th>
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<td><strong>Vocal Fold</strong></td>
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LAP and GCF results expressed as proportion of pretreatment measures. Dogs were implanted with autologous cultured MPCs or MPCs with enhanced MEE. Movement scores on scale of 0 (no movement) to 4 (normal movement).

GCF = glottic closing force; LAP = laryngeal adductor pressure; MEE = motor endplate expression; MPC = muscle progenitor cells.
than similar experiments without these cells. More significantly, purposeful adduction of the vocal fold was observed with a glottic closure reflex on swallow. This effect appears to be due to both increased muscle mass, as evidenced by increased myofiber diameter as well as increased innervation (based on motor endplate-to-nerve contact), with a further increase when motor endplate expression was enhanced in dog 3. These data support a potential role for MPC implantation in the treatment of patients with RLN injury.

Kodama et al. found significant increases in muscle transcription factors MyoD and M-cadherin in denervated rat thyroarytenoid muscle, which return to baseline after nerve recovery. These factors activate native MPCs and stimulate their proliferation. Cultured MPCs added to the denervated muscle would be expected to respond similarly to these transcription factors, as apparently occurred in these experiments. Although we did not specifically study the relationship between innervation status and MPC survival, there was a mosaic pattern of uptake throughout the muscle rather than uniform uptake, supporting the concept that the innervation status may have played a role in the MPC-myofiber fusion process.

The RLN has a strong tendency to regenerate after injury, but the adductor and abductor fibers reinnervate the laryngeal muscles randomly, resulting in a range of potential outcomes. By implanting MPCs into only one muscle, we have the potential to tip the scale in favor of adduction for unilateral cases, or abduction in bilateral cases. The scale could be further tipped by inhibiting the antagonistic muscle from reinnervating, for example, by early injection of vincristine. We have previously reported that adductor function improved when reinnervation of the posterior cricoarytenoid was inhibited by injecting it with vincristine.

Further experiments examining variables such as timing, number of cells to implant, roles of other nerve and muscle growth factors, magnitude of effect with other reinnervation methods such as ansa cervicalis, effect on voice production, and effect of MPC implantation into the posterior cricoarytenoid muscle are planned. The procedure to implant these cells is fairly simple and should be within the skillset of any otolaryngologist who performs vocal fold injections. Commercial entities have already begun offering a service to extract and culture MPCs from muscle samples. Thus, this approach may be closer to the ideal treatment for vocal paralysis.

CONCLUSION

Implantation of autologous-derived muscle progenitor cells was found to significantly increase adductor strength in a canine model of RLN transection and repair. Further work is warranted to evaluate this approach as a potential new therapy for vocal fold paralysis.

BIBLIOGRAPHY


