Combined therapeutic effects of low power laser (980nm) and CoQ10 on Neuropathic Pain in adult male rat

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Abstract

Background: Neuropathic pain (NP) is one of the most suffering medical conditions that often fail to respond to certain pain therapy. Although its exact etiology is still unknown the role of reactive oxygen species (ROS) and oxidative stress were explored by many researchers. Neuropathies either central or peripheral lead to painful condition as well as social and economic isolation, thus various therapies were used to treat or reduce the pain. Laser therapy and antioxidant drugs have separately considered as treatment for NP, but the combination of them have not been used yet. In order to study the combination effects of Low Level Laser Therapy (LLLT) and Coenzyme Q10 (CoQ10) the present study was designed.

Methods: Sixty adult male rats (230-320g) were used in this experimental study that divided into six groups (n=10). Chronic constriction injury (CCI) was used to induce neuropathic pain. The CoQ10 or vehicle, a low level laser of 980nm was used for two consecutive weeks. Thermal and mechanical paw withdrawal thresholds were assessed before and after surgery on 7th and 14th days.

Results: As we expected CCI decreased the pain threshold, whereas CoQ10 administration for two weeks increased mechanical and thermal threshold. The same results obtained for laser therapy using the CCI animals. Combination of laser 980nm with CoQ10 also showed significant differences in CCI animals.

Conclusion: Based on our findings the combination of CoQ10 with LLLT showed better effects than each one alone. In this regard we believe that there might be cellular and molecular synergism in simultaneous use of CoQ10 and LLLT on pain relief.

Keywords: Low Level Laser Therapy, Neuropathic pain, Chronic Constriction Injury, Coenzyme Q10


Introduction

Various agents including direct nerve and spinal cord trauma; viral infections and metabolic diseases such as diabetes may trigger neuropathic pain (NP). As clinical laboratory examination shows that the neuropathic pain is often independent of any obvious signs of inflammation; it is sometimes described as ‘non-inflammatory pain’. The International Association for the Study of Pain (IASP) defines NP as pain ‘initiated or caused by a primary lesion or dysfunction in the nervous system’ (1). Despite of this definition that refers to mainly the cause, the exact mechanism of the events following the injury or trauma remain poorly understood. There are certain evidences that confirm cellular events following injury that mainly emphasize on the role of cellular organelles such as mito-

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chondria (2). The first mitochondrial dys-
function described in the 1960s and during
the last two decades the role that it plays in
health, disease, and aging have been report-
ed by others. Several studies showed that
free radical; oxidative stress and inflamma-
tion have major role in the pathogenesis of
neurodegenerative diseases, such as amyotro-
phic lateral sclerosis, epilepsy, migraine
headaches, strokes, Alzheimer and Parkin-
son’s diseases and NP resulting in mito-
chondrial dysfunction (3-5). Mitochondrial
dysfunction has been shown in rats with
painful peripheral neuropathies (6). It is
reported that the major reason for mito-
chondrial dysfunction is reactive oxygen
species (ROS) production thus antioxidant
could be a good candidate and therapeutic
strategy for decreasing the severity of the
damage to mitochondria. Ubiquinone
CoQ_{10} is a vital cofactor in complexes I to
III of the mitochondrial electron transport
chain, which acts as an electron acceptor
and also a key component of the mito-
chondrial respiratory chain for adenosine tri-
phosphate synthesis (7-9). In addition to its
unique role in mitochondria, CoQ_{10} is a po-
tent antioxidant and scavenging free rad-
cals and inhibiting lipid per oxidation (10,
11). The CoQ_{10} has bioenergetics and anti-
inflammatory effects that protect against
apoptosis of neurons and cells from oxida-
tive stress in vivo (12-15). The previous
studies carried out by Kohli et al. and El-
Abhar et al. showed that CoQ_{10} possesses
anti-ulcer potential as well (16,17). Ghule
et al. have documented that CoQ_{10} provides
protection against isoproterenol-induced
cardiotoxicity and cardiac hypertrophy pre-
clinically, and Burke et al. showed that it
could be used as a treatment for systolic
hypertensive patient (18, 19). CoQ_{10} treat-
ment improves endothelial function and blood
flow; thus, long-term treatment may be
effective by improving oxygenation of the
peripheral nerves (20). Hernandez-
Ojeda et al. reported that a 12-wk treatment
with ubiquinone significantly improves di-
abetic polyneuropathy in patients with type
II diabetes (21).

As drug therapy it may lead to unwanted
and undesirable side effects hence other
therapeutic procedures including physical
methods have been improved due to the
absence of side effects (22). Low level laser
therapy (LLLT) is well known for its anti-
flammatory, analgesic and tissue repair
effects (23-28). It seems that some mecha-
nisms of low level laser involved in mito-
chondrial respiratory chain and oxidative
stress biomarkers (29). According to Karu
et al. laser exposure can lead to an increase
in mitochondrial electrochemical activity
and ATP synthesis (30). Eells et al. showed
that cytochrome c oxidase is the main pho-
to acceptor of laser light (31). Other re-
searchers postulated that laser therapy in-
fluences oxidative stress parameters such as
changes in antioxidant enzyme activity and
the production of ROS (32-35). The ab-
sorption of laser light have shown to acce-
lerate the transfer of electrons (respiratory
chain) and induces an initial ROS pro-
duction, specifically increasing the produc-
tion of superoxide anion (32). Despite the
known clinical effects of LLLT and CoQ_{10},
to our knowledge there are no study on
combined effects on NP. Thus the present
study designed first to compare the effects
of CoQ_{10} and LLLT on neuropathic pain
model and explore the combination of these
two procedures on same model.

Methods

Animals

Sixty adult male Wistar rats (250–320 g)
were used in this study with food and wa-
ter ad libitum. The animals were divided
into six groups (n=10) as follows:
- CCI group: animals that were subjected
to surgical procedure, without undergoing
treatment.
- Coenzyme Q_{10} group: received 200mg
/kg/day intraperitoneal (i.p) injection of Co
Q_{10}(Tishcon, NY,USA)
- Vehicle group: received 200mg /kg/day
(i.p) injection vehicle of CoQ_{10}
- Laser therapy group (980nm): laser ir-
radiation with energy density of 4 J/cm^2
and intensity of 0.248 (W/cm^2)
• Laser 980nm+CoQ$_{10}$ group: received 200mg /kg/day (i.p) injection of CoQ$_{10}$ and laser 980nm.
• Laser 980nm+Vehicle group: received 200mg /kg/day (i.p) injection vehicle of CoQ$_{10}$ and laser 980nm.

All animals were subjected to the behavioral evaluation before surgery. To induce NP, the sciatic nerve injury model described by Bennett and Xie was used (36).

**Treatment**

The day after surgery, vehicle and CoQ$_{10}$ groups received 200 mg/kg (i.p) injection of CoQ$_{10}$ (CoQ$_{10}$ is in LiQsorb form) for 14 days.

A CW diode laser emitter with following specification was used in this study. A laser with wavelength of 980 nm, power of 70mW (Aixiz; model: AH980-6015AC), the energy density of 4 J/cm$^2$, power density of 0.248 W/cm$^2$ and beam area $\sim$ 0.238 cm$^2$ was used. The irradiation was as follows: two points on two ends of surgical incision and another at the mn time 11.3s for visible wavelength and 16.13s for NIR one.

Laser calibration was done prior to use. Three points of the surgical incision were irradiated transcutaneously with no direct skin conidpoint. Treatment was started on the first day after the surgery and was continued for two weeks daily at the same time between 10-12 AM.

**Functional analysis**

Behavioral study was carried out before and after surgery on 14$^{th}$ day.

**Thermal withdrawal threshold**

Using a Plantar Test apparatus (Ugo-Basile, Italy) thermal hyperalgesia, the latency to withdrawal of the hind paws from a focused beam of radiant heat applied to the plantar surface. The animals were placed in an acrylic box with glass floor and the plantar surface of their hind paw exposed to a beam of infrared radiant heat. The paw withdrawal latencies were recorded at infrared intensity of 50 and three trials for the right hind paws were performed and for each reading, the apparatus was set at a cut-off time of 25s. Each trial separated by an interval time of 5 minutes.

**Mechanical withdrawal threshold**

Mechanical paw withdrawal thresholds were assessed with the Randall–Selitto method using an Analgesy-meter apparatus (UgoBasile, Italy). This instrument exerts a force that was increased at a constant rate. The force was applied to the hind paw of the rat, which was placed on a small plinth under a cone shaped pusher with a rounded tip (1.5 mm in diameter).The rat was held upright with the head and limb to be tested free, but most of its body cradled in the hands of the experimenter. The paw was then put under the pusher until the rat withdrew the hind paw. Each hind paw was tested twice, with a 10 min interval between the measurements and mechanical paw withdrawal thresholds were calculated as the average of two consecutive measurements.

**Statistical analysis**

Using SPSS 19.0 statistical analysis was done, and the results presented as means ± SD, and p-value less than 0.05 was considered to be significant.

**Results**

For functional evaluation of gait we used the Plantar Test and Randall–Selitto method preoperatively and those recorded on the 14$^{th}$ day after surgery. Our results were as follow:

**Plantar Test**

The thermal withdrawal threshold of the control group was, on average, 18.91±4.08 sec of the data recorded prior to the injury. For the CCI group 12.42±4.82 sec and10.70±5.02 sec on the 7$^{th}$ day and the 14$^{th}$ day respectively after surgery. For the CoQ$_{10}$ group, the mean values were 18.91±4.09 sec and 16.15±4.52 sec on the 7$^{th}$ and the 14$^{th}$ day respectively after surgery.

For the Vehicle group, the mean values were 14.67±5.64 sec and 13.86±4.91
sec on the 7th and the 14th respectively day after surgery. For the LLLT 980nm group, the mean values were 16.13±4.11 sec and 14.18±3.35 sec on the 7th and the 14th day respectively after surgery. For the LLLT 980nm+CoQ10 group, the mean values were 19.02±3.02 sec and 19.11±4.61 sec on the 7th and the 14th day after surgery. For the LLLT 980nm+Vehicle group, the mean values were 17.64±5.22 sec and 17.54±4.96 sec on the 7th and the 14th day respectively after surgery. By using ANOVA, the results among the CCI and treatment groups considered significant. However, there were no significant difference between the 7th, 14th post-surgery days of the CoQ10 group and the control group; but there was significant difference between the 7th, 14th post-surgery days in the LLLT 980nm group and the control group (p< 0.01, p< 0.001) re-

Fig. 1. Mean values of the Thermal Paw Withdrawal Threshold obtained from the groups during the study period (before surgery (control), the 7th day after surgery). Asterisks represent significant differences from CCI group (*** p< 0.001) and (### p< 0.001, ## p< 0.01) represent significant differences from control group.

Fig. 2. Mean values of the Thermal Paw Withdrawal Threshold obtained from the groups during the study period (before surgery (control), the 14th day after surgery). Asterisks represent significant differences from CCI group (*** p< 0.001, **p< 0.01, *p< 0.05) and (### p< 0.001, ## p< 0.01) represent significant differences from control group.
respectively; and there were no significant difference between the 7th, 14th post-surgery days in the LLLT 980nm+CoQ10 group and the Control group; also between LLLT 980nm+vehicle group and the control group. The comparison between the LLLT 980nm+CoQ10 group and LLLT 980nm+Vehicle group showed there was no significant difference in both values. There was no significant difference between the 7th post-surgery days in the LLLT 980nm+CoQ10 group and the CoQ10 group and there was significant difference between the 7th post-surgery day of the LLLT 980nm+Q10 group and the LLLT 980nm group at (p< 0.01). Comparison of the results among the LLLT 980nm+CoQ10 group and treatment groups (CoQ10 and LLLT 980nm) illustrated significant difference (p< 0.05, p< 0.001) on the 14th day after surgery (Fig 1&Fig 2).

**Randall–Selitto method**

The mean of mechanical withdrawal threshold of the control group was 19.18±4.66 g before surgery. The means
for the CCI group were 10.17±4.18 g and 9.15±4.20 g on the 7th and the 14th day respectively after surgery. For the CoQ10 group, the mean values were 15.29±5.50 g and 13.19±4.12 g on the 7th and the 14th day after surgery. For the Vehicle group, the mean values were 12.09±3.92 sec and 9.75±3.15 sec on the 7th and the 14th day respectively after surgery. For the LLLT 980nm group, the mean values were 14.15±4.25 g and 12.35±5.28 g on the 7th day and the 14th day respectively after surgery. For the LLLT 980nm+CoQ10 group, the mean values were 14.65±5.77 sec and 12.72±4.63 sec on the 7th and the 14th day respectively after surgery. For the LLLT 980nm+Vehicle group, the mean values were 13.6±3.50 sec and 10.98±2.99 sec on the 7th and the 14th day respectively after surgery. Statistical analysis indicated that the difference between control group and the CCI group on the 7th, 14th post-surgery days, was significant (p< 0.001); also difference between CoQ10 group and the CCI group on the 7th, 14th post-surgery days, was significant (p< 0.001, p< 0.01); and difference between LLLT 980nm group and the CCI group on the 7th, 14th post-surgery days, was also significant (p<0.01). Moreover, difference between LLLT 980nm+CoQ10 group and the CCI group on the 7th, 14th post-surgery days, was significant (p< 0.001, p< 0.05). Difference between LLLT 980nm+Vehicle group and the CCI group on the 7th post-surgery day was significant (p< 0.01) but there was no significant difference on 14th day post-surgery. Also, there was significant difference between the 7th, 14th post-surgery days of the treatment groups and the control group (p< 0.001). In a comparison between the LLLT 980nm+CoQ10 and LLLT 980nm+Vehicle groups, there were no significant differences in the values on the 7th, 14th post-surgery days and comparison between the LLLT 980nm+CoQ10 group and treatment groups (CoQ10 and LLLT 980nm), showed no significant difference on the 7th, 14th days (Fig 3 & Fig 4).

Discussion

Our finding showed that LLLT and CoQ10 alone and combined after 1 week increase thermal and mechanical sense thresholds compared to the CCI animals. The results were the same for two weeks of intervention.

To explain the cellular mechanisms that led to these findings, the nature and pathology of NP should be considered. It is generally accepted that neuropathic pain hyperalgesia depends on an increase in proinflammatory cytokines (37). In addition, NO a diffusible multifunctional transcellular messenger also contribute to hyperalgesia. It acts directly by sensitizing peripheral nerve or indirectly by influencing the local inflammatory process. NO is also involved in the transmission and modulation of nociceptive information at the periphery, spinal cord and supraspinal level (38). Other factors including cytokines, such as tumor necrosis factor alpha (TNF-α) and interleukin-10 (IL-10) are important for pain behavior following nerve injury. It is shown that these factors are associated with mitochondrial dysfunction and lead to increasing ROS production and oxidative stress generation (39). In addition to their pronociceptive action, TNF-α and NO act as proapoptotic messengers (43, 44). TNF-α is responsible for a cascade of cellular events that result in mitochondrial dysfunction. It acts via reducing complex III activity, increasing ROS production and causing damage to mtDNA (40-41).

The LLLT is widely used for its cellular therapeutic effects, which lead to wound healing, pain relief, reduction of edema and inflammation. During the period of LLLT, absorption of red or near-infrared photons by cytochrome c oxidase in the mitochondrial respiratory chain causes an increase in cellular respiration (42). Silveira et al. evaluated the effects of low level laser therapy (904 nm) with varied irradiation intensity on mitochondrial respiratory chain activity and some oxidative stress markers. They showed LLLT reduces the complex II activity of the mitochondrial respiratory chain.
chain and they concluded that LLLT could protect the cell against oxidative damage to membrane lipids, due to the decreases in both superoxide anion production and oxidative stress. (43). The reduction of oxidative damages has been postulated as one of the main mechanisms following using LLLT which induces an increase in SOD activity, thus lead to decrease in tissue damages and the maximization of the healing process (44-46). Various mechanisms for therapeutic efficacy of low level laser irradiation have been proposed, including increases in mitochondrial activity and ATP levels, production of low levels of reactive oxygen species, induction of transcription factors NF-κB, and inhibition of apoptosis (47). Khalil et al. have shown that N-type Ca$^{2+}$ channel activation plays a role in nerve repair (48). Following increased ATP and protein synthesis after LLLT, the expressions of growth factors and cytokines increase and activation of calcium channels resulting in increased intracellular calcium concentration, ultimately lead to cell survival (49-55).

Increases in pain relief factor such as beta-endorphins, blocked depolarization of C-fiber afferent nerves (56), axonal sprouting and nerve cell regeneration (57), decreased bradikynin levels, ion channel normalization (58), stabilization of the cell membrane (59), enhancement of ATP synthesis (60), stimulated vasodilation along with release histamine, NO and serotonin (61), reduction in interleukin-1β levels (62), increasing angiogenesis (63), enhancing superoxide dismutase (64), decreasing C-reactive protein and neopterin levels (65) are other reported mechanisms for reducing pain by red and near infrared light.

Regarding CoQ10 it is reported that it can decrease neurological symptoms in patients with Parkinson and Huntington diseases. It is also shown that CoQ10 may play an important role in neuroprotection against diabetic neuropathy and other neurodegenerative disorders (66, 67). Zhang et al. demonstrated the potential benefits of CoQ10 as a potent antioxidant and its ability to relieve neuropathic pain in the type I diabetic mouse model (68). Also, Shi et al. reported that the CoQ10 may represent a promising therapeutic strategy for type II diabetic neuropathy (69). The CoQ10 neuroprotection may also leads to functional improvement of respiratory chain activity and prevention of neuronal apoptosis (68). It also acts throughout inhibiting oxidative stress and reducing inflammation by down-regulating of proinflammatory factors (11). The CoQ10 intensely reduced apoptotic cell death, attenuated ATP decrease, and hindered DNA fragmentation elicited by all apoptotic stimuli that is accompanied by inhibition of mitochondrial depolarization, cytochrome c release (70). Tsai et al. showed that CoQ10 significantly reduced the activation of NF-κB, suppressed the expression of P53 and the expression of Bax and led to a significant increase in expression of the antiapoptotic protein Bel-2 and suppressing oxidative stress-related responses by modulating NO-related signaling (71). The role of CoQ10 is to reduce hypertension-mediated oxidative damage (72), increases the antioxidant capacity of glutathione reductase and superoxide dismutase (SOD) also reported (73). Nonetheless the CoQ10 treatment improves endothelial function and blood flow; thus, long-term treatment may be effective by improving oxygenation of the peripheral nerves (74). An increase in the concentration of CoQ10 might affect mitochondrial respiratory function and early supplementation should be administrated in cases of deficiency (77). Since these events are due to mitochondrial PTP opening, Papucci et al. suggested the antiapoptotic activity of CoQ10 could be related to its ability to prevent PTP opening and thus apoptosis (70). It is reported by Singh et al. that CoQ10 supplements could increase the levels of vitamins A, C, and E (75, 76), hence some of its effects might be related to this function.

Since better results was obtained in combined therapy (CoQ10+LLLT 980nm) and based on our knowledge from literature we believe that there might be separated or
synergetic mechanisms for this phenomenon. It is possible that each of these modalities that we used acts in its own way to reduce pain, prevents apoptosis or inhibits the inflammation process. There are numerous evidences presented that support this possibility. It is also possible that they acted together with same or other mechanisms. From this point of view it is shown that LLLT and CoQ10 under different or same pathway are simultaneously able to inhibit proinflammatory process (11, 23, 25), enhancing mitochondrial respiratory chain (11, 42) inhibiting or down regulating the apoptotic cascade (43, 68, 71) and decreasing the effects of oxidative stress (72-74, 43-46). The specific mechanisms for these events are still unknown and more studies needed to explain them, and the possibility of adverse effects of LLLT and CoQ10 should be considered in future.

Conclusion
The CoQ10 can prevent deleterious effects of nerve injury and laser application at 980nm was also effective in promoting early functional recovery. The combination of CoQ10 with LLLT showed better effects than each one alone. There might be cellular and molecular synergism in simultaneous use of CoQ10 and LLLT. Under careful guide clinical application of these modalities may be used in treatment of the NP.

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References


47. Karu T1. "Mitochondrial Signaling in Mammalian Cells Activated by Red and Near-IR Radiation," Photochem Photobiol 2008; 84, 1091-1099
Low power laser and CoQ10


72. Murad LB, Guimaraes MR, Vianna LM. Effects of decylubiquinone (coenzyme Q10 analog) supplementation on SHRSP. Biofactors 2007;


