Adenosine A₁ Receptors in the Central Nervous System: Their Functions in Health and Disease, and Possible Elucidation by PET Imaging

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Abstract: Adenosine is a neuromodulator with several functions in the central nervous system (CNS), such as inhibition of neuronal activity in many signaling pathways. Most of the sedating, anxiolytic, seizure-inhibiting and protective actions of adenosine are mediated by adenosine A₁ receptors (A₁R) on the surface of neurons and glia. Positron Emission Tomography (PET) is a powerful in vivo imaging tool which can be applied to investigate the physiologic and pathologic roles of A₁R in the human brain, and to elucidate the mechanism of action of therapeutic drugs targeting adenosine receptors, nucleoside transporters and adenosine-degrading enzymes. In this review article, we discuss (i) functions of adenosine and its receptors in cerebral metabolism; (ii) radioligands for A₁R imaging: xanthine antagonists, non-xanthine antagonists, and agonists; (iii) roles of A₁R in health and disease, viz. sleep-wake regulation, modulation of memory retention and retrieval, mediating the effects of alcohol consumption, protecting neurons during ischemia and reperfusion, suppression of seizures, modulating neuroinflammation and limiting brain damage in neurodegenerative disorders. The application of PET imaging could lead to novel insights in these areas. Finally (iv), we discuss the application of PET in pharmacodynamic studies and we examine therapeutic applications of adenosine kinase inhibitors, e.g. in the treatment of pain, inflammation, and epilepsy.

Keywords: Adenosine, Alcohol Abuse, Alzheimer Disease, Brain, Drug Development, Epilepsy, Inflammation, Multiple Sclerosis, Pain, Parkinson’s Disease, Positron Emission Tomography, Receptor Imaging, Sleep, Stroke.

1. INTRODUCTION

1.1. Sources, Regulation and Fate of Extracellular Adenosine

The purine nucleoside adenosine is not a classical signaling substance, as adenosine is neither stored nor released from vesicles. The nucleoside plays a neuromodulatory role by affecting the excitability of neurons that release neurotransmitters such as glutamate, y-amino butyric acid (GABA), acetylcholine and dopamine [1-12]. Adenosine is involved in homeostatic reduction of cellular excitability during stress and trauma via its interaction with receptors on the cell surface. Moreover, adenosine is involved in the regulation of synaptic plasticity. Balanced activation of inhibitory and facilitatory adenosine receptors modulates long term potentiation (e.g., in the hippocampus) [13-15].

Metabolic pathways involved in the formation and removal of adenosine are presented in Fig. (1). Extracellular adenosine may originate from intracellular adenosine - which can pass the plasma membrane via an equilibrative nucleoside transporter (ENT), or by hydrolysis of locally released adenine nucleotides such as adenosine triphosphate (ATP), adenosine diphosphate (ADP), adenosine monophosphate (AMP) and to a lesser extent cyclic adenosine monophosphate (cAMP). Production of extracellular adenosine is the result of the breakdown of such nucleotides by ecto-nucleotidases [16-18]. The rate-limiting step is the conversion of AMP to adenosine which is catalyzed by ecto-5'-nucleotidase (CD73). The biochemical and pharmacological properties of this enzyme have been extensively characterized [16,19]. 5'-Nucleotidase is inhibited by ATP and ADP [18]. The quantitative importance of this mechanism has been confirmed by a kinetic characterization of the breakdown of extracellular ATP at the cholinergic striatal synapse [20].

Extracellular adenosine is subject to metabolic degradation by adenosine deaminase (ADA) which results in the formation of inosine [21]. Another route of adenosine inactivation is the reversible reaction catalyzed by S-adenosyl homocysteine (SAH) hydrolase [22]. Formation of SAH from adenosine and homocysteine is restricted since homocysteine levels are rate-limiting. In the brain, the SAH pathway is a quantitatively negligible pathway of adenosine catabolism [23]. The major route of adenosine removal under normal conditions is phosphorylation to AMP by adenosine kinase (AK).

1.2. Classification of Adenosine Receptors

The adenosine receptor (AR) family consists of the A₁, A₂A, A₂B and A₃ subtypes (A₁R, A₂AR, A₂BR and A₃R, respectively). A₁R and A₂B inhibit whereas A₂AR and A₂BR stimulate production of the second messenger, cAMP. A₁R and A₁R are activated by nanomolar concentrations of adenosine whereas A₂BR and A₃R become activated only when adenosine levels rise into the micromolar range during inflammation, hypoxia or ischemia [24-26]. The four AR subtypes from rat, mouse, human and other species have been pharmacologically recognized, cloned, purified and expressed [27-29]. In the following pages, we will focus on the A₁R and the potential contribution of positron emission tomography (PET) imaging to the study of its involvement in physiological processes.

1.3. Regional Distribution and Signaling of A₁R

The A₁R is the most strongly preserved AR subtype among different animal species [28]. A₁R exhibit the highest affinities for adenosine and synthetic agonists of all AR subtypes [30]. They are distributed throughout the body and are also highly expressed in the brain, especially in hippocampus, frontal cortex, thalamic nuclei, basal ganglia and dorsal horn of the spinal cord. Peripheral organs with high A₁R expression include eye, adrenal gland, heart and aorta.

The regional distributions of A₁R in human and rodent brains are similar but not completely identical. In human cerebellum, A₁R densities are low in contrast to rat cerebellum, where moderate A₁R expression is noted [31-36]. Different neurons express different levels of A₁R. In rat brain, the highest A₁R immunoreactivity is observed in pyramidal neurons of layer 5 of the cerebral cortex, and in pyramidal cells in fields CA2 and CA3 of the hippocampus. In layer 5, immunoreactivity is detected in cell bodies, dendrites and initial segments of axons [37].
Activation of A₁Rs inhibits adenylyl cyclase, closes voltage-dependent Ca²⁺ channels, and activates K⁺ channels. Signalling of this AR subtype occurs through Gᵢ/o pathways in various cells (including neurons). As a result, the neuronal activity is suppressed [38,39]. In presynaptic regions, adenosine inhibits neurotransmitter and neuropeptide release, including the release of glutamate, substance P and calcitonin gene related peptide [40]. In postsynaptic areas, adenosine abolishes sensory transmission and causes membrane hyperpolarisation [41,42].

2. RADIOLIGANDS FOR A₁R IMAGING

PET is a medical imaging technique providing information on tissue biochemistry rather than anatomy. PET imaging has several unique properties: high sensitivity, low radiation dose, possibility to correct data for attenuation and scatter (thus quantitative), radioactive labeling of natural substances or drugs with high specific radioactivity so that these can be used as tracers to monitor the pharmacokinetics of the non-radioactive compounds. PET may therefore be applied to measure regional AR densities in the living human brain and the dose-dependent occupancy of cerebral AR by therapeutic drugs. A comprehensive overview of PET tracers for the different AR subtypes has been presented in some recent reviews [43,44].

Several ligands for PET imaging of A₁R have been prepared (see Table 1 and Fig. 2). These include xanthine A₁R antagonists, non-xanthine A₁R antagonists and A₁R agonists. All compounds bind with nanomolar affinity to A₁R. The best-characterized tracers are [¹¹C]MPDX and [¹⁸F]CPFPX. Both can be applied for PET studies of cerebral A₁R in humans. The long physical half life of [¹⁸F] (109.8 min) as compared to [¹¹C] (20.4 min) allows longer scanning times with [¹⁸F]CPFPX than with [¹¹C]MPDX. Because of this difference in half life, [¹⁸F]CPFPX can be distributed to remote imaging sites without cyclotron facilities, in contrast to [¹¹C]MPDX. However, the radiation dose that subjects will receive after injection of [¹⁸F]CPFPX (300 MBq) is greater that that of [¹¹C]MPDX (300 MBq): 5.3 mSv vs. 1.05 mSv, respectively ([45] and Ishiwata, unpublished data). Thus, multiple-injection protocols are possible with [¹¹C]MPDX but not with [¹⁸F]CPFPX. Since each tracer has specific advantages and disadvantages, tracer selection will be based on historic interest and the facilities at one’s disposal rather than on clear superiority of a certain compound.

Efforts to develop A₁R ligands for PET with improved properties might focus on antagonists with reduced lipophilicity and improved water solubility, e.g. compounds with non-xanthine structures. However, the first reported example of such tracers, [¹¹C]FR194921, did not produce better results in experimental animals than [¹¹C]MPDX or [¹⁸F]CPFPX [46].

3. PHYSIOLOGICAL ROLE OF A₁R AND CHANGES OF A₁R EXPRESSION IN DISORDERS OF THE CNS

3.1. Sleep-Wake Regulation

Adenosine plays an important role in the induction of sleep after prolonged wakefulness [47]. Prolonged wakefulness with its associated prolonged neuronal activity increases extracellular adenosine levels in the forebrain of conscious cats, whereas these levels diminish during sleep [48]. A [¹⁸F]CPFPX-PET study in humans has indicated that in addition to changes of extracellular adenosine, A₁R are upregulated in cortical and subcortical regions of the brain after prolonged wakefulness (max. 15.3%), which suggests that changes of A₁R expression are contributing to homeostatic sleep regulation [49]. Short periods of total sleep deprivation (3 or 6 h) result in increases of A₁R mRNA but no
This compound was prepared for Single Photon Emission Computed Tomography (SPECT) rather than PET imaging.

### Table 1. Development of Radioligands for PET Imaging of A1R

<table>
<thead>
<tr>
<th>Ligand</th>
<th>A1R affinity</th>
<th>Studies performed</th>
<th>Findings</th>
<th>References</th>
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<tr>
<td>Xanthines</td>
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<tr>
<td>[^{11}C]KF15372 (8-Dicyclopropylmethyl-3-propylxanthine)</td>
<td>3.0 nM (K_i)</td>
<td>Biodistribution study in mice Ex vivo autoradiography (mice/rats) PET study in anesthetized monkeys</td>
<td>About 57% specific binding (to A1R not A2R) Tracer distribution in brain reflects regional A1R density Decreased binding in superior colliculus after unilateral eye removal Tracer distribution in brain reflects regional A1R density About 50% reduction in uptake after treatment with “cold” KF15372</td>
<td>[254-256]</td>
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<tr>
<td>[^{11}C]EPDX (2-Ethyl-8-dicyclopropylmethyl-3-propylxanthine)</td>
<td>1.7 nM (K_i)</td>
<td>Biodistribution study in mice</td>
<td>About 50% specific binding (to A1R not A2R)</td>
<td>[257]</td>
</tr>
<tr>
<td>[^{11}C]MPDX (8-Dicyclopropylmethyl-1-methyl-3-propylxanthine)</td>
<td>4.2 nM (K_i)</td>
<td>Biodistribution study in mice Metabolite analysis in mice Ex vivo autoradiography (rats) Radiochemical synthesis improved. PET study in anesthetized rats PET study in anesthetized monkey Human PET study (healthy volunteers)</td>
<td>Initial brain uptake higher than EPDX and KF15372 but faster washout. Dosimetry data indicate acceptable radiation dose in human studies. Metabolites appear in plasma but brain activity is mainly parent at 30 min. Decreased binding in superior colliculus after unilateral eye removal. About 55% specific binding (to A1R not A2R). In animal model of dystonia, tracer binding in hippocampus is decreased. --- Distribution volume of tracer in brain reflects regional A1R density. Bound tracer can be displaced by an excess of cold A1R antagonist. In a cat model of stroke, losses of A1R can be detected in ischemic areas. The magnitude of these losses indicates severity of the insult and predicts subsequent complications (including mortality). Good brain uptake, distribution reflects regional A1R density. Tracer distribution in brain reflects regional A1R density. Pattern differs from that of a flow tracer or a glucose analog. Distribution volume (Logan plot) or binding potential (compartment model analysis) can be used for quantification purposes.</td>
<td>[257] [258] [257,259,260] [261] [262] [263] [155,156] [238] [264,265] [266]</td>
</tr>
<tr>
<td>[^{11}F]CPFPX (8-Cyclopentyl-3-[3-fluoropropyl]-1-propylxanthine)</td>
<td>0.6-1.4 nM (K_i) (K_mouse, pig, human) 4.4 nM (K_i) (rat)</td>
<td>Biodistribution study in mice Metabolite analysis in mice Ex vivo autoradiography (rats) Animal PET study in rats Human PET study (healthy volunteers) Metabolite study (liver microsomes)</td>
<td>Distribution in brain reflects regional A1R density. Metabolites appear in plasma but brain activity is mainly parent at 60 min. About 70% of brain uptake is specific (to A1R) and reversible. Tracer distribution in brain reflects regional A1R density (&gt;90% specific). Brain well-visualized, bound tracer can be displaced by A1R antagonist. Tracer distribution in brain reflects regional A1R density. Tracer kinetics in human brain are appropriate for quantitative imaging. Distribution volume (Logan plot) or binding potential (compartment model analysis) can be used for quantification purposes. Simplified study protocols are possible (venous rather than arterial blood sampling, bolus-infusion or single bolus administration of the tracer). Short scanning protocols (60 min) are possible in humans. Boundtracer can be displaced by cold CPFPX in all brain regions. Non-invasive procedure (reference tissue model) is suitable for quantification of A1R in human brain. Tracer is metabolized by cytochrome CYP1A2. Its metabolism can be inhibited by therapeutic drugs like fluvoxamine.</td>
<td>[267] [268] [269] [270] [271,272] [273] [224] [274] [275,276]</td>
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<tr>
<td>[^{111}I]CPIPX 1 (8-Cyclopentyl-3-[[E]-3-iodoprop-2-en-1-yl]-1-propylxanthine)</td>
<td>0.8-7.9 nM (K_i) (K_mouse, rat, pig cortex)</td>
<td>Ex vivo autoradiography (rats)</td>
<td>Tracer binding is largely nonspecific. Thus, this ligand is not suitable for imaging purposes. The iodine radioselabeling results also in loss of selectivity for the A1R.</td>
<td>[277]</td>
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<td>Non-xanthines</td>
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<tr>
<td>[^{11}C]FR94921 (2-(1-methyl-4-piperidinyl)-6-(2-phenylpyrazolo[1,5-a]-pyridin-3-yl)-3(2H)-pyridazinone)</td>
<td>2.9 nM (K_i)</td>
<td>Ex vivo autoradiography (rats) PET study in conscious monkeys</td>
<td>Tracer distribution in brain reflects regional A1R density. About 50% specific binding (to A1R not A2R). Brain well-visualized, tracer accumulates in cortex, striatum, thalamus.</td>
<td>[46]</td>
</tr>
<tr>
<td>Agonists</td>
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<tr>
<td>5-O-(methyl[^{75}Se]seleno)N(_6)-cyclopropyladenosine</td>
<td>0.9 nM (K_i) (pig cortex)</td>
<td>Radiochemical synthesis described</td>
<td>No in vivo data reported</td>
<td>[278]</td>
</tr>
<tr>
<td>5'-N-(2-[^{18}F]fluoroethyl)-carboxamidoadenosine</td>
<td>Nanomolar range</td>
<td>Radiochemical synthesis described</td>
<td>No in vivo data reported May bind not only to A1R but also to other AR subtypes</td>
<td>[279]</td>
</tr>
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*This compound was prepared for Single Photon Emission Computed Tomography (SPECT) rather than PET imaging.*
detectable increases of A1R expression in rat brain [50]. However, longer periods of total sleep deprivation in rodents (12 or 24 h) are accompanied by a significant upregulation of A1R (up to 14%) in various brain areas [51, 52]. [3H]Phenylisopropyladenosine (PIA, Fig. 3) saturation binding assays have indicated that A1R densities in cortical and subcortical regions of rat brain are increased not only after total sleep deprivation, but also after 48 and 96 h of partial, rapid eye movement (REM) sleep deprivation, whereas affinity (Kd) values for agonist binding are not significantly altered [53]. After restriction of sleep and also after performance of a difficult learning task, cerebral synchronized slow wave activity (SWA) is enhanced during the next sleeping period, and this activity is related to the subsequent improvement of cognitive performance [54, 55]. Activation of A1R is necessary for the increase of SWA. If this increase is impaired (e.g. because of knockout of the A1R gene) animals fail to maintain normal cognitive function. Thus, adenosine appears to be an important homeostatic sleep factor, and A1Rs are involved in the regulation of sleep.

After administration of a selective A1R agonist, N6-cyclopentyladenosine (CPA, Fig. 3), either by the systemic or the cerebroventricular route, SWA increased in rats during non-REM sleep [56]. Such stimulation of A1R mimics the effect of total sleep deprivation in rodents. A similar effect on sleep is observed when extracellular adenosine levels in the mammalian brain are raised by administering inhibitors of nucleoside transport [57]. When levels of extracellular adenosine in the basal forebrain are raised by microdialysis, vigilance of rats is significantly impaired [58]. This effect on vigilance is completely blocked after co-administration of a selective A1R antagonist, 8-cyclopentyltheophylline (CPT, Fig. 3), with adenosine [58]. On the other hand, infusion of CPT into the basal forebrain diminishes the sleeping ability (both slow-wave and REM sleep) of cats [57]. Infusion of A1R antisense in the cholinergic basal forebrain of rats inhibits the translation of A1R mRNA, resulting in decreased non-REM sleep and increased wakefulness [59]. Such pharmacological experiments have provided additional support for the important role of A1R in sleep regulation. Agonists for this receptor usually promote [60-62] while antagonists diminish [60, 63] sleep.

In rat brain, prolonged wakefulness with accompanying increases of extracellular adenosine and stimulation of A1R increases the activity of the transcription factor NF-kappaB [64, 65]. This transcription factor regulates expression of several modulatory substances, such as interleukin-1B and tumor necrosis factor alpha, which shows a diurnal rhythm. Some effects of adenosine on sleep homeostasis, particularly the phenomenon of “sleep debt” may be triggered via this mechanism.

Orexinergic neurons in the lateral hypothalamus also express A1R [66]. Adenosine and A1R agonists inhibit activity of the hypocretin/orexin neurons in this area via A1R which promotes sleep [67, 68]. On the other hand, blockade of A1R in such neurons causes a pronounced increase in wakefulness [68, 69]. Adenosine reduces the frequency of action potentials in hypocretin/orexin neurons by depressing excitatory synaptic transmission to these cells. An additional mechanism involved in the sleep-promoting effects of adenosine may be suppression of the activity of histaminergic neurons in the tuberomammillary nucleus via A1R [70]. Thus, in addition to its effects in basal forebrain, adenosine promotes sleep by reducing the activity of orexinergic and histaminergic neurons in the hypothalamus [67].

An additional brain region involved in sleep regulation is the pontine reticular formation. Microinjection of the A1R agonist N6-cyclopentyladenosine (CPA) or inhibition of the formation of cAMP in this area increases REM sleep [71]. Another study has shown that administration of an A1R agonist (N6-p-sulfophenyladenosine) decreases the (arousal-promoting) release of the neurotransmitter acetylcholine and increases the recovery time from halothane anesthesia [7].

Neurons in the previously mentioned brain areas are wake-active. Thus, suppression of their activity via stimulation of A1R promotes sleep. In contrast to the regions mentioned above, the lateral preoptic area of rat hypothalamus is an area with an abundance of sleep-active neurons. A1R agonists and the adenosine transport inhibitor 4-nitrobenzyl-thiоinosine have opposite effects in this area as in other regions of the brain, i.e. they increase wakefulness rather than sleep [72]. Thus, the adenosine-mediated effects on the sleep-wake cycle are both neuron- and region-dependent.

PET may be applied to study the involvement of A1R in the regulation of human sleep. Increased expression of A1R in the human cortex after prolonged wakefulness has already been demonstrated [49]. Future PET studies could examine the effect of partial (REM) sleep deprivation in humans, and cerebral A1R expression in sleeping disorders like narcolepsy.

3.2. Learning and Memory

Acute stimulation of A1R by agonists at micromolar doses has been reported to severely impair both the acquisition and retention of memory in various animal and in vitro models, such as long-term potentiation in rat hippocampal slices [73], passive avoidance retention in mice [74, 75], working memory in a three-panel test [76], and acquisition of conditional fear conditioning [77] or short-term social memory in rats [78]. These cognitive deficits are attenuated, or abolished, when brain slices or experimental animals are pretreated with selective A1R antagonists such as DPCPX. Thus, activation of A1R in many regions of the CNS (hippocampus, ventral striatum, posterior cingulate cortex) may negatively modulate information processing in the brain and may impair memory retention [73-76]. Depending on the test setup (dose, region of administration, time of the day), acute administration of a selective A1R antagonist has either no effect or it can facilitate memory performance of rodents [75, 78, 79].

In contrast to acute administration, chronic administration of an A1R agonist (daily i.p. injections of CPA during a 9-day period)
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results in facilitation of spatial learning and memory of mice tested in a Morris water maze. These improvements are probably related to downregulation of A1R [80].

However, studies of the behavioral phenotype of mice lacking A1R have indicated that A1R are not essential for rodent learning. Such mice show normal motor coordination but reduced muscle strength. Overall spontaneous motor activity is similar to that of wild-type controls, but activity peaks during the light/dark cycle are flattened, which is consistent with A1R regulating the sleep-wake rhythm. A1R−/− mice show enhanced aggression and decreased exploratory behavior indicating increased anxiety. However, their working memory in five different water maze tasks is not significantly impaired. The knockouts have a shorter lifespan than controls (LT50 reduced from 26 to 20 months), which suggests that A1R play an important protective role in mammalian tissues during aging [81,82]. In a follow-up study which included a six-arm radial tunnel maze test, A1R−/− mice were found to display normal spatial learning but to habituate more slowly to the test environment [83]. Thus, stimulation of A1R may be required for habituation, i.e. suppression of the processing of irrelevant information.

3.3. Effects of Ethanol

Various effects of alcohol consumption appear to be mediated by adenosine and A1R. Ethanol metabolism in the liver causes formation of acetate, which circulates in the body at millimolar concentrations and is finally incorporated into acetyl-coenzyme A with concomitant production of AMP and adenosine [84]. Acute administration of ethanol results also in inhibition of the facilitated diffusion of nucleosides [84,85]. The inhibitory effect is specific for one particular subtype of ENT (ENT1) [86,87] and can be observed both in cultured cells [84,85,88] and in cerebellar synaptosomes [89,90]. Thus, ethanol augments the rate of adenosine formation and reduces adenosine uptake. Both mechanisms may increase the extracellular levels of adenosine.

Initial attempts at measuring changes of adenosine levels within the brain after administration of ethanol or acetate were unsuccessful, probably because it is difficult to homogenize tissue, or to collect adenosine, while avoiding adenosine degradation [91,92]. Later analytical and microdialysis studies indicated that the levels of acetate and extracellular adenosine in cortical areas of rat brain are significantly increased (up to 4-fold) after administration of physiologically relevant doses of ethanol [93,94].

A functional relationship between ethanol and adenosine was suggested by the fact that dipryridamole, an inhibitor of ENT1, promotes ethanol-induced motor impairment (EIMI) [95]. Increases of EIMI were also noted after administration of the ENT inhibitor dilazep or the AR agonist R-PIA, whereas the AR antagonist theophylline suppressed EIMI [96] Several subsequent studies demonstrated that A1R agonists accentuate and A1R antagonists attenuate EIMI, when infused into the motor cortex [97] or striatum [98,99]. AR antagonists like theophylline or caffeine (Fig. 3), and lipophilic AR agonists like cyclohexyladenosine (CHA) modulate EIMI also after systemic administration. Experiments in which subtype-selective AR antagonists were administered either alone or in combination with agonists have indicated that the A1R subtype is involved in modulation of EIMI, although a contribution of A2R cannot be ruled out [97,99,100]. Co-administration of cAMP analogs, pertussis toxin or the (R)- and (S)-enantiomers of AR agonists with ethanol suggested involvement of G-protein-coupled A1R and adenylyl cyclase [101,102]. The importance of A1R was proven by the fact that A1R antisense, applied orally, systemically or directly into the striatum or cerebellum reduced the regional A1R density and antagonized EIMI, whereas a mismatch control sequence had no effect [103,104]. A1R in the motor cortex, striatum and cerebellum, but not in hippocampus [98] appear to affect EIMI via adenosine-induced decreases in glutamate release [105,106] and/or changes of chloride conductance via chloride channels coupled to the GABA-benzodiazepine receptor complex [102,107].

Besides playing a role in EIMI, adenosine is involved in other physiological responses related to the consumption of ethanol. The ENT1 inhibitor dipryridamole prolongs, and the AR antagonist theophylline reduces the duration of ethanol-induced sleep [95]. Ethanol and acetate also potentiate the anesthetic effect of sevoflurane and isoflurane through metabolically generated adenosine and stimulation of A1R [108-111]. In humans, the AR antagonist caffeine reverses most of the sedating effects of ethanol (sleepiness, lack of alertness, impaired memory) but not ethanol-induced dizziness [112]. A recent study in rodents showed that ethanol promotes non-REM sleep but does not affect REM sleep. The somnogenic effect of ethanol is related to adenosine inhibition of wake-promoting neurons in the basal forebrain via A1R. Bilateral microinjections of the selective A1R antagonist DPCPX in this area reduce the effect of ethanol on non-REM sleep [113]. A study in which ethanol was administered to mice, either alone or in combination with selective AR agonists and antagonists, and animals were tested for anxiety in the elevated plus-maze, has indicated that activation of A1R also mediates the anxiolytic effect of ethanol [114].

Adenosine and A1R are not only involved in the motor impairing, sleep-promoting and sedating effects of ethanol, but also in countering the negative symptoms of ethanol withdrawal. Withdrawal signs include tremors and audiogenically induced seizures are suppressed by an A1R agonist (CCPA), and this beneficial effect is blocked after co-administration of an A1R antagonist (DPCPX) [115]. Other negative symptoms of ethanol withdrawal, such as hyperexcitability [116] and increased anxiety [117,118] are also ameliorated upon stimulation of A1R. AR antagonists (DPCPX, caffeine) are neurotoxic when administered during ethanol withdrawal, particularly in female mice, and these neurotoxic effects are reversed by an A1R agonist (CCPA). Sex differences observed for neurotoxicity of A1R antagonists during ethanol withdrawal are probably related to N-methyl-D-aspartic acid (NMDA)-receptor-mediated downstream signalling which is more pronounced in females than in males [119,120].

Observed changes of A1R densities in rodent brain during ethanol exposure appear to be dependent on the experimental paradigm, the radioligand which is used for binding assays and the brain area that is studied. Using the agonist 3H]R-PIA, increases of Bmax without any change of KB were noted in the cerebral cortex of rats, 15 min after administration of ethanol (1.5 g/kg, [96]). In a later study, the same authors noted that the observed increase (+40.7%) is transient, receptor densities returning to the control value within 60 minutes [121]. Chronic administration of ethanol is also accompanied by an increased binding (+23%) of the agonist 2-chloro-N6-cyclopentyladenosine ([3H]CCPA, Fig. 3) in rat cerebral cortex. This increase persists longer than the one observed after acute administration. Elevated receptor densities are observed 3, 12 and 24 h after the last consumption of ethanol, but the ethanol effect disappears after 3 to 6 days [122]. Increased binding of the A1R agonist [3H]CHA was also noted in the cerebral cortex of mice following chronic administration of ethanol [123]. The increase is most pronounced after multiple episodes of ethanol withdrawal, and may be a compensatory inhibitory response to withdrawal seizures [124]. In contrast to the changes observed with A1R agonists, cortical binding of the A1R antagonist [3H]DPCPX is not affected by ethanol treatment [116,122]. Whereas most studies reported a transient increase of A1R agonist binding upon acute or chronic administration of ethanol, one old [95] and one recent [125] study reported decreases of A1R expression in some brain areas of rats. Decreased A1R expression in the wake-promoting basal forebrain may be related to insomnia associated with ethanol withdrawal [125].
Only a single PET study has examined changes of A1R expression after acute exposure of animals to ethanol [126]. In that study, Wistar rats were treated with a combination of ethanol and the AK inhibitor ABT-702, and scanned with the A1R ligand [11C]MPDX. A striking (40-45%) increase of tracer distribution volume and binding potential was noted in target areas such as hippocampus, striatum and cerebral cortex, 20-90 min after treatment. Additional PET studies could be performed to study the effect of ethanol only, either in rodents or in the human brain.

3.4. Cerebral Ischemia

Levels of extracellular adenosine in the brain are dramatically increased during ischemia. In patients with transient ischemic attack (TIA) or stroke, a rapid rise of the plasma concentration of adenosine occurs in peripheral venous blood, presumably because of spillover from the brain, and this increase persists for days (TIA) or weeks (stroke) [127]. Extracellular adenosine in the brain inhibits synaptic neurotransmission including the release of excitatory amino acids [128,129], leading to a better matching of energy demand and energy supply in ischemic areas and a reduction of delayed excitotoxicity [130]. Through A1R, adenosine promotes both the spontaneous electrical shutdown of the ischemic brain [131] and post-ischemic electrocortical burst suppression [132,133]. When levels of extracellular adenosine in mouse brain are reduced by transgenic overexpression of AK, postischemic cell death is increased [134].

The importance of A1R stimulation was also evident in studies regarding ischemic preconditioning. When neurons or living animals are exposed to a short period of sublethal ischemia, they are better protected to a subsequent serious ischemic insult. This beneficial effect of preconditioning disappears in the presence of an A1R antagonist like DPCPX, suggesting that A1R stimulation is involved [135-139]. The mechanisms underlying induction of rapid tolerance by a sublethal ischemic insult are not fully understood. Increases in protein kinase C activity, mitogen-activated protein (MAP) kinase activity, Akt activity, nitric oxide production and mitochondrial K<sub>ATP</sub> channels may all be involved [135-139]. Activation of presynaptic K<sup>+</sup> channels via stimulation of A1R may decrease evoked neurotransmitter release by hyperpolarization of the presynaptic membrane and thus improve resistance of the brain to ischemia.

In various animal and in vitro models, acute administration of A1R agonists [140-143], inhibitors of adenosine uptake (propentofylline but not dipyridamole) [144], or inhibitors of AK [134] has been shown to result in protection against ischemic brain damage and reperfusion injury. Long-term treatment of gerbils with caffeine causes an upregulation of cerebral A1R (10-17%) and greater resistance of neurons to ischemia induced by bilateral carotid artery occlusion [145]. Increasing the binding of adenosine to A1R by administration of an allosteric enhancer also results in decreased brain damage after a hypoxic insult [146]. In contrast, acute administration of an A1R antagonist such as DPCPX aggravates the consequences of cerebral ischemia [141,142,147].

Therapeutic application of A1R agonists in stroke patients may be complicated by the fact that such compounds can have diametrically opposite effects after chronic and acute administration. Acute treatment with an A1R agonist may reduce postischemic neuronal losses whereas chronic treatment with the same compound increases brain damage [142,148]. Other agonists are neuroprotective even during chronic treatment [149]. The underlying mechanisms are far from clear since the consequences of chronic administration of A1R ligands can not always be related to up- or downregulation of A1R [142].

Many studies have examined changes of A1R expression in the brain of experimental animals after cerebral ischemia. In most studies, rapid decreases of A1R mRNA and protein were observed during reperfusion [150-152] but in one study, decreases were noted at the mRNA but not the protein level [153]. These (slightly) discrepant findings may be due to the fact that different models of ischemia were employed and animals were examined at different intervals after the ischemic insult. Some changes appear only at intervals greater than 24 hours. Changes of A1R expression during ischemia have been little examined, as opposed to changes during reperfusion. In a single study, increases of A1R expression (at the mRNA and protein level) were noted during bilateral carotid artery ligation with a return to normal values immediately after reperfusion [154].

An interesting study from Japan examined changes of cerebral A1R in cat brain following an ischemic insult, using PET and the radioligand [11C]-MPDX. Decreases of A1R were noted, and the magnitude of these losses increased with increasing severity of the...
In many studies, co-administration of A1R antagonists was probably important for the therapeutic outcome of hypoxia-induced convulsions [168]. The location of intracerebral injection of kainic acid [166], intraperitoneal injection of pilocarpine [167] and caudate nucleus kindling [162], intrahippocampal injection of piriform cortex kindling [164], hippocampal kindling [162,165], and entorhinal cortex kindling [163], were also effective in other animal models of epilepsy, such as entorhinal cortex kindling [163], piriform cortex kindling [164], hippocampal kindling [162,165], caudate nucleus kindling [162], intrahippocampal injection of kainic acid [166], intraperitoneal injection of pilocarpine [167] and hypoxia-induced convulsions [168]. The location of intracerebral administration is probably important for the therapeutic outcome [169]. In many studies, co-administration of A1R antagonists was shown to result in a reduction of the anticonvulsant effect, which indicates that the A1R subtype is involved in the beneficial action of the agonists.

Inhibitors of the enzyme AK can be systemically administered and can increase extracellular adenosine levels in metabolically active brain regions. Such compounds show similar anticonvulsant actions as A1R agonists but lack the undesired peripheral side effects of these drugs [170]. AK is regionally overexpressed in epilepsy and this overexpression appears to contribute to the development and progression of seizure activity [134,171,172]. Local administration of adenosine by implanting encapsulated myoblasts could be a promising strategy for long term treatment of focal epilepsy [175].

Further evidence for the involvement of the A1R in seizure suppression was obtained in animal models where A1R antagonists were administered. In a cat model of epilepsy (general seizures induced by intracortical injection of penicillin), the A1R antagonist CPT significantly prolonged the cycle period of seizures by increasing the duration of ictal discharge, in contrast to 7-aminoinsobutyric acid or opioid peptides [174]. Adenosine may accumulate during the interictal phase and be cleared during the ictal phase in status epilepticus. In a rat model of epilepsy (electrically induced seizures), secondary seizures were prolonged after administration of an A1R antagonist, and partial seizures were converted into generalized motor seizures [175]. In another rat model of epilepsy (i.p. administration of pilocarpine), the A1R agonists DPCPX and 3,7-dimethyl-1-propargylxanthine (DPMX) showed proconvulsant effects, by significantly reducing the latency to develop status epilepticus [167]. Theophylline also lowered the seizure threshold and prolonged hyperthermia-induced seizures in juvenile rats [176]. Using a selective A1R antagonist (DPCPX), evidence was obtained that the inhibitory effect of low frequency stimulation of the perforant path on kindling acquisition in rats is mediated by stimulation of A1R [177].

Changes of cerebral A1R densities have been assessed both in animal models of epilepsy and in human brain post mortem. In a rat model of acute general seizure (i.p. injection of a convulsive dose of bicuculline), a widespread increase of A1R (H-CHA binding) was noted, which was particularly evident in hippocampus, amygdala, substantia nigra and septum [178]. In a mouse model of general seizure (pentylentetrazol-induced convulsion) [179], A1R were upregulated in most brain areas but downregulated in the basal ganglia [180]. In tissue samples acquired from patients with temporal lobe epilepsy, a 48% increase of A1R density was observed in neocortex as compared to control samples from non-epileptic subjects [181]. However, in another study on human temporal lobe epilepsy, A1R binding in temporal cortex was found to be reduced compared to normal postmortem controls [182]. A 15% decline of A1R density was also noted in the basal ganglia and thalamic nuclei of genetic absence epilepsy rats from Strasbourg compared to wild-type littermates [183]. Even greater losses of A1R were noted in the hippocampus and cerebral cortex of kainate-treated, hippocampus-kindled and amygdala-kindled rats, animal models of chronic epilepsy [184-187].

These conflicting results (either an upregulation or downregulation of A1R) may be related to differences in the experimental setup in animal models and differences in patient selection in human studies. An acute seizure, or a limited number of seizures may be accompanied by upregulation of A1R, or increased coupling of A1R to G-proteins [188,189], as a protective mechanism enhancing the anticonvulsant effect of endogenous adenosine. However, chronic seizures may cause a significant death of neurons with accompanying losses of A1R. The effects of partial and general seizures may also be different and the age (or developmental stage) of the subjects may affect the response of A1R to kindling [178,190].

### 3.6. Traumatic Brain Injury

Studies in A1R knockout mice have confirmed that this subtype plays an important role in suppressing neuronal hyperactivity. When normal and A1R knockout mice were subjected to controlled cortical impact – an animal model of traumatic brain injury (TBI) - seizure scores were much higher in the knockouts and only the knockout animals developed lethal status epilepticus [191]. Similarly, unilateral hippocampal kainate injection caused non-convulsive status epilepticus in wild-type mice but severe convulsions and subsequent death of the animals in A1R knockouts [192]. The authors concluded that activation of A1R by adenosine is crucial in keeping an epileptic focus localized. Status epilepticus results in widespread adenosine release throughout the brain and suppression of the excitability of neurons remote from the epileptic focus via stimulation of A1R. In A1R knockout mice, this protective mechanism is lacking, so that severe convulsions and lethal status epilepticus can develop [192].

In another animal study on mild TBI, A1R knockout mice were shown to display a 20-50% enhanced microglial response compared to their wild-type littermates. Moreover, stimulation of A1R in BV-2 (immortalized mouse microglia) cells inhibited microglial proliferation [193]. Thus, A1Rs appear to play an anti-inflammatory role in TBI-induced neuroinflammation.

To the best of our knowledge, no PET studies on changes of A1R expression in epileptic patients or in animal models of epilepsy and TBI have been performed. Thus, there is considerable opportunity for imaging studies in this area.

### 3.7. Neuroinflammation

Besides its well-known function as an inhibitor of neuronal overactivity and its involvement in the regulation of sleep, adenosine has been proposed to act as an endogenous anti-inflammatory agent [194]. In the CNS, A1Rs are expressed not only on neurons but also on glia [195]. A1R stimulation in microglia, the endogenous immune cells of the brain, may have both pro- and anti-inflammatory effects, depending on the presence or absence of other factors in the environment, such as phorbol 12-myristate 13-acetate [196]. An early study reported that simultaneous activation of both A1R and A2aR stimulates microglial proliferation, whereas selective A1R or A2aR agonists when applied alone have no effect [195]. However, later studies have indicated that in most situations, A1R agonists suppress neuroinflammation.
In cultured astrocytes, CCPA enhanced the release of nerve growth factor [197], a compound which is essential for neuronal protection and a suppressor of neuroinflammation within the specific environment of the brain [198]. In plasmacytoid dendritic cells, adenosine has been suggested to play a dual role: first, chemotaxis to the site of inflammation is stimulated via A1R, then, the extent of the inflammatory response is limited by inhibition of the production of several cytokines such as interleukin-6, interleukin-12 and interferon-α [199].

The importance of A1R in controlling neuroinflammation was highlighted by studies of experimental allergic encephalomyelitis (EAE). Mice lacking A1R developed a much more severe, progressive-relapsing form of EAE than their wild-type littermates. Reduced densities of A1R in microglia of wild-type mice were observed during the neuro-inflammatory phase of EAE. Upregulation of A1R by treatment of normal mice with caffeine reduces EAE severity, and this beneficial effect of caffeine can be enhanced by concomitant administration of an A1R agonist [200].

Changes in cerebral A1R density caused by glioma invasion have been examined with the tracer [18]F[CPPFPX and PET, both in an animal model (F98 glioma-bearing rats) and in a patient with recurrent glioblastoma multiforme. In the animal model, A1R were also quantified by in vitro and in vivo autoradiography and immunohistochemical analysis. A1R were shown to be upregulated (by 36 to 46%) in a zone directly surrounding the tumor, and to be localized in activated astrocytes [205]. It would be interesting to study changes of A1R expression with microPET in animal models of neuroinflammation (e.g., the EAE model, the LPS model, or virally induced encephalitis). Such studies have not yet been reported.

3.8. Human Diseases of the CNS

3.8.1. Alzheimer’s Disease (AD)

Since A1R signaling can be neuroprotective, many investigators examined changes of regional A1R density in human brain in neurodegenerative disorders. Initial autoradiographic studies were focused on AD and the hippocampus, a brain region involved in memory. A significant loss of A1R was observed in the CA1 (-47%) and dentate gyrus molecular layers (-46%) of the hippocampus but not in the CA3 [206]. Another study reported 40-60% decreases in all areas of the hippocampus, the most striking losses occurring in the molecular layer of the dentate gyrus [207]. Still another investigation reported substantial decreases in the dentate gyrus but A1R densities close to normal in CA1 and CA3 [208]. The former two investigations used the A1R agonist [3H]CHA whereas the last study employed the antagonist ligand [3H]CPDPPX.

Binding of an A1R agonist ([3H]R-PIA) and antagonist ([3H]CPDPPX) in the AD hippocampus were later directly compared. Both ligands detected prominent losses of A1R in the dentate gyrus. Decreased agonist binding was observed in CA1 and outer layers of the parahippocampal gyrus, whereas losses of antagonist binding were noted in the subiculum and CA3. These decreases reflected reductions of receptor number (Bmax) rather than reductions of the affinity (Kd) of A1R for the radioligands [209].

In the striatum of AD patients, 30-36% losses of A1R were noted both in the caudate nucleus and putamen, and these losses appeared to parallel the decrease of choline acetyl transferase [210].

An immunohistochemical study from Spain showed that A1R are redistributed in the hippocampus and cerebral cortex of AD patients in comparison to age-matched controls. A1R accumulate in degenerating neurons and are co-localized with β-amyloid in senile plaques and with tau in neurons with tau deposition. Studies in the human neuroblastoma cell line SH-SY5Y indicated that A1R stimulation increases the production of soluble forms of amyloid precursor protein, and the phosphorylation and translocation of tau to the cytoskeleton. By inhibiting the deposition of amyloid and enhancing the translocation of tau, A1R stimulation may slow down the process of neurodegeneration [211].

An upregulation of A1R was detected in the frontal cortex of AD patients (both at early and advanced stages of the disease), using quantitative autoradiography and the radioligand [3H]DPCPX [212]. However, a PET study in AD patients and elderly normal subjects indicated significant decreases of the binding potential of [11C]MPDX in the temporal and medial temporal cortices and thalamus of the patients with no significant change in other areas of the brain [213] (Fig. 4). Discrepant findings in human studies may be related to the facts that different patient groups were selected (early vs. late onset AD), different brain regions were examined, and different techniques were used for quantification (immunohistochemistry, ligand binding). Moreover, a transient upregulation of A1R may be followed by an eventual receptor loss.

3.8.2. Pick’s and Creutzfeld-Jakob Disease

In the frontal cortex of individuals with Pick’s [214] and Creutzfeldt-Jakob [215] disease, similar increases of A1R density were noted as in patients with AD, using quantitative autoradiography and [3H]DPCPX. No PET studies with [11C]MPDX or [18]F[CPPFPX in such patients have been reported.

3.8.3. Multiple Sclerosis (MS)

Several studies have reported changes of AR signaling in patients with MS. Plasma levels of TNF-α in such patients are significantly higher and levels of adenosine are significantly lower than in control subjects. Stimulation of peripheral blood mononuclear cells (PBMC) with a selective A1R agonist (R-PIA) inhibits the mitogen-stimulated production of TNF-α in healthy subjects but not in MS patients, whereas the opposite is observed for the mitogen-stimulated production of interleukin-6 [216]. A1R densities in PBMC and in brain tissue from MS-patients are significantly decreased (by 53% and 49%, respectively) compared to age-matched controls [217]. Thus, both A1R densities and the coupling of A1R to cytokine signaling systems appear to be altered in MS. However, no PET studies with A1R ligands have been performed in this patient group.
3.8.4. Parkinson’s Disease

In the 1-methyl-4-phenyl-1,2,3,6-tetrahydropyridine mouse model of Parkinson’s disease, the drug paeoniflorin proved capable of reducing neurodegeneration and inhibiting neuroinflammation by activation of A1R [218]. Thus, modulation of neuroinflammation via A1R may be a novel approach towards treatment of neurodegenerative disease.

Deep brain stimulation (DBS) is frequently applied for the treatment of movement disorders and may also benefit individuals with psychiatric disease. Recently, it was shown that the mechanism underlying the beneficial effect of DBS is a local release of ATP which is extracellularly metabolized to adenosine and suppresses tremor via A1R. The effect of DBS can be mimicked by intrathalamic infusion of A1R agonists. On the other hand, AR antagonists like caffeine can trigger or exacerbate essential tremor [219].

3.8.5. Schizophrenia

A partial loss of A1R during birth and a corresponding reduction of the control of dopamine activity in later life has been proposed to play a role in the inhibitory deficit in schizophrenia [220,221]. Association between a single nucleotide polymorphism of the A1R gene (rs3766553) and schizophrenia was indeed noted in a Japanese population [222]. PET studies of cerebral A1R in patients with schizophrenia have not yet been performed.

4. PHARMACODYNAMIC STUDIES

4.1. A1R (ant)agonists

PET has important applications in the study of pharmacodynamics, i.e. assessment of the effects of drugs in the healthy and diseased body, including their mechanisms of action and the relationship between drug concentration and effect. During the development of CNS drugs, PET is often used to measure the dose-dependent occupancy of target receptors in the human brain by a non-radioactive test compound. PET is also capable of measuring the metabolic response of tissues to treatment quantitatively, repeatedly and noninvasively, both in experimental animals and humans.

Only a few PET studies regarding A1R occupancy by cold antagonists have been reported in the literature. An interesting paper from Germany showed that the binding of 18F-CPFPX in rat brain is reduced after treatment of animals with caffeine, shortly before injection of the tracer. At a dose of 4 mg/kg, corresponding to consumption of three to four cups of coffee by a human being, tracer binding was strongly (ca. 50%) suppressed, suggesting ~70% receptor occupancy [223]. Another study showed that 18F-CPFPX bound to A1R in human brain can be dose-dependently displaced by injecting non-radioactive CPFPX [224]. A microPET study from our own group has indicated that A1R in rat brain are almost completely occupied after administration of DPCPX (3 mg/kg, i.p.), 20 min before injection of 11C-MPDX [126].

Thus, the dose-dependent occupancy of A1R in the brain by test drugs may be assessed by PET. Dose-dependent effects of A1R agonists (or AK inhibitors, see 4.2) on organ metabolism could be assessed as well, using the radiolabeled glucose analog [18F]FDG, but such studies have not yet been reported.

4.2. AK Inhibitors

AK regulates intra- and extracellular adenosine concentrations by phosphorylation of adenosine to AMP. Although ADA also removes adenosine by converting it to inosine, the reaction catalyzed by AK is the most important pathway of adenosine removal under physiological conditions [225]. Since the major adenosine-specific nucleoside carrier acts as a non-concentrative, bi-directional, facilitated diffusion transporter, adenosine transport is driven by the concentration gradient across the cell membrane. Inhibition of AK raises intracellular adenosine, diminishes the concentration gradient and decreases the cellular uptake of adenosine, resulting in increased extracellular adenosine concentrations, particular under pathophysiological conditions and in tissues or brain regions where the formation of adenosine is increased by net catabolism of ATP [226-228]. An in vivo study in rats has shown that AK inhibitors (AKIs) augment the increases of...
extracellular adenosine during excitotoxic insults in the striatum but do not affect striatal adenosine levels in vehicle-treated controls [228]. Thus, AKIs represent a strategy for potentiating the protective actions of endogenous adenosine during tissue trauma [229]. This therapeutic approach may be advantageous in cases where not a single subtype (e.g., A1R) but rather a multiplicity of AR subtypes should be stimulated for the beneficial effect [230].

Three applications of AKIs have been proposed. First, intrathecally administered AR agonists [231-233] and AKIs [232-234] have antinociceptive effects in experimental animals. These effects are counteracted by selective AR antagonists but not by A2AR antagonists suggesting involvement of A1R stimulation where not a single subtype (e.g., A1R) but rather a multiplicity of AR subtypes is involved [229]. This therapeutic approach may be advantageous in cases where tissue trauma-induced elevation of endogenous adenosine and subsequent adenosine A1R stimulation are responsible for the observed protective actions of adenosine during tissue trauma [228]. Thus, AKIs represent a strategy for potentiating the protective actions of adenosine during tissue trauma. A2AR antagonists suggest involvement of A1R stimulation where not a single subtype (e.g., A1R) but rather a multiplicity of AR subtypes is involved. This therapeutic approach may be advantageous in cases where tissue trauma-induced elevation of endogenous adenosine and subsequent adenosine A1R stimulation are responsible for the observed protective actions of adenosine during tissue trauma.

Second, AR agonists and AKIs have shown anti-inflammatory efficacy in various animal models of acute and chronic inflammation [238,239,240-248]. A third potential application of AKIs is in the treatment of epilepsy. These compounds suppress seizures in rodent models, such as the bicuculline-induced seizure [249] and the maximal electroshock [170,250,251] model, presumably via an interaction of adenosine with cerebral A1R. For that reason and because upregulation of the enzyme AK is involved in epileptogenesis [171], AKIs are considered promising anticonvulsants [170,252,253].

If a ligand could be developed of which the binding is sensitive to competition by endogenous adenosine, PET imaging could be applied to assess changes of extracellular adenosine induced by AKIs.

CONCLUSION

The pharmacodynamics of A1R agonists and AKI can be applied to elucidate the role of A1R in the normal and diseased human brain and to study the pharmacodynamics of A1R agonists and AKI.

CONFLICT OF INTEREST STATEMENT

The authors declare that they have no conflict of interest.

REFERENCES


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manipulation of endogenous adenosine A1 receptor imaging. Current Medicinal Chemistry, 2011 Vol. 18, No. 2


