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Regression of cervical radiculopathy after laser therapy treatment – a case report.

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Cervical radiculopathy is the clinical description of pain and/or neurological symptoms resulting from any type of condition that irritates a nerve in the cervical spine (neck). Any condition that somehow compresses or irritates a cervical nerve can cause cervical radiculopathy.

Discogenic disease affecting the cervical spine is common cause of cervical radiculopathy and represents a disabling conditions which is caused by a damaged vertebral disc, particularly due to degenerative disc disease. Cervical radiculopathy caused by degenerative changes was first described by Parkinson in 1817 and still remains one of the major contributors for neck pain, commonly seen condition across many patient populations [1, 2].

Cervical radiculopathy symptoms typically include pain, weakness, or numbness in the areas served by the affected nerve. Pain can be felt in one area only, like the shoulder, or progress along the entire arm and into the hand and fingers

The treatment involves nonsurgical (such as rest, physical therapy, manual manipulation, pain management with medications or injections) and surgical (anterior cervical discectomy and fusion and artificial disc replacement) treatments. Usually, if there is no improvement in symptoms after 6 to 12 weeks of treatment and nonsurgical treatments are not providing pain relief from cervical radiculopathy, or if neurological symptoms of arm or hand numbness and weakness continue to progress, surgery may be considered. Surgical intervention of the cervical spine can cause serious complications.

A woman 46 years old was referred to our study for the relief of pain associated to cervical radiculopathy. MRI of the neck showed signs of discogenic disease with disc desiccation at C2-C3, C4-C5 and C5-C6.

A slight loss of disc height was observed from C3-C4 to C5 (Figure 1). Presence of fluid, probably related to inflammation, was detected at the C3-C4 level, where a disc herniation was also shown. Disc herniation was located centrally and towards the right respect to midline, exerting a mass effect on the spinal cord, which was 50% narrowed. A small posterior disc protrusion was reported at the C5-C6 level, while in correspondence of C6-C7 level uncovertebral osteophytosis was present. Based on this radiographic data and on the clinical evaluation performed, the doctor proposed laser therapy to the patient in the attempt of proving pain relief and avoid cervical spine surgery.

The treatment plan included laser therapy in the cervical area and complementary botanical anti-inflammatory medicine, containing Rhodiola rosea, Morinda citrifolia, Tribulus terrestris, Uncaria tomentosa, Dioscorea villosa, Capsicum annuum.

The patient was treated with a dual wavelength, high power IR laser (Multiwave Locked System (MLS®) laser, M6, ASA srl, Vicenza, Italy), using the following treatment parameters:

- Handpiece: 50% intensity, frequency of 700 Hz, for 8 minutes utilizing energy of 9.5 joules/cm^2.
- Robotized head: 50% intensity, frequency of 700 Hz, for 8 minutes utilizing energy of 2.5 joules/cm^2.

Sensitive area trigger points were been identified and treated with handpiece, while robotized head was used to cover the overall treatment area.

Treatment was performed every day for 8 consecutive days.

At the end of the treatment, the patient was pain free and, remarkably, MRI conducted to evaluate the patient 2 months after the first radiographic assessment (Figure 2) revealed that spontaneous regression of the herniated disc had occurred, with 90% restitution of the spinal cord space.

In the reported case, not only MLS® therapy provided an effective non-invasive approach to treat cervical pain, but the remarkable result observed in this case is the successful outcome on the spinal cord narrowing. It is important to note that there have been fewer reports of spontaneous regression of cervical disc herniation, especially ones confirmed by magnetic resonance imaging [3, 4]. Many factors related to the regression process have been recognized, including the age of the patient, dehydration of the expanded nucleus pulposus, resorption of a hematoma, revascularization, penetration of herniated cervical disc fragments through the posterior longitudinal ligament (PLL), the size of disc herniation, and the existence of cartilage and annulus fibrous tissue in the herniated material. Resorption of a herniated

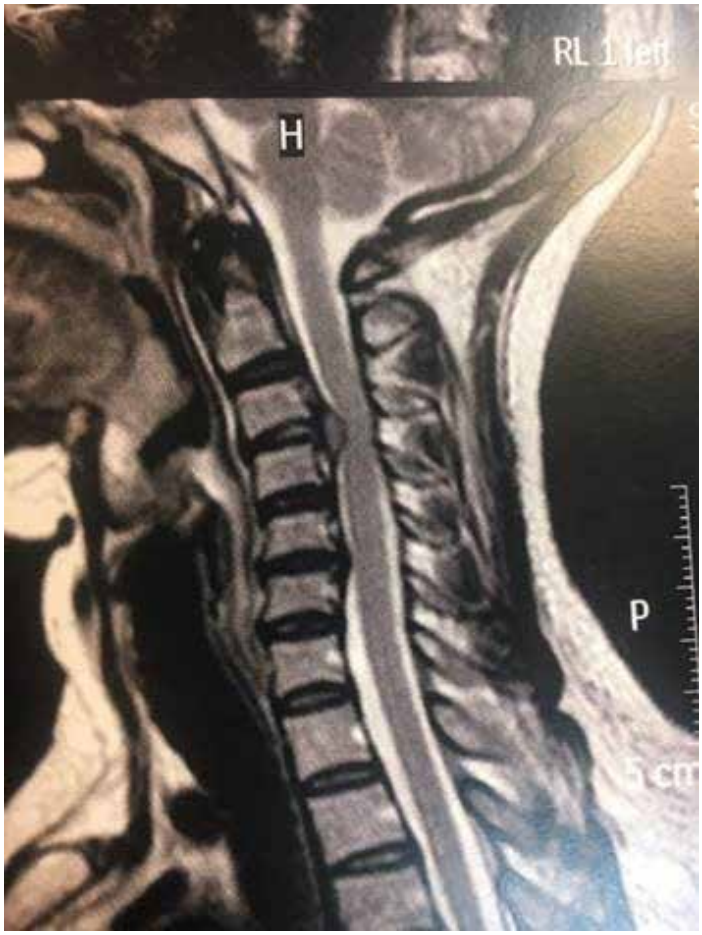

Figure 1: Sagittal MRI pre-treatment

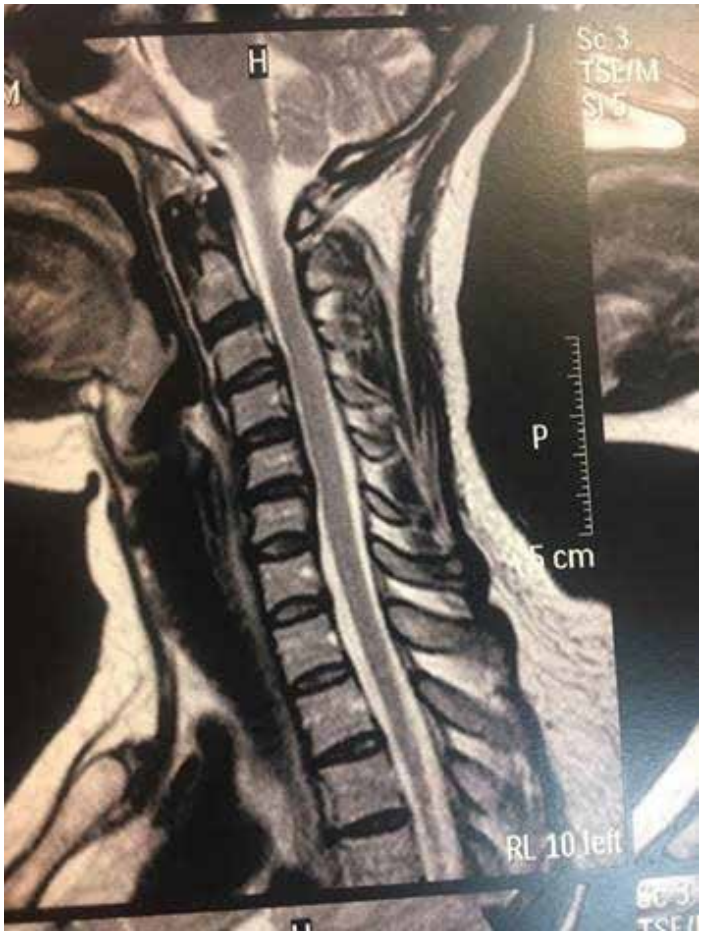

Figure 2: Sagittal MRI after MLS treatment

nucleus pulposus is thought to occur via an inflammatory reaction in the outermost layer of the herniation, with macrophages as the major cellular population [5]. It can be hypothesized that MLS® therapy could be a useful method to facilitate the mentioned factors.

In conclusion, the main result for the patient was elimination of pain and avoidance of surgical intervention, which in our experience is the most common outcome of this type of cervical condition.

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Combined use of Armourbite and MLS® in temporomandibular disorders, craniofacial pain and neuromuscular dysbalance.

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ABSTRACT

Temporomandibular disorder (TMD) is a nonspecific diagnosis that includes a group of conditions involving the muscles of mastication and/or the temporomandibular joint (TMJ). TMD comprises a wide range of clinical symptoms, such as headache, facial and jaw pain, neck pain or movement limitation, etc. and severely impact on patient quality of life.

The incidence of the TMD in the general population is widespread and many people suffer to a greater or lesser degree from these disorders.

Current conservative gold standard treatment is represented by occlusal splints, but recently other therapeutic approaches are being used, among which laser therapy is giving interesting results.

The aim of this study is to report on four cases in which the combination of MLS® laser treatment and the Armourbite splint was used to relief TMD symptoms. In order to provide some early comments on the comparison with the results obtained with splint alone, 2 patients with similar characteristics and treated only with Armourbite have been included in this report as well.

In the studied patients, the MLS® laser therapy together with Armourbite splint represented an effective and fast treatment for TMD and in most cases the treatment was able of reestablishing the neuromuscular functions. Clinical studies are needed to confirm these preliminary observations and determine the most appropriate treatment parameters.

INTRODUCTION

The temporomandibular disorders (TMD) represent a range of clinical disorders involving the masticatory muscles, the temporomandibular joint and associated structures. Symptoms associated to TMD include: headaches; facial pain; jaw pain; sore, chipped, broken, or worn teeth, clicking or popping in the jaw, and limited jaw movement. In addition to pain symptoms, signs are frequently found joint sounds such as clicks or crackle and limitation or deviation of mandibular opening. Some patients may experience all of the reported symptoms, while other will report only a few of those problems.

The area of the face where the temporomandibular joint (TMJ) is located is a complex of bones, including the teeth, muscles, and nerves. Because of this, TMJ conditions affect many areas of the body, from the top of the head in migraine-like headaches to numbness or tingling in the arms and pain in the neck or shoulders.

Data released by the American Academy of Orofacial Pain (AAOP) estimate that 75% of the population in the United States has presented signs and / or symptoms of TMD. These conditions are present in the very young population, increase with age to eventually decrease after age 50. The highest prevalence in the population is between 20 and 40 years of age. Globally, epidemiological studies have shown that approximately 10% of the population is affected, and 30-year-old women are the population segment most likely to be affected by TMD [1, 2].

It is known widely in the literature that, in most of the cases, TMD are due to a multifactorial etiology and the competition of multiple risk factors. The multifactorial etiology of the disorder requires a multidisciplinary treatment approach with a team that is responsible for the management of patients with problems of the stomatognathic system. Among the factors that can lead to TMD, the main one are trauma (i.e. car accident, sport injury), improper occlusion, joint inflammation, grinding or clenching of teeth, neuromuscular imbalance, diseases such as rheumatoid arthritis or degenerative osteoarthritis and sleep disorders.

The variety of disorders collected under the name of TMD makes diagnosis and treatment challenging. An accurate diagnosis is critical for successful treatment. Real-time objective physiologic data such as electromyography represent a useful

tool to support the dentist in providing the appropriate diagnosis as gives details information on craniomandibular alignment.

The therapy of the TMD is essentially based on conservative approaches and reversible, including counseling and the realization of occlusal splints constitute the reference standard, together with any drug therapy support. Splints are designed to fit over the teeth. They prevent the upper and lower teeth from coming together, based on the fact that the role of occlusion in the etiology of TMD has been widely documented in the dental literature [3].

Armourbite is a splint designed with the aim of creating an optimal spacing of the jaw by placing space between molars, preventing teeth from clenching. The specific design of Armourbite allows rotation of the lower jaw down and forward to help relieve pressure on the TMJ.

Recently, some studies have been addressing the use of alternative treatments, such as transcutaneous electrical nerve stimulation (TENS), ultrasound, trigger point injections and acupuncture. Laser therapy has also been considered for the treatment of TMD [4-6], based on the fact that its main effects, such as healing promotion, analgesic and anti-inflammatory effects, can play an important role in reducing signs and symptoms associated with TMD.

Given the multifactorial origin of TMD, the ideal treatment should include synergic strategies, targeting the different aspects of the condition in order to provide the patient with the most successful treatment.

In this light, the objective of this study was to report the preliminary experience on a random sample of 4 patients in which the combination of MLS® laser treatment and the Armourbite splint was used to relief TMD symptoms. In order to provide some early comments on the comparison with the results obtained with splint alone, 2 patients with similar characteristics and treated only with Armourbite have been included in this report.

In order to evaluate appropriately the patient neuromuscular dysbalance, the electromyograph BTS TMJOINT was used.

MATERIALS AND METHODS

A group of patients coming from Dr Janke's and Dr Rosswag's practice have considered in this report. The material and methods applied had the following common aspects.

The inclusion criteria were: age ≥18 and <75 years, presence of a retained TMJ opening, presence of parafunctions (clenching and bruxism), cervical spondylosis, neuromuscular dysbalance of the elevator muscles of the jaw (masseter and temporalis) evaluated with BTS TMJoint (BTS Bioengineering, Italy).

Patients wearing pacemakers, pregnant, subjects with severe comorbidities (such as hypertension, diabetes mellitus, cardiac rhythm), subjects with severe respiratory disease (COPD), outcomes of major traumatic diseases, subjects with chronic encephalopathy and cerebral disorders (i.e. Parkinson's disease, epilepsy) and severe postural conditions (such as congenital torticollis, asymmetry of the lower limbs) were excluded from the study.

At the first visit, clinical evaluation was performed, myofascial pain type was indicated (i.e. masseter/temporal muscle hypertonia, cervicalgia, trapezius muscle hypertonia, sternocleidomastoid muscle hypertonia, TMJ pain or others), trigger points and irradiation areas were recorded by the dentist and the presence of edema, cervical arthrosis, muscle contracture, wound, trigger points, bruxism/clenching and/or other specific conditions was reported. Additionally, the patient was asked to estimate the number of pain events during the day and during the week.

At the same visit, electromyograph (BTS TMJoint, BTS Bioengineering, Italy) was used to provide a gnathological examination of dental occlusion by recording electromyographic activity of the masseters and temporalis (left and right).

At each therapy session, the following assessments were performed:

- pain evaluation using the VAS scale (pre and post therapy)
- muscle contracture
- cervical spine range of motion (left and right)

Additionally, reactions, side effects and further notes were recorded.

The Armourbite group patients were treated with splint only (Armourbite Mouthpiece, BiteTech, UK).

The Armourbite and MLS® group received MLS® Laser Therapy (Mphi D, ASA S.r.l., Italy). MLS® laser is a class IV NIR laser with two synchronized sources (laser diodes). These emit at different wavelengths, peak power and emission mode. The first one is a pulsed 905 nm laser diode with 25 W peak optical power. The pulse frequency may be varied in the range 1-2000 Hz, thus varying the average power delivered to the tissue. The second laser diode (808 nm) may operate in continuous (power 1.1 W) or pulsed mode (repetition rate 1-2000 Hz, 550mW mean optical power, with a 50% duty ratio independently of the repetition rate). The two laser beams are emitted synchronously and the propagation axes are coincident. The treatment was carried out by treating the patient with a holistic approach consisting in the treatment of muscle contracture and trigger points. The following operating parameters were applied according to the static and dynamic protocol. Static protocol for TMJ treatment includes treatment of the condyle and masseter area (Energy delivered= 47J) and also of trigger points on the sternocleidomastoid (SCM), if present (Energy delivered=3J

for point). Static protocol for shoulder and cervical pain includes treatment over paravertebral area from C3 to C7 bilaterally and the upper trapezius (Energy delivered= 41J). If present, trigger points on the upper trapezius area and on SCM area are treated (Energy delivered=3J for point).
During dynamic protocols, MLS® treatment is performed in scanning mode on areas where muscles are in motion.
TMJ treatment is performed during depression/elevation movements and mandibular lateral excursion. Cervical area treatment involves the application during cervico-cranial rotation, and extension/flexion and lateral flexion movements. For dynamic trigger point treatment, the patient has to actively extend the belly of the muscle, with the help on the operator, and in this condition the supraspinatus muscle trigger points must be specifically treated.

RESULTS

Six individuals have been included in this case report. Two patients received Armourbite treatment and four patients received Armourbite together with MLS® treatment.

Case #1 - Patient treated with Armourbite

Female patient, 57 years old presenting headache and back, neck and shoulder pain and reported sleeping problems. At clinical evaluation, hip height and leg length differences were observed.
Myofascial painful points were located at the masseter/temporal and trapezius muscles.
Muscle contracture, trigger points and bruxism/clenching were also present. The patient reported pain events during the time with a duration of less than 5 hours and a weekly occurrence of pain events between 3 and 5 times.
The patient received Armourbite treatment and was followed up for 5 weeks. In this period, VAS score improved of 6 points, from 8 to 2.
Muscle contracture was also evaluated on a 10-point scale and changed from 8 to 2 in the observation period.
Cervical spine range of motion improved from 50° on the right side and 50° on the left side at the first assessment to 90° on the right side and 90° on the left side after the observation period. Back pain was reduced of 50% at the end of the treatment.
Headache, sleeping and hip/leg discrepancy issues were solved after the treatment with Armourbite.

Case #2 – Patient treated with Armourbite

Male patient, 36 years old presenting neck problems. Myofascial painful points were located at the trapezius muscle, on the left and right side. The patient reported pain events during the time with a duration between 5 and 10 hours/day and a weekly occurrence of pain events between 1 and 3 times.
The patient received Armourbite treatment and was observed for 4 days. In this period, VAS score related to neck pain immediately improved of 7 points, from 8 to 1.

Case #3 - Patient treated with Armourbite+MLS®

Female patient, 25 years old presenting neck problems. Myofascial painful points were located at the left side of trapezius muscle. Trigger points were present. The patient reported pain events during the time with a duration between 5 and 10 hours/day and a weekly occurrence of pain events between 3 and 5 times.
The patient received Armourbite + MLS® treatment for 3 consecutive days. MLS® treatment was performed using the scanning mode on the upper trapezius with the following parameters: Frequency 700 Hz; Intensity 50%; Time 1′ 30″ per side. Dose is 1,24J/cm^2.
The VAS score immediately improved of 7 points from 8 to 1. Trigger point pain also improved from 8 to 3 on the third day.

Case #4 – Patient treated with Armourbite+MLS®

Female patient, 56 years old presenting Atlas displacement, painful left TMJ side, neck pain and limited range of motion. Myofascial painful points were located at masseter/temporal, sternocleidomastoid and trapezius muscle, additionally, cervicalgia was reported. Muscle contracture, trigger points and bruxism/clenching were also present.
The patient reported more than 10 hours/day of pain events and a weekly occurrence of pain events of 5 or more days.
The patient received Armourbite + MLS® treatment and was followed up for 3 months.
The treatment involved a first phase with the use of Armourbite Mouthguard alone, the second phase involved the MLS® treatment which comprised 5 sessions over 3 months: from 1 to 4, using the static program, while session #5 was carried out with the dynamic protocol.
The static and dynamic programs involve the use of the following parameters:

- Frequency:350 Hz; Intensity: 50%; Time: 3′;
- Frequency:700 Hz; Intensity: 50%; Time: 2′ 30″;
- For Trigger points: Frequency:10 Hz; Intensity: 25%; Time:25″;

Energy dose for each trigger point is 1 J/cm^2
Energy dose for each area for static program is in the range 0.8 – 2,5 J/cm^2
Energy dose for each area for dynamic program is <0.5 J/cm^2
The VAS score immediately improved of 7 points from 7 to complete and stable pain elimination. Full range of motion was recovered at the end of the treatment sessions.

Case #5 – Patient treated with Armourbite+MLS®

Male patient, 45 years old presenting very limited neck range of motion. The patient reported to be able to sustain only up to 30 min in the sitting position, as after this time both leg numbness occurred. Myofascial painful points were located on the right side at masseter/temporal, TMJ, sternocleidomastoid and trapezius muscle, additionally, cervicalgia was reported. Muscle contracture, trigger points and bruxism/clenching were also present.

The patient reported more than 10 hours/day of pain events and a weekly occurrence of pain events of 5 or more days.

The patient received Armourbite + MLS® treatment and was followed up for 4 weeks.

The treatment involved a first phase with the use of Armourbite Mouthguard alone, the second phase involved the MLS® treatment which comprised 5 sessions over 1 week: from 1 to 4, using the static program, while session #5 was carried out with the dynamic protocol.

The static and dynamic programs involve the use of the following parameters:

- Frequency:350 Hz; Intensity: 50%; Time: 3′;
- Frequency:700 Hz; Intensity: 50%; Time: 2′ 30′′;
- For Trigger points: Frequency:10 Hz; Intensity: 25%; Time:25′′;

Energy dose for each trigger point is 1 J/cm^2

Energy dose for each area for static program is in the range 0.8 – 2,5 J /cm^2

Energy dose for each area for dynamic program is <0.5 J/cm^2

The VAS score improved of 9 points from 10 to 1.

Range of motion improved of 50% after the first phase with Armourbite and full range of motion was recovered after the second phase with MLS® therapy.

The problem related to the sitting position dramatically improved and the patient reported the possibility of sitting for more than 5 hours without lower limb numbness occurrence.

Case #6 – Patient treated with Armourbite+MLS®

Female patient, 26 years old reporting pain after sleeping. Myofascial painful points were located at the left side of masseter/temporal muscle. Trigger points and bruxism/clenching were present. The patient reported between 1 and 5 hours of pain events during the day and a weekly occurrence of pain events between 1 and 3 times.

The patient received Armourbite + MLS® treatment and was followed up for 9 days.

The MLS® treatment involved 4 sessions performed with the static program dedicated to the masseter area, using the following parameters: Frequency 350 Hz; Intensity 50%; Time 30′. Dose is 0.8 J/cm^2.

The VAS score immediately improved of 6 points from 7 to 1.

DISCUSSION

As a general comment, both the treatments used (splint and laser therapy) were well tolerated by the patients and no adverse effects have been reported.

Armourbite is a splint designed to re-establish the neuromuscular balance in the masticatory system. The impact of the Armourbite treatment can both treat local painful symptoms, and also deeply affect quality of life, such as eliminating headache and sleeping disorders. This is confirmed by the two cases, #1 and #2, which received Armourbite treatment alone.

Laser application is effective in reducing TMD symptoms, especially pain [7], and has influence over masticatory efficiency [8].

Therefore, the combination of Armourbite splint and MLS® laser therapy seems to be a promising and practical approach to address the complex TMD picture.

The combined therapeutic protocol including Armourbite and MLS®, applied in 4 of the reported cases, was easy to follow, very effective and was able to provide results in a limited number of sessions. In particular, it was evidenced that some selected cases can obtain beneficial outcome even in just 3 days of treatment, as happened for case #3.

Therefore, MLS® appeared to be a treatment able to maximize the positive effects of Armourbite: the joint effect of the two strategies is exemplified in case #5, where 50% improvement in range of motion was obtained with the use of Armourbite and then the addition of MLS® treatment allowed for a full range of motion restoration.

In fact, MLS® laser therapy can reduce inflammation, decrease muscle contracture and improve muscle function by inducing the synthesis and/or modulation of proteins involved in the regulation of inflammasoma activity, anabolic processes, contraction/relaxation processes [9].

In order to make the most from the treatment of TMD with MLS® laser therapy, a global approach is recommended. This involves not only the local painful point treatment, but includes the all muscle groups and trigger points that are involved in the pathology, directly or indirectly. To maximize the effect of the treatment, static and dynamic procedures have been defined. Generally, the first treatment phase involves the static treatment and the dynamic procedure completes the therapy in the latter sessions i.e. case #4 and case #5. The static treatment aims at decontracting, reducing inflammation and pain. The dynamic protocol adds to these effects the proprioceptive and joint recovery. The combination of the two is especially indicated in high complexity situations, where several painful areas can be identified and the pain symptoms are also associated to other problems, for examples limited ROM and bruxism/clenching (case #4) and also limb

problems (case #5).
The reported cases demonstrate the positive outcome in the TMD treatment when the combination of Armourbite splint and MLS® therapy is used, nevertheless, more clinical information are needed to clarify the mechanism of action of this protocol and confirm the clinical significance. A randomized controlled study would be the ideal clinical method to further study the combination of these two approaches in the treatment of TMD and related issues.
Key features for reliable studies are the reporting of allocation, blinding, sequence generation, withdrawals, intention-to-treat analysis, and any other potential source of bias in the study. In addition, there should be use of well-validated standardized outcomes so that the RCTs could be compared with other similar trials [10].

CONCLUSION

In the reported cases, the MLS® laser therapy together with Armourbite splint represented a very effective, fast, predictable and successful treatment for TMD and in most cases the treatment was able of reestablishing the neuromuscular functions exceeding the clinical expectations. Additional clinical studies are required to confirm this preliminary experience in the combination of MLS® and Armourbite, to optimize treatment modalities and to identify the patients that can get the most by this therapeutic combination.

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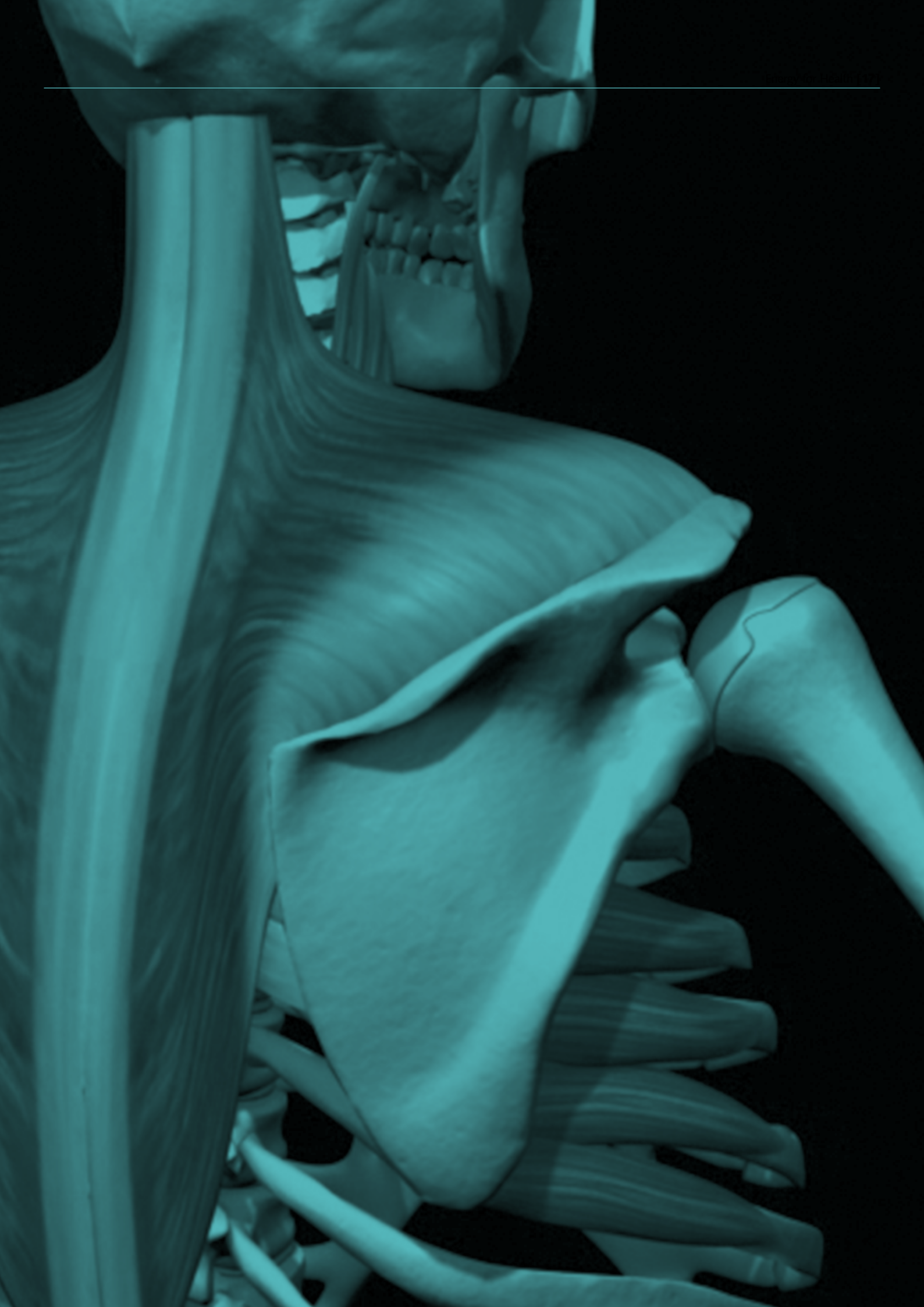

Study on the mechanisms underlying the biological effects of extremely low frequency electromagnetic fields (ELF EMFS) on a fibroblast model.

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In the last decades, electromagnetotherapy generated an intense interest for the medical treatment of some pathological states related to the musculoskeletal system. In particular, extremely low frequency (ELF) electromagnetic fields (EMFs) are used to improve tissue regeneration in bone non-union fractures, to facilitate skin wound healing and to reduce pain symptomatology. This therapy represents a valid and non-invasive approach widely used to treat the area of interest limiting the adverse effects related to drug administration. The molecular mechanisms by which ELF EMFs act on cell behavior is still not completely known, but numerous and heterogeneous effects have been observed on a very large number of biological processes. These effects vary in relation to the treatment parameters and intrinsic susceptibility of specific cell lines.

In order to study the molecular mechanism by which ELF EMFs act on fibroblasts, the mouse-derived NIH3T3 cell line was chosen as the experimental model to carry out some biochemical investigations. After EMF exposure, the cells showed an increased level of ROS and a decreasing activity of the enzyme pyruvate kinase (PK), leading to a slowdown of the glycolytic flux and a redirection of glycolytic metabolites towards the pentose phosphate pathway (PPP). Hence, the results of the study define a coherent biochemical mechanism by which ELF EMFs are able to promote a shift of cell metabolism from catabolic to anabolic processes. Additional investigations such as the evaluation of reduced glutathione levels, are however necessary to confirm the mechanism.

INTRODUCTION

Extremely low frequency (ELF) electromagnetic fields (EMFs) have generated a growing interest for their use in medicine. This therapeutic treatment represents a safe, non-invasive approach, characterized by lack of toxicity and the possibility of being combined with other available therapies. Furthermore, one of the main advantages of electromagnetic therapy is the possibility of applying the treatment exclusively to the targeted area in order to minimize the adverse effects affecting non-targeted tissues and organs.

Electromagnetic therapy is successfully used for the medical treatment of several pathological conditions such as disorders related to musculoskeletal system, Parkinson's disease, multiple sclerosis [1] and, even though the biochemical and molecular basis is still unknown, the Food & Drug Administration (FDA) approved the use of ELF EMFs as safe for treating bone pathologies and delayed fractures. In fact, it has been reported that EMFs are able to promote proliferation and differentiation of osteoblasts [2]. Another common application of electromagnetic therapy is to facilitate the healing process in chronic wounds because electromagnetic treatments seem to influence the process of tissue repairing by acting on various secondary messengers [3]. From a molecular point of view, it seems that electromagnetic therapy exerts an anti-inflammatory effects in treated tissues due to a down-regulation of COX-2 expression and a lower production of PGE-2 [4].

Hence, electromagnetic therapy constitutes an adjuvant therapy and a valid alternative to use when traditional medicine do not produce any significant improvement and, for these reasons, it is necessary to increase the molecular and biochemical comprehension related to the mechanism of action of ELF EMFs on biological systems in order to

improve its therapeutic potential.

The biological effects of ELF EMFs have been investigated in several in vitro studies and results indicate that ELF EMFs have heterogeneous effects on a very large number of biological processes such as cell cycle distribution and proliferation [5, 6], cell migration [7], apoptosis [8], gene expression [9] and differentiation [10]. All of these effects vary in relation to frequency, amplitude, length of exposure and are also related to intrinsic susceptibility of different cell types. Sul et al. [11], for example, have compared the effects of electromagnetic exposure (60 Hz, 2 mT) on four kinds of human cell lines demonstrating that there is a specific cell-type response to EMFs, tightly correlated to the duration of exposure. Moreover, different effects can be observed even when similar cells are exposed to EMFs. In fact, when HaCaT and NHEK cells are exposed to EMFs (60 Hz, 1,5 mT), a G1 arrest is detected in HaCat cells, while no effects on cell proliferation and cell cycle distribution is observed in NHEK cells [12].

A lot of assumptions have been made to explain how physical stimulus is converted to chemical signal, but the transduction pathway by which EMF acts on cells, has not been elucidated. Calcium signaling plays an important role in regulating proliferation, differentiation and apoptosis and it was reported that ELF EMFs can alter the levels of cytosolic Ca2+ [13], although this effect seems to be specific to the cell type and the EMFs parameters applied. Another important molecular response to ELF EMFs is represented by an increasing level of intracellular reactive oxygen species (ROS) in cells exposed to EMFs [14]. Since ELF EMFs seems to work by affecting the redox state of cells by promoting variations of physiological ROS levels, biological processes can be influenced by the electromagnetic treatment and this aspect could provide a possible molecular mechanism to explain the beneficial effects of electromagnetic therapy. In fact, it was demonstrated that increasing levels of ROS occurred after ELF EMFs treatment, taking to the activation of the molecular events able to induce cell proliferation due to the activation of redox signals involving NFkB proteins [15].

Since ROS can act as signaling molecules deeply involved in regulating cellular processes and metabolism, via cysteine oxidation, as recently reported in literature [16, 17], the activities of the enzymes involved in the principal metabolic pathways have been evaluated in NIH3T3 cells exposed to ELF EMFs. In particular, our attention has been focused on the isoform M2 of pyruvate kinase (PKM2) because it has been described that the oxidation of Cys358 causes the inhibition of the enzyme [18]. In order to establish whether ELF EMFs can exert metabolic modifications in NIH3T3 cells, the intracellular levels of ROS, the enzymatic activity of PK, citrate synthase (CS) and the endogenous concentrations of ATP have been evaluated after EMF exposure.

MATERIALS AND METHODS

Cell cultures

Mouse embryonic fibroblasts (NIH3T3 cell line) were used as cellular model to investigate the cellular and molecular effects of ELF EMFs. Since this model system has been used in a multitude of different studies, NIH3T3 cells were chosen to conduct the investigation because it represent a well characterized cellular model. Cells were grown at 37°C, in 5% CO^2/air atmosphere, in Dulbecco's Modified Eagle Medium (DMEM) (Sigma-Aldrich) supplemented with 10% (v/v) heat- inactivated foetal calf serum (FCS) (Biowest) and 2 mM L-glutamine (Biowest). Cells were seeded (3.0×105) in 100 mm Falcon dishes and propagated every 3 days with a 0.25% trypsin solution (Sigma-Aldrich) Cells were purchased from ATCC (ATCC CRL-1658). No antibiotics were used in cell cultures. Cell cultures were periodically tested for Mycoplasma contamination.

Experimental setup for exposure cells to ELF EMFs

Cell exposure to ELF EMFs was carried out by a medical device commercially available (Easy Qs device), produced by ASAlaser (Vicenza, Italy). The source of EMFs constituted of a rectangular shaped surface applicator provided of 12 coils. Each coil generates a sinusoidal signal and magnetic flux density was longitudinally and transversely evaluated by the company that realizes the device.

In our investigations two different electromagnetic treatments were evaluated. Cells were exposed for 20 minutes to the frequencies of 25 Hz (1.62 mT) and 50 Hz (2.4 mT). During the time of exposure to EMFs, control and treated cells were kept under the same environmental conditions. Cells were seeded (2.0×105) on 60 mm Petri dishes and cultured until reaching exponential growth phase. Hence, cells were treated with EMFs and prepared for the assays.

MTT assay

MTT assay is a rapid colorimetric analysis routinely used to investigate the state of cell energy metabolism and possible cytotoxic effects. This assay is based on the principle that metabolically active cells are able to convert a yellow water-soluble tetrazolium salt, 3-(4,5-dimethylthazolk-2-yl)-2,5-diphenyl tetrazolium bromide) (MTT), into a purple colored formazan product by mitochondrial succinate dehydrogenases (SDH). MTT assay was also used to evaluate the enzymatic activity of SDH because it has been demonstrated that SDH activity and MTT reduction were closely related [19]. Cells were exposed to EMFs and MTT assay was performed immediately after the end of treatment and 24 hours later. Cells were incubated for 40 minutes with 1 mM thiazolyl blue tetrazolium bromide (Sigma-Aldrich). At the end of incubation, the medium was removed and DMSO was added in each plate to dissolve formazan crystals. The absorbance signal was read at 570 nm by a microplate reader (Infinite M200PRO, Tecan). The background absorbance was read at 630 nm and subtracted from signal absorbance to obtain normalized absorbance values.

Immunofluorescence analysis

Cells were fixed on the cover slides using

4% formalin for 10 minutes, permeabilized for 5 minutes with 0,1% Triton X-100 and blocked for 1 hour with 3% FBS in PBS solution at room temperature. For tubulin detection, mouse anti α-tubulin antibody conjugated with Alexa Fluor 488 (1:500; Life Technologies) was incubated for 2 hours at room temperature. Actin was stained for 20 minutes with CF594 conjugated Phalloidin (1:40; Biotium), at room temperature. Nuclei were stained by Fluoroshield with DAPI mountant (Sigma-Aldrich).

Measurement of intracellular ROS

The level of intracellular ROS was quantified by fluorescence with 2'-7,-dichlorofluorescein diacetate (DCFH2-DA, Sigma-Aldrich, Italy), as described by Bass et al. [20]. Before ELF EMFs exposure, cells were incubated with DCF-DA (20 μM) for 1 hour at 37°C. After treatment to EMFs, cells were immediately washed twice with PBS and the relative levels of fluorescence were quantified by a multi-detection microplate reader (Infinite M200PRO, Tecan; λex=485 nm; λem=535 nm). Fluorescence values were reported as mean of fluorescence intensity. Hydrogen peroxide was used as a positive control (80 μM, for 30 minutes).

Experimental setup for enzymatic activities assays

Cells were treated with EMFs and prepared for biochemical investigations which have been conducted 5 and 24 hours after EMFs exposure.

The enzymatic activities of pyruvate kinase (PK) and citrate synthase (CS) have been evaluated in order to detect a possible alteration in cell metabolism following treatment with EMFs. In order to verify a possible role of ROS in regulating enzymatic activities, DASA-10 (Sigma-Aldrich), diamide (Sigma-Aldrich) and H_2O_2 (Sigma-Aldrich) were used in enzymatic activities evaluations. DASA-10 is a little molecule that binds to the isoform M2 of PK and cover cys358, maintaining the - SH of cys358 in its reduced state, and then, protecting PKM2 (PKM2) from ROS-induced inhibition [18]. In our experiment DASA-10 was used at 20 μM for 1 hour before treatments. Some further control groups were establish in order to assess the protective action of DASA-10 in oxidative conditions and these groups are listed below:

- Control cells were treated with H_2O_2 (80 μM) for 40 minutes.
- Control cells were treated with diamide (250 μM) for 15 minutes.
- Control cells were treated wit DASA-10 (20 μM) for 1 hour and then with H_2O_2 (80 μM) for 40 minutes.
- Control cells were treated with DASA-10 (20 μM) for 1 hour and then with diamide (250 μM) for 15 minutes.

The activities assays were repeated after incubating the samples for 2 hours with 2 mM dithiothreitol (DTT).

This experimental design was also utilized in the evaluation of ATP levels.

Cell lysis

Cell lysis was performed in cold buffer (50 mM Tris-HCl pH 7.4) containing Sigma protease inhibitors mix (1:100, v/v), DTT (5 mM), or not DTT. After 30 min of incubation on ice, lysates were sonicated (three short bursts) and centrifuged in a microcentrifuge for 30 min at 12.000 g (4°C). Supernatants were used for the

Fig 1:

MTT assay in NIH3T3 cells exposed to EMFs was performed immediately after the exposure (T_0) and after 24 hours. Two different EMF treatments were compared (25 Hz and 50 Hz). Results are expressed as a percentage of the absorbance signal of control cells (indicated as 100%).

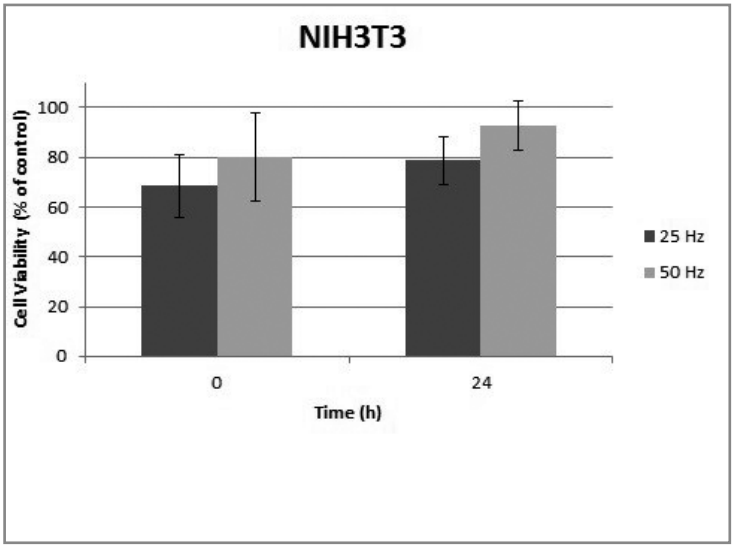
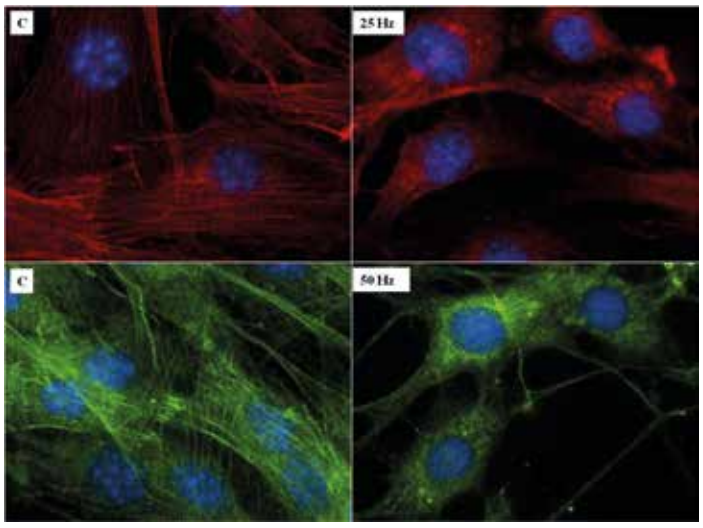


Fig 2:

Immunofluorescent analysis of cytoskeleton architecture in NIH3T3. Upper row: fluorescent microscopy of F-actin stained with Phalloidin (red) and nuclei with DAPI (blue). Cells were fixed 24 hours after EMF treatment. Lower row: fluorescent microscopy of α-tubulin (green) and nuclei with DAPI (blue). Images were collected at 100x magnification.



evaluation of enzymatic activities with respect to proteins content.

Determination of total proteins content

Total proteins concentration was determined spectrophotometrically according to the Bradford method [21], using a reagent produced by Sigma-Aldrich.

Pyruvate kinase (PK) activity (EC 2.7.1.40)

The enzymatic assays were performed at 30°C spectrophotometrically using an UV-2100 spectrophotometer (Shimadzu). PK activity was determined according to Hess and Wieker [22], with slight modifications, monitoring the NADH oxidation at 340 nm. The values of 6.22 mM-1 cm- 1 and 14.15 mM-1 cm-1 are considered to be the NADH molar extinction coefficients. One unit of activity is defined as that quantity of enzyme which transforms one µmole of substrate in one minute, at 30°C.

The assay mixture consisted of 50 mM triethanolamine (pH 7.6), 8 mM MgSO4, 5 mM EDTA, 75 mL KCl, 1.5 mM ADP, 0.15 mM NADH, 5 µg/ml lactate dehydrogenase. The reaction was started by adding the substrate (0.8 mM phosphoenolpyruvate).

Citrate synthase (CS) activity (EC 2.3.3.1)

The citrate synthase is the key enzyme of the Krebs cycle ant it catalyzes the synthesis of citric acid from oxaloacitic acid and acetyl-CoA. Citrate synthase activity was evaluated in order to establish Krebs cycle functionality. For the determination of CS activity, the citrate synthase assay kit (Sigma-Aldrich; CS0720) was used.

ATP bioluminescent assay

The possible effects of EMFs exposure on cellular energy metabolism were evaluated by measuring the levels of adenosine 5'-triphosphate (ATP). For the quantitative determination of intracellular ATP levels, bioluminescent assay kit (Sigma-Aldrich; FLAA) was used. The assay is based on the luciferin-luciferase reaction that utilizes ATP to oxidize D-luciferin producing adenyl-luciferin. During the enzymatic reaction, ATP is consumed and light is emitted. Hence, the light emitted is proportional to ATP content.

Statistical analysis

Statistical analysis was calculated based on two-tailed t-test using Prism Graphpad. Differences were considered statistically significant for $P < 0.05$. All data are presented as mean ± DS of thee independent experiments.

RESULTS

MTT assays

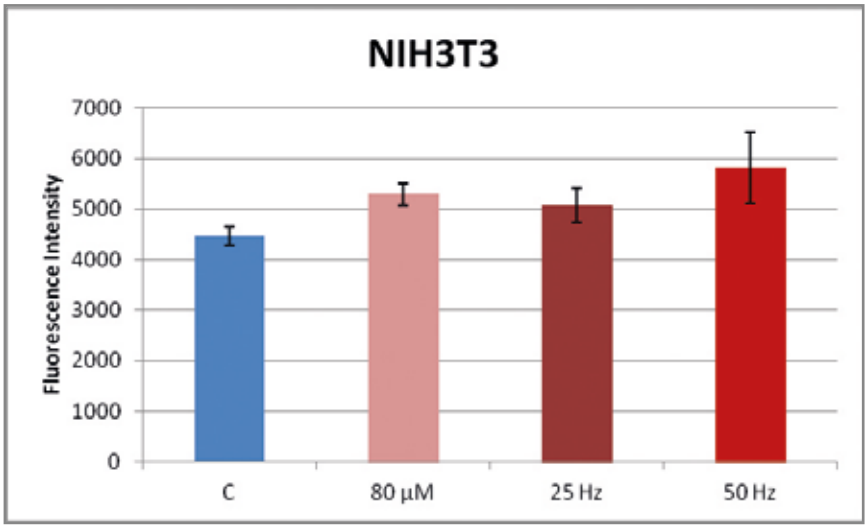
MTT assay was performed in order to estimate cell metabolic activity and possible cytotoxic effects of EMFs on cells. NIH3T3 cells were treated with ELF EMF radiation for 20 minutes and the assays were performed immediately at the end of EMF exposure (T_0) and after 24 (T_{24}). The results are reported in figure 1 and they indicate that the EMF effects on cell viability were quite heterogeneous with regards to exposure parameters. In fact, when cells were treated with 50 Hz EMFs, no significant changes in cell viability have been observed, whereas cells treated with 25 Hz EMFs showed a reduction in the absorbance signal immediately after the end of treatment. Nevertheless, it should be noted that this difference resulted less marked after 24 hours, indicating a recovery in cell metabolism or in the cell number.

Cytoskeleton

Cytoskeleton is the fundamental structure that allows both cellular movement and shape maintaining and it is also fundamental in coordinating vesicles trafficking and the organelles motion. Immunofluorescence analysis of the main cytoskeleton components (actin microfilaments and microtubules) has been conducted 24 hours after EMF treatment in order to evaluate possible morphological changes after EMF treatment. In figure 2 immunofluorescence results are reported. In control cells (left column) cytoskeleton components appear well defined, showing actin microfilaments homogeneously distributed and a well organized pattern for microtubules. In treated cells (25 Hz for actin and 50 Hz for tubulin), alterations in cytoskeleton structure are evident for actin microfilaments and for microtubules: the precise organization found in control cells is totally lost and cytoskeleton components appear completely unstructured.

Fig 3:

Evaluation of intracellular ROS levels in NIH3T3 cells. ROS production results higher in exposed cells (25 Hz and 50 Hz) rather than control cells. H_2O_2-treated cells were used as positive control (80 µM for 30 minutes).



Evaluation of ROS and enzymatic activities

Since it has been reported that ELF EMFs could act on cells, inducing an increased intracellular level of ROS [23], measurements of ROS production were conducted after EMFs exposure using $DCFH_2$-DA assay. NIH3T3 cells were labeled with $DCFH_2$-DA, as previously described in "Materials and Methods" section and then cells were exposed for 20 minutes to EMFs at 25 Hz (1.62 mT) and 50 Hz (2.4 mT). Results show that ROS production is significantly higher in cells exposed to EMFs (Fig. 3) and the increasing fluorescence of DCF is registered in both treatments. In particular, NIH3T3 result more susceptible when exposed at 50 Hz EMF (2.4 mT) rather than 25 Hz EMF (1.62 mT).

Enzymatic activities assays

NIH3T3 cells express the M2 isoform of PK, an homotetramer composed of four 56 kDa subunits containing three cysteine residues; Cys^{31}, Cys^{358}, Cys424. Cys^{358} is located in a beta-barrel that includes residues essential for the catalytic activity. Recent literature widely described how the oxidation of Cys^{358} causes the inhibition of PKM_2 and how this inhibitory effect could be reverted using reductive agents, such as DTT [18]. Since evaluations of intracellular ROS level demonstrate an increasing ROS production in cells exposed to EMFs, an inhibitory effect on PK activity following EMF treatment was assumed.

In figure 4 have been reported the specific activity levels of PK. Diamide and H_2O_2 have been used as positive control of Cys358 oxidation of PKM2; H_2O_2 causes oxidation due to ROS generation, whereas diamide is an oxidant compound which act selectively on -SH groups of proteins. DASA- 10 is a small molecule used as a protective agent for Cys^{358} oxidation of PKM2 because it binds the subunit of PKM2 at the level of Cys^{358}, preventing Cys^{358} oxidation and the consequent inhibitory effect on PKM2. Hence, cells treated with DASA-10 constitute a negative control.

Cells treated with DASA-10 (Dasa-10 group) show an higher PK activity rather than control cells and this effect can be explained due to the protective action exerted by DASA-10 during the cell lysis because lysis buffer do not contain any antioxidant agent (DTT). The specific activity of PK in cells treated with H_2O_2 or diamide (H_2O_2 group and diamide group) appears lower than that of control cells, indicating that an inhibitory effect of PKM2 occurred. When cells are pretreated with DASA-10 and then exposed to H_2O_2 (or diamide), the specific activity of PK results comparable with "DASA-10" group. Once again, data indicate that DASA-10 preserve the activity of PKM2, protecting Cys^{358} from oxidation. The activity level of PK in cells exposed to 25 Hz results similar to those of positive control (H_2O_2 group and diamide group). When cells are pretreated with DASA-10 and then exposed to 25 Hz (DASA-10_25 Hz), PK activity results comparable to "DASA-10_H_2O_2" group, indicating that EMFs and H_2O_2 could act through the same effector substance, ROS. As regards "50 Hz" and "50 Hz_DASA-10" groups, the specific activities level are comparable to those observed in "25 Hz" and "25 Hz_DASA" groups. In order to establish whether could be possible restoring PKM2 activity using reductive agents (DTT) which could reduce Cys^{358} of PKM2, every experimental group was evaluated immediately after cell lysis (no DTT), and after an incubation of 2 h with DTT 2 mM,. When PKM2 was inhibited by H_2O_2, diamide and EMF treatments (both 25 and 50 Hz), it was possible to restore its specific activity after incubation with DTT, showing activity values comparable to control group. The protective action exerts by DASA- 10 on the activity of PKM2 and its restoring following DTT incubation demonstrate that the inhibition of PKM2 is attributable at least in part to the oxidation of Cys^{358}. Moreover, results indicate that EMF treatments could act on the activity

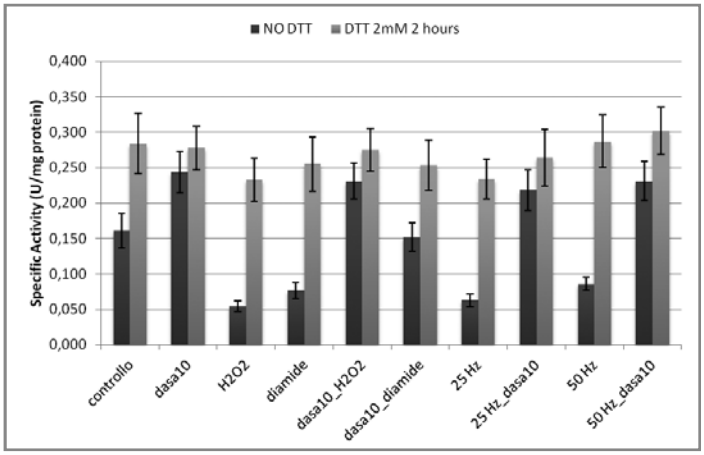


Fig 4:
Specific activities of PK in NIH3T3, evaluated 5 hours after treatments. Control: No treated cells. DASA- 10: Cells treated with DASA-10 (20 uM for 1 h). H_2O_2: Cells treated with H_2O_2 (80 uM for 40 min). Diamide: Cells treated with diamide (250 uM for 15 min). Dasa10_H_2O_2: Cells pre-treated with DASA-10 (20 uM for 1 h) and then exposed to H_2O_2 (80 uM for 40 min). Dasa10_ Diamide: Cells pre-treated with DASA-10 (20 uM for 1 h) and then exposed to diamide (250 uM for 15 min). 25 Hz: cells exposed for 20 minutes to ELF EMFs at 25 Hz. 25 Hz_DASA-10: Cells pre-treated with DASA-10 (20 uM for 1 h) and then exposed to EMFs at 25 Hz. 50 Hz: cells exposed for 20 minutes to ELF EMFs at 50 Hz. 50 Hz_DASA-10: Cells pre-treated with DASA-10 (20 uM for 1 h) and then exposed to EMFs at 50 Hz. The activity of PK was evaluated in the cellular samples immediately after lysis (no DTT; black bar) and after DTT incubation (2 mM, 2 hours) (grey bar).

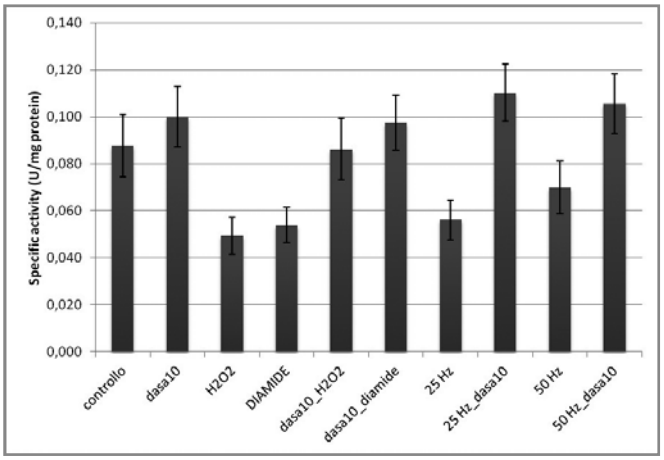


Fig 5:
Specific activities of CS in NIH3T3, evaluated 5 hours after treatments. Control: No treated cells. DASA- 10: Cells treated with DASA-10 (20 uM for 1 h). H_2O_2: Cells treated with H_2O_2 (80 uM for 40 min). Diamide: Cells treated with diamide (250 uM for 15 min). Dasa10_H_2O_2: Cells pre-treated with DASA-10 (20 uM for 1 h) and then exposed to H_2O_2 (80 uM for 40 min). Dasa10_ Diamide: Cells pre-treated with DASA-10 (20 uM for 1 h) and then exposed to diamide (250 uM for 15 min). 25 Hz: cells exposed for 20 minutes to ELF EMFs at 25 Hz. 25 Hz_DASA-10: Cells pre-treated with DASA-10 (20 uM for 1 h) and then exposed to EMFs at 25 Hz. 50 Hz: cells exposed for 20 minutes to ELF EMFs at 50 Hz. 50 Hz_DASA-10: Cells pre-treated with DASA-10 (20 uM for 1 h) and then exposed to EMFs at 50 Hz.

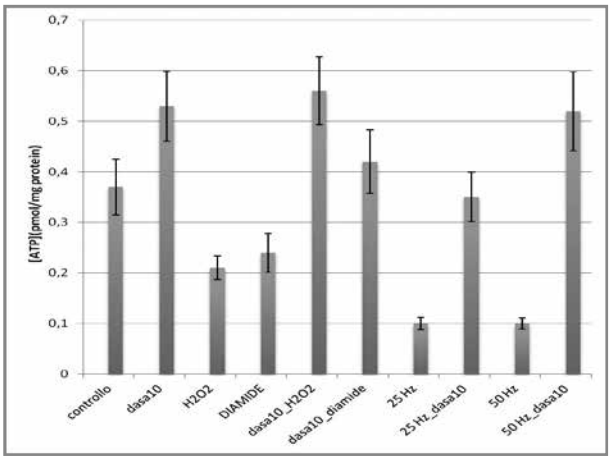


Fig 6:
ATP concentrations (pmol/mg protein) in NIH3T3 cells, evaluated 5 hours after treatments. Control: No treated cells. DASA-10: Cells treated with DASA-10 (20 uM for 1 h). H_2O_2: Cells treated with H_2O_2 (80 uM for 40 min). Diamide: Cells treated with diamide (250 uM for 15 min). Dasa10_H_2O_2: Cells pre-treated with DASA-10 (20 uM for 1 h) and then exposed to H_2O_2 (80 uM for 40 min). Dasa10_Diamide: Cells pre-treated with DASA-10 (20 uM for 1 h) and then exposed to diamide (250 uM for 15 min). 25 Hz: cells exposed for 20 minutes to ELF EMFs at 25 Hz. 25 Hz_DASA-10: Cells pre-treated with DASA-10 (20 uM for 1 h) and then exposed to EMFs at 25 Hz. 50 Hz: cells exposed for 20 minutes to ELF EMFs at 50 Hz. 50 Hz_DASA-10: Cells pre-treated with DASA-10 (20 uM for 1 h) and then exposed to EMFs at 50 Hz.

level of PK with a mechanism ROS- mediated.
The inhibition of PKM2 mediated by the oxidation of Cys^{358} implies a deficiency of pyruvate, resulting in a lower production of ATP by Krebs cycle. Therefore, the activity levels of PK have been related to the specific activity of CS in order to evaluate the functionality of Krebs cycle. CS, key enzyme of Krebs cycle, catalyzes the condensation reaction of one molecule of acetyl-CoA and
a molecule of oxalacetate to form citrate, triggering Krebs cycle. The activity levels of CS are reported in figure 5.
Similarly as for PK activity, the specific activity of CS in cells treated with EMFs (both 25 Hz and 50 Hz) show groups are comparable to "DASA-10_H2O2" and "DASA-10_diamide". Here again, when cells are pretreated with DASA-10 and then exposed to EMFs (both 25 Hz and 50 Hz), the specific activity levels of CS are comparable to those of control cells.

ATP concentrations

Intracellular ATP concentration was measured in order to evaluate if the variations observed in PK and CS activity levels may lead to variations of ATP contents. Results are presented in figure 6.
When cells are exposed to EMFs, the concentration of ATP is significantly reduced (both 25 Hz and 50 Hz groups). When cells are pretreated with DASA-10, ATP concentration results comparable to control cells (25 Hz_ DASA-10 group) and higher than control cells (50 Hz_DASA-10 group).

DISCUSSION

The MTT assay is a colorimetric assay for assessing cell metabolic activity. Tetrazolium dye essays can also be used to measure cytotoxicity (loss of viable cells) or cytostatic activity (shift from proliferation to quiescence) due to different causes.
The results of MTT essays performed on samples exposed to EMFs showed a lower absorbance in comparison with untreated controls. The difference was more evident immediately after the exposure than at T=24h. The absorbance is related to the number of cells and also to their metabolic state. Seeing that after 24h there is a partial recovery, we hypothesized that the absorbance decrease could indicate a temporary metabolic slowdown or a temporary shift from proliferation to quiescence rather than a lower cell viability.
Immunofluorescence experiments, performed staining actin and tubulin, showed that the organization of the main cytoskeletal elements was altered and both microfilaments and

microtubules seemed depolymerized . These cytoskeletal alterations are in agreement with the increase in ROS concentration found after exposure to EMFs and provide important morphological information about the possibility that ROS could act also promoting the cytoskeleton remodeling, enriching the variety of molecular effects exerted by EMF on cells. In fact, it has been reported that ROS could affect the balance between polymerization/depolymerization of actin filaments and microtubules [25]. In particular, it has been reported that an increased level of intracellular ROS seems to be related to a lower polymerization of cytoskeletal elements through effects on PKM2 [26]. Our experimental results are consistent with the literature, because we found that cells exposed to EMFs present an increased level of ROS, enhanced depolymerization and an active remodeling of cytoskeleton. Hence, a molecular mechanism by which EMF can act on the cytoskeleton remodeling of cells is proposed.

PK is the enzyme that catalyzes the final reaction of glycolysis where a phosphate group is transferred from phosphoenolpyruvate (PEP) to ADP, yielding to the formation of one molecule of pyruvate and one molecule of ATP. There are several isoforms of PK and PKM2 isoform is highly susceptible to oxidation at the level of Cys^{358}. The oxidation of Cys^{358} results in the inhibition of the catalytic activity of the enzyme, promoting a slowdown of the glycolytic flux. In fact, since the PKM2 activity results inhibited by the oxidation of Cys^{358}, pyruvate is not synthesized and the

glycolytic flux slows down, promoting the accumulation of metabolites that are diverted to the pentose phosphate pathway (PPP), causing a metabolic shift toward anabolic processes. These considerations indicate that the redox state of the cells represent a way of regulating the enzymatic reactions involved in cellular metabolism [24]. In fact, cells with high anabolism (e.g. neoplastic cells, embryonic cells and cells involved in repair processes) are characterized by metabolic regulation mechanisms strictly related to their redox state and our experimental evidences support this kind of metabolic regulation also in NIH3T3 cells.

According to literature, our results indicate an increased intracellular ROS level after EMF treatments [14] and, since NIH3T3 cells express the isoform M2 of PK, a metabolic shift toward anabolism has been hypothesized.

In fact, our findings demonstrated that PK activity decreased after EMF exposure (25 Hz and 50 Hz), while ROS levels increased, similarly to what happens as a result of oxidative stress (H_2O_2) . The same effect was observed when cells were treated with diamide, a chemical compound used for the specific oxidation of -SH groups in proteins. From these observations we can assume that the mechanism by which ROS and diamide act, is similar and it includes the oxidation of Cys^{358}, promoting the inhibition of PKM2. These considerations are supported by the results obtained when cells were pre-treated with DASA-10, a specific molecule used to protect the oxidation of Cys358 in PKM2: cells pre-treated with DASA-10 and then exposed EMFs, or to oxidant treatments, did not show reduced PKasic activity compared with controls. Moreover, PKasic activity resulted totally restored after DTT incubation, showing values of specific activity comparable to those of control.

The decrease in PKM2 activity fits with the depolymerization of cytoskeleton: recently, an interaction between PKM2 and the elements of cytoskeleton has been demonstrated [26].

Pyruvate is a key metabolite connecting different metabolic pathways such as glycolysis, gluconeogenesis, Krebs cycle, fatty acids synthesis. In fact, it can be converted in acetyl-CoA by pyruvate dehydrogenase and it can be diverted towards Krebs cycle and fatty acid synthesis. Therefore, pyruvate provides the substrate of CS, the key enzyme of Krebs cycle, which catalyzes the condensation reaction of a molecule of acetyl-CoA and a molecule of oxalacetate to form citrate, triggering Krebs cycle. In this context, the activity level of PK is strictly correlated to CS activity and ATP production.

Indeed, the results of the experiments showed that in cells exposed to EMFs a decrease in CS activity also occurs. All that, prompted us to hypothesize that also a slowdown of the Krebs cycle, with consequent decrease in ATP production, could occur. This hypothesis was then supported by data concerning ATP concentration: samples exposed to EMFs showed ATP levels markedly lower than controls. Moreover, the results obtained with the MTT essays reinforce our hypothesis of a metabolic shift following EMF treatments. In fact, MTT was performed not only to evaluate possible cytotoxic effects of EMF treatment, but also to provide a general evaluation of the activity of succinate dehydrogenase (SDH), the common enzyme between Krebs cycle and the electron transport chain. Although MTT assay for SDH activity results less accurate than classic methods used in enzymatic activity determinations, it provides a first assessment of the electron transport chain efficiency that is strictly related to the production of ATP. The results of the MTT assay are consistent with a framework of Krebs cycle slowdown, decrease in CS activity, lower efficiency of the electron transport chain and decrease in ATP production.

To sum up, our results demonstrate a molecular mechanism by which ELF EMFs are able to promote a metabolic shift toward anabolic processes in NIH3T3 cells, inducing an increased level of intracellular ROS first, and a reduced activity of PKM2 then. The slowdown of glycolytic flux causes the accumulation of glycolytic intermediates which are diverted to PPP, a metabolic pathway with anabolic character. In fact, PPP promotes the production of 5-carbon sugars, required for nucleotides synthesis in cell proliferation, and generation of reduced NADPH, the cofactor implicated in anabolic processes such as lipid synthesis. Moreover, NADPH is also involved in regeneration of glutathione (GSH), constituting the antioxidant system implicated in maintaining a basal level of ROS inside the cells. As a result, the effects of ELF EMFs are assumed to be temporary, because the increased ROS level following EMF treatment is constrained by the antioxidant system, that is supported by the production of NADPH through PPP with a positive feedback.

This mechanism, that starts as response to a

stress, could trigger a series of anabolic pathways in cells expressing PKM2, which are generally characterized by high anabolic rates.

In conclusion, in NIH3T3 fibroblasts, and probably in all the cells expressing PKM2, ELF EMFs induce a shift of the cell metabolism from catabolic to anabolic processes via a temporary increase in the ROS levels that can be controlled by the antioxidant system through a feedback mechanism.

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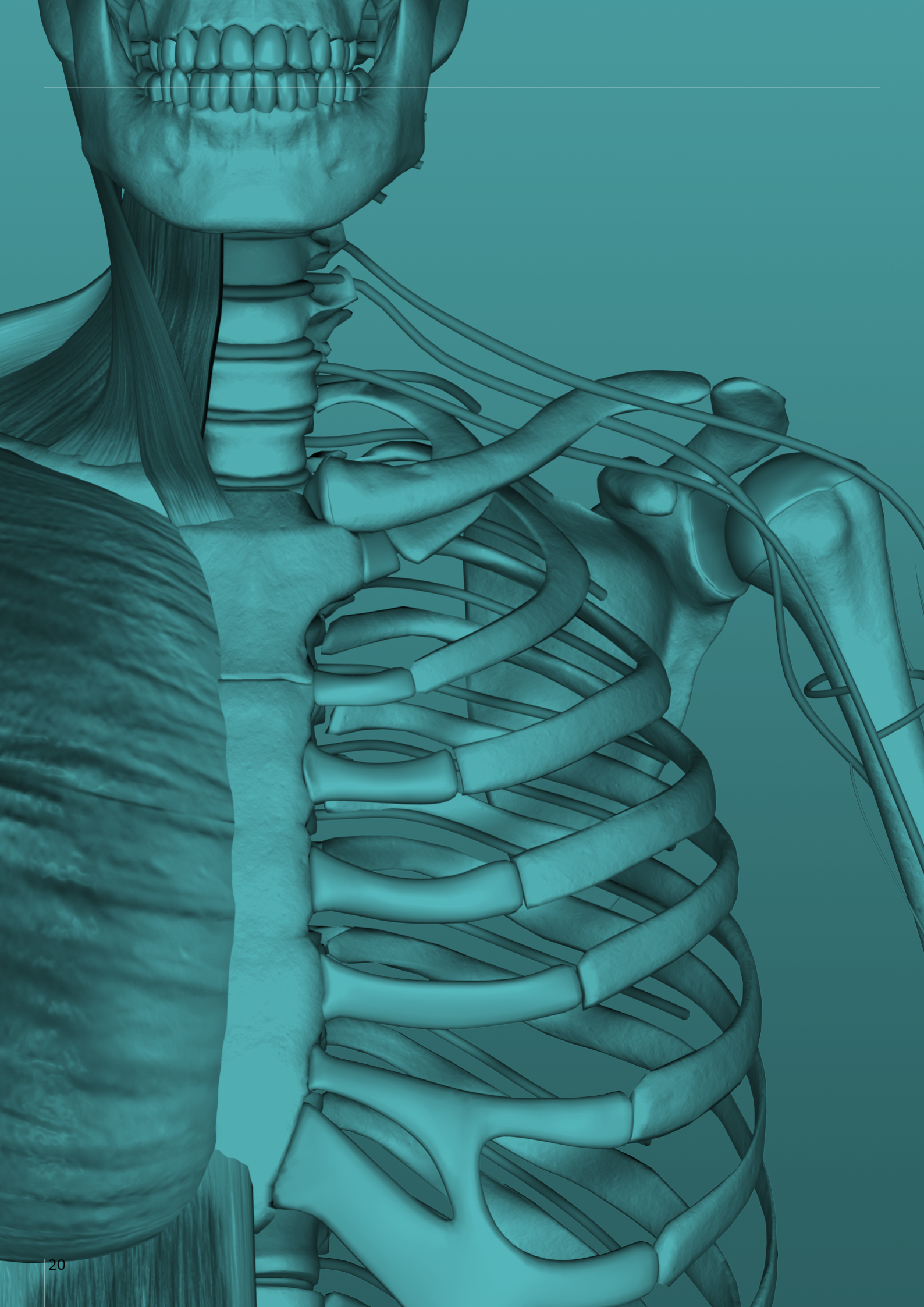

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2. Michaeli W. Extrusion Dies. Hanser Publishers, Munich, Vienna, New York, 1984.

Reference to a chapter in an edited book:
3. Gmünder FK, Cogoli A. Effect of space flight on lymphocyte function and immunity. In: Fregly MJ, Blatteis CM, eds. Handbook of Physiology. Oxford:University Press, 1996, vol. 2, pp 799-813.

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