Sonodynamic therapy as an adjunctive treatment on *porphyromonas gingivalis* induced periodontitis in rats with diabetes

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Acknowledgements

This study was funded by the Natural Science Foundation, Heilongjiang Province of China (grant number H2017022); National Key Technology Support Program of China (grant number 2013BAI03B06).

Abstract

Purpose: The aim of this study was to evaluate the efficacy of sonodynamic therapy (SDT) *porphyromonas gingivalis* (Pg) induced periodontitis in rats with diabetes.

Methods: Colony forming unit and the intracellular reactive oxygen species (ROS) of Pg (ATCC 33277) was detected. Periodontal disease was induced by orally administering Pg and placing ligatures around the cervix of the first maxillary molar. After 4 weeks, the rats were received three treatments: irrigation with sterile saline solution (control group); scaling and root planing (SRP) (SRP group); hypodermic injection of 40 μg/mL HMME with 3 W/cm^2 low-intensity ultrasound irradiation every other day (1 MHz, 600 s) (SRP+SDT group). All rats were euthanized at 10 days postoperatively. The maxilla was taken for histological examination. The distance between the cementoenamel junction (CEJ) and the alveolar bone crest (ABC) was measured to access the level of alveolar bone.

Results: When Pg was treated with ultrasound (3 W/cm^2 for 10 min) at 40 μg/mL HMME concentration, 4.7 lg reduction in CFU in SDT ($P<0.01$). The intracellular ROS in SDT group had a significant difference in comparison with the control group ($P<0.01$). In the D group, the intragroup analysis revealed less bone loss in the SRP+SDT treatment than in the control and SRP treatment ($P<0.05$). Intergroup analysis (ND and D groups) showed a greater bone loss in the ND group treated with SRP compared to the D group treated with SRP+SDT.

Conclusions: SDT was an effective adjuvant therapy to SRP on induced periodontitis in rats with diabetes.

Keywords: *porphyromonas gingivalis;* periodontitis; diabetes; sonodynamic therapy; alveolar bone loss.

Introduction

About one-half of the adult population suffers from moderate to severe periodontal diseases that are also potentially associated with diabetes mellitus [1]. The hyperglycemic environment promotes the expression of toll-like receptors in periodontal tissues, making diabetic patients more susceptible to periodontitis [2]. Diabetes mellitus also causes differentiation dysfunction of osteoblasts, and decreased the density of alveolar bone [3]. Additionally, periodontitis can affect glycemic control in diabetic patients and induce various diabetic complications [4].

Porphyromonas gingivalis (Pg), a Gram-negative and obligate anaerobe bacterium, is associated with many chronic systemic diseases, such as rheumatoid arthritis, cardiovascular diseases, diabetes mellitus and even cancers [5, 6]. Researchers have found that Pg infection induced the expressions of TNF-α and IL-6 and might be an important risk factor for diabetes mellitus [7]. Pg, as a periodontal pathogen, utilizes multiple virulence factors, such as LPS, gingipains, and cytotoxic. These virulence factors are helpful to breakdown the host-defense mechanisms, damage the connective tissue and cause the alveolar bone loss around the teeth [8]. According to the systematic and retrospective reviews, scaling and root planing (SRP) is the main treatment for periodontal disease. It can effectively eliminate the dental plaque and calculus in 85% of instrumented root surfaces when the periodontal depth of pockets was 4-6 mm. However, SRP fails to remove the bacterial toxins which hide in the connective tissue and furcation area [9, 10]. The most common adjunctive therapy of periodontitis is applying the local or systemic antibiotics. However, considering the large usage of antibiotics during the therapeutic process, many bacteria may gain resistance, particularly to the tetracyclines by limiting the drug access to the cell or generating antibiotic enzymes. Moreover, antibiotics may cause some side effects, such as nausea, xerostomia and stomachache [11].

Sonodynamic therapy (SDT) is a promising treatment for killing cancer cells using low-intensity

ultrasound with sonosensitizers. When the low-intensity ultrasound reaches the target, it can activate sonosensitizers and generate reactive oxygen species (ROS) [12]. Hematoporphyrin monomethyl ether (HMME) is an effective sonosensitizer in SDT with a stable structure, lower dark toxicity, higher singlet oxygen yield to induce cell apoptosis via the mitochondrial apoptotic pathway [13]. The major advantages of SDT are its strong penetrating power, noninvasive, no drug resistance and initiation of activity only when irradiated to ultrasound [14]. Recently, many studies have indicated satisfactory results with SDT in inhibiting bacteria such as methicillin-resistant *staphylococcus aureus* (MRSA) [15], *bacillus cereus* and *escherichia coli* [16]. Our previous study showed that HMME-mediated SDT could effectively inhibit the growth of *staphylococcus aureus* [14]. In addition, HMME combined with low-intensity ultrasound could effectively alleviate the alveolar bone loss in experimental periodontal disease in rats [17, 18].

Although SDT has been shown effective on various bacteria, sonosensitizer-mediated SDT on Pg has not been reported up to date. The purpose of this study is to evaluate the effect of HMME-mediated SDT on Pg and the role of SDT as a repeated adjunctive treatment on experimentally induced periodontal disease in rats with diabetes. SDT may be an alternative adjunctive treatment for suppressing the alveolar bone resorption in diabetics who suffer from periodontal disease.

Materials and methods

Bacterial strain and culture

Porphyromonas gingivalis (Pg) strain (ATCC 33277) was cultured in brain-heart infusion (BHI, Difco, Detroit, MI) broth which supplied with 10 μg/mL hemin (Sigma-Aldrich, USA) and 0.2 μg/mL vitamin K (Sigma-Aldrich, USA). The bacteria were cultured in a 37 ℃ anaerobic chamber (5% H_2, 10%CO_2, and 85% N_2). After 5 days, the Pg suspensions were diluted with a sterile saline solution and

set to an optical density (OD_{630nm}) of approx 1×10^7 cells/mL.

Animals

Fifty-four adult female Wistar rats, weighing 200-250 g, from the Animal Facility of the Second Affiliated Hospital of Harbin Medical University, were used. Before the study, all rats were allowed to acclimatize to the laboratory environment for 7 days. This study was approved by the Use Committee of Harbin Medical University (Harbin, People's Republic of China), in accordance with the National Institutes of Health guide for the care and use of Laboratory animals (NIH Publications No. 8023, revised 1978).

Induction of diabetic rats

After 12 h fasting period, diabetes was induced in half of the animals by an intraperitoneal injection of 60 mg/kg of streptozotocin (STZ) (Sigma, St. Louis, MO, USA). Other rats were injected with 0.1 mol/L citrate buffer as control. Diabetes mellitus was confirmed via the caudal vein 48 h after the STZ administration by the measurement of a blood glucose levels above 300 mg/dL. Blood glucose levels were recorded before the diabetic induction and at the end of the periodontal treatment.

Experimental periodontal disease induction

Intraperitoneal anaesthesia was induced by administering ketamine (80 mg/kg) and dexedetomidine (0.6 mg/kg). The maxillary first molars of each rat received a 3-0 silk ligature around the cervix to induce experimental periodontal disease. Animals were given sulfamethoxazole (1 mg/mL) and trimethoprim (200 μg/mL) in their drinking water for 3 days to inhibit the commensal bacteria. After a 3-day resting period without antibiotics, a 500 μL mixture of 5% carboxymethyl cellulose sodium and Pg (1×10^7 cells/mL) was orally administered for 3 times, each interval 48 h. After 4 weeks, ligatures were removed from all animals. The process above was operated by the same experienced

operator (Deshu Zhuang). Then the rats in each group (ND and D groups) were randomly received one of three treatments (6 rats/treatment): irrigation with sterile saline solution (control group); scaling and root planing (SRP) with a manual curette (13–14 mini-five Gracey curette, Hu-Friedy, USA) through distal-mesial traction movements in buccal and lingual areas and cervical–occlusal traction movements in furcation and interproximal areas, then irrigated with l00 μL sterile saline solution. (SRP group); SRP and hypodermic injection of 40 μg/mL HMME with 3 W/cm^2 low-intensity ultrasound irradiation every other day (1 MHz, 600 s) (SRP+SDT group).

SDT treatment *in vivo and in vitro*

The HMME sterile solution was purchased from Xianhui Pharmaceutical co., Shanghai, People's Republic of China. The HMME solution was injected into the periodontal tissue between the first and second maxillary molars using an insulin syringe (1 mL) in dark. The low-intensity ultrasound used in this study was provided by Harbin Institute of Technology (Harbin, People's Republic of China), with a frequency of 1.0 MHz, a pulse repetition frequency of 100 Hz and a duty factor of 10%. After 90 min HMME application, ultrasound was applied to the alveolar bone area between the first and second maxillary molars with a connection of medical ultrasonic coupling agent. The ultrasound was released with a diameter of 6 mm and a low intensity of 3 W/cm^2 for 600s every other day, which calibrated with a hydrophone (Onda Corp., Sunnyvale, CA, USA) in degassed distilled water. All animals were euthanized after 10 days of periodontal treatment.

In vitro, the bacteria suspension was cultured in the 96-well plate, and positioned in a water bath and 5 cm directly away from the ultrasound transducer (diameter 3 cm, resonance frequency 1 MHz, duty factor 30%, repetition rate 100 Hz). The ultrasound intensity was 3 W/cm^2 as measured by a needle hydrophone (HNC-1000, Onda Corp., Sunnyvale, CA) inside the well. The Pg suspension was

133 divided into five groups: SDT in different HMME concentration (10-40 μg/mL) under 10 min
134 ultrasonic time, SDT in different ultrasonic time (2-10 min) with 40 μg/mL HMME, different HMME
135 concentration (10-40 μg/mL) treatment alone with no ultrasound, ultrasound treatment alone in
136 different ultrasonic time (2-10 min) with no HMME, and the control (no treatment).

137 Colony forming units (CFU) assay

138 After the SDT treatment *in vitro*, all the suspensions were diluted serially (10^{-1}-10^{-5}) using the
139 sterile saline solution. Then cultured in Columbia blood ager (Beijing Land Bridge Technology co.,
140 LTD, China) in a 37 ℃ anaerobic chamber (5% H_2, 10%CO_2, and 85% N_2). After 5 days of incubation,
141 the Pg viability was counted by CFU.

142 Intracellular ROS detection

143 The intracellular ROS was detected by using ROS assay kit (Beyotime Reagent Co., China). 10
144 μM DCFH-DA was added to the bacteria suspensions for 20 min incubation. The suspensions were
145 washed three times with sterile saline solution, and the fluorescence intensity of DCFH-DA was
146 observed under a laser scanning confocal microscope (LSCM) at 488 nm excitation and 525 nm
147 emission wavelengths. The level of ROS was analyzed using an Image-Pro Plus 6.0 software (Media
148 cybernetics, USA).

149 Histologic and histometric analysis

150 The maxillas were collected and fixed in paraformaldehyde (10%) for 48h, and then placed in
151 ethylenediaminetetraacetic acid (EDTA) demineralizing solution for 4 weeks. Paraffin serial sections of
152 6μm in mesio-distal direction were obtained and stained with hematoxylin and eosin (H&E), and
153 photographed using a digital camera attached to a light microscope (Carl Zeiss, Germany). The linear
154 distance from the CEJ to ABC in the alveolar bone area between the first and second maxillary molars

was measured by an image analysis software (ImageJ, Version 1.51r, National Institute of Health, USA).

Statistical analysis

The histometric data were statistically analyzed using SPSS 22.0 software, and expressed as the mean ± standard deviation. In vitro, the differences of interblock were performed with a one-way analysis of variance (ANOVA). After the in vivo experiment, the intragroup and interblock were analyzed with a two-way ANOVA followed by Tukey's test. The statistical significance was set at $P<0.05$.

Results

CFU counting

The antibacterial efficiency of HMME-mediated SDT on Pg was showed by the CFU/mL counts. As shown in Fig. 1, after the SDT treatment, the growth of Pg decreased when the HMME concentration increased from 10 to 40 μg/mL with 3 W/cm^2 ultrasonic intensity for 10 min. And 4.7 lg reduction in CFU When HMME concentration reached 40 μg/mL ($P<0.01$). But there was no significant effect when treated HMME alone in different concentration ($P>0.05$). As the ultrasound irradiation time increased after SDT treatment, the growth of Pg decreased rapidly (Fig. 2). There was also no significant effect when treated ultrasound alone in 2 and 4 min ultrasonic time. However, when the ultrasound irradiation time increased at 6 min, the growth of Pg reduced to 6.1 lg ($P<0.01$). And 1.5 lg reduction in CFU when the ultrasonic time was 10 min ($P<0.01$). In Fig. 3, when Pg was treated with ultrasound (3 W/cm^2 for 10 min) at 40 μg/mL HMME concentration, the number of CFU decreased 4.7 lg compared to the control group ($P<0.01$).

Production of intracellular ROS

The intracellular ROS was observed using a ROS fluorescence probe DCFH-DA by LSCM. As shown in Fig. 4, the fluorescence was present a large number of cells in the SDT group, and a part of cells in the ultrasound alone group, but a few cells in the control and HMME alone group. Furthermore, the intensity of fluorescence in SDT and ultrasound alone group had a significant difference in comparison with the control group in Fig. 5 ($P<0.01$).

Blood glucose

As shown in Table 1, there was no significant difference in blood glucose level among the animal in ND group at all experimental periods. After the STZ administration, the blood glucose level in D group presented a significant difference compared to the initial of diabetic induction.

Histological analysis

Most specimens in ND and D control groups showed disordered connective tissue with intense inflammatory infiltrate and areas of bone resorption. In ND SRP group, there was organized bone with thin bone trabeculae in Fig 6. And specimens in D SRP group demonstrated connective tissue with scattered mild inflammatory infiltrate and bone resorption. At 10 days post-treatment, there was no inflammatory infiltrate in the well-developed connective tissue in the ND and D SRP+SDT groups. The bone trabeculae were thick and the cementum areas presented normally without resorption.

Alveolar bone loss

In the D group, Intragroup analysis revealed less bone loss in the SRP treatment compared to control treatment in Table 1 ($P<0.05$). However, there was no significant bone loss between SRP treatment and control treatment in the ND group ($P>0.05$). Both ND and D groups assessment demonstrated less bone loss in the SRP+SDT treatment than in the control and SRP treatment ($P<0.05$). Intergroup analysis (ND and D groups) showed greater bone loss in the ND group treated with SRP

199 compared to the D group treated with SRP+SDT.

200 **Discussion**

201 *Pg*, as the major pathogenic microorganism, plays an important role in promoting the
202 development and progression of periodontal disease [8]. Previous studies have reported that HMME
203 combined with laser or ultrasound has an antimicrobial effect on whether Gram-positive or
204 Gram-negative bacteria, such as MRSA, *Escherichia coli* and even supragingival plaque [15, 16, 11].
205 In our previous study, HMME-mediated SDT could effectively kill more than 95% of *Staphylococcus*
206 *aureus* [14]. In the present study *in vitro*, the number of Pg CFU decreased 4.7 lg compared to the
207 control group, when treated by HMME (40 μg/mL)-mediated SDT in Fig. 3. Sun et al. [11]
208 demonstrated that higher HMME concentration led to a stronger antimicrobial effect. Our results
209 showed that the CFU of Pg decreased when increased the HMME concentration from 10 to 40 μg/mL
210 in SDT. Furthermore, for same HMME concentration, the antimicrobial effect of SDT depends on the
211 ultrasonic time. When the ultrasonic time increased from 2 to 10 min, the growth of Pg reduced 4.3 lg
212 ($P<0.01$). The Pg suspension that received ultrasound alone treatment showed CFU reduction when the
213 ultrasonic time rises to 6 min. Such observation is probably due to the effective antimicrobial action of
214 ultrasound, as the previous study mentioned [14].

215 ROS, a general term of oxygen-containing free radicals and peroxides, is related to oxygen
216 metabolism in bacteria [19]. In normal conditions, the production and elimination of ROS in cells are
217 balanced. ROS can activate cellular transcription factors and promote the cell proliferation and
218 differentiation, when it is at a low concentration. However, overproduction of ROS is more reactive
219 than non-free radicals and easily reacts with other molecules, resulting in cell membrane lipid
220 peroxidation, protein and DNA damage [20]. Previous studies have reported that the mechanism of

SDT in cancer cells apoptosis was thought to be induced by acoustic cavitation [12, 21]. Sonosensitizers are highly sensitive and selective to metabolically active cells. When ultrasound irradiates the cells, microbubbles in the liquid are formed and catastrophically implode, then excite the sonosensitizer to produced the excessive ROS, which irreversibly damages the cell cytoplasmic membrane, mitochondrial proteins, and eventually eradicate cells [22]. In the present study, the changes of intracellular ROS fluorescence level in four groups were observed by LSCM. Compare to the control group, the ROS fluorescence is significantly enhanced in the SDT group. These findings demonstrated that ROS was excessively generated during the HMME-mediated SDT treatment, and might be necessary to induce the antibacterial effect.

Our present in vivo study evaluated the efficacy of HMME-mediated SDT on Pg induced experimental periodontal disease in rats with diabetes. STZ was used to damage the pancreas β cells to change the pancreatic function in secretion. After the STZ administration 48 h, the blood glucose level in D group presented a significant difference compare to the initial of diabetic induction. The diabetes may increased the severity of periodontitis, and the bone loss in D group was higher than the ND group ($P<0.05$), which is in agreement with Aral et al. who evaluated bone loss both in induced-periodontitis and periodontitis with diabetes [23]. Furthermore, diabetes could increase oxidative stress, change the accumulation of advanced glycation end products, and activate inflammatory cytokine release [24]. It also enhanced alveolar bone resorption and decreased the number of osteoblasts and periodontal ligament fibroblasts [25].

Our previous studies demonstrated that HMME mediated SDT could effectively suppress the alveolar bone resorption [17]. This study compared the influence of SDT as an adjunctive treatment on Pg induced periodontitis in rats with diabetes. The histometric analysis showed that whether in ND or

in D group, less bone loss was presented in the SRP+SDT treatment than in the control and SRP treatment ($P<0.05$). In addition, intergroup analysis (ND and D groups) showed less bone loss in the D group treated with SRP+SDT compared to the ND group treated with SRP. This could be explained by the ability of ultrasound to promote angiogenesis and collagen synthesis in damaged areas [26, 27]. Gu XQ et al. found that low-intensity pulsed ultrasound could facilitate the calcium salt deposition as well as new bone maturation [28]. Another explanation might be the antibacterial activity of SDT. Studies have indicated that SDT could generate ROS, which effectively damages the bacterial membrane, protein and DNA [29]. Thus, it might restrain the bacterial colonization, alleviate the periodontium inflammation and enhance the tissue healing.

Conclusions

In summary, our present study demonstrates HMME-mediated SDT has a remarkable antibacterial effect on Pg *in vivo* and *in vitro*. The excessive generation of ROS might be a crucial part of the antimicrobial mechanism of SDT. In addition, the results indicated that HMME-mediated SDT might be a promising complementary method for treating periodontal diseases.

Funding

This study was funded by the Natural Science Foundation, Heilongjiang Province of China (grant number H2017022); National Key Technology Support Program of China (grant number 2013BAI03B06).

Conflict of Interest

The authors declare that they have no conflict of interest.

Ethical approval

All applicable international, national, and/or institutional guidelines for the care and use of

265 animals were followed.

266 **Informed consent**

267 Informed consent was obtained from all individual participants included in the study.

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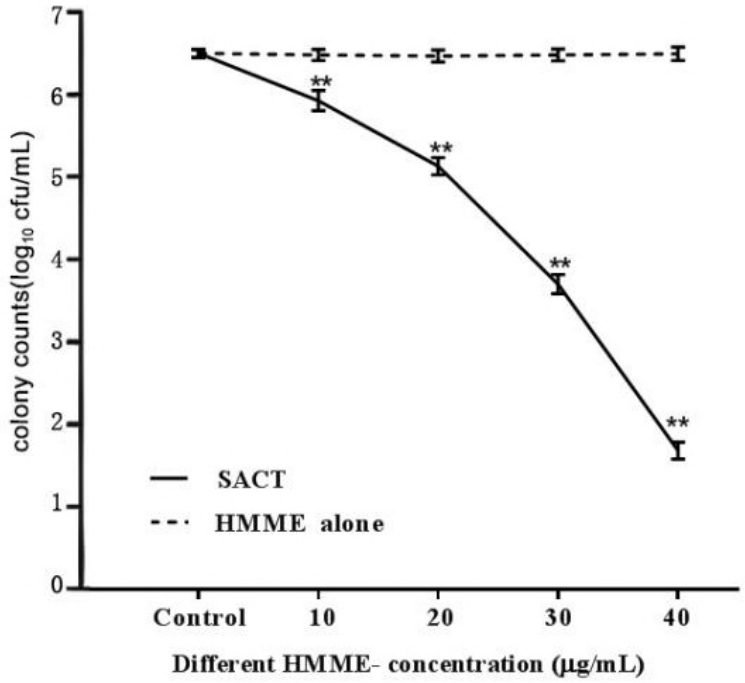
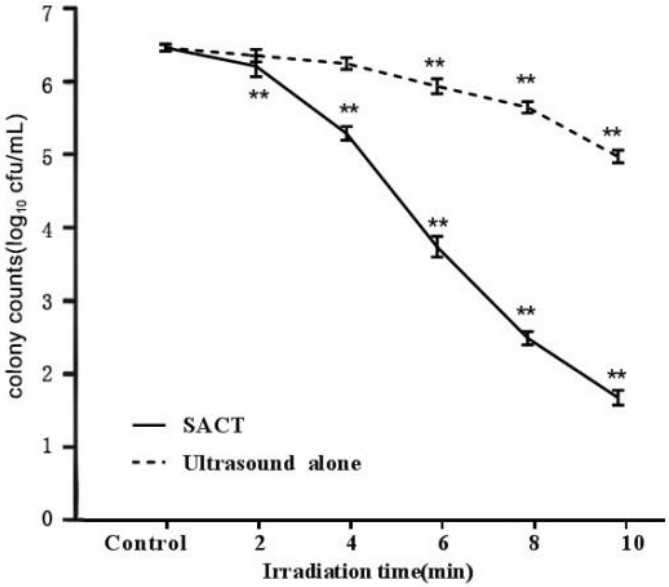
358 **Figures and illustrations**



359

360 **Fig.1** Reduction in CFU after SDT with variation of HMME concentration on Pg. HMME
361 concentration ranged from 10 to 40 µg/ml were used in combination with a ultrasound intensity of
362 3 W/cm^2. Data represent mean values (n=10), and error bars represent standard deviations. **P
363 <0.01 compared with the control group.



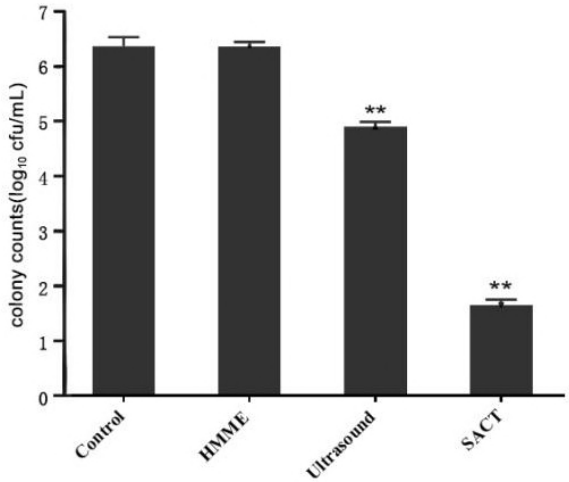
364

365 **Fig.2** Reduction in CFU after SDT with variation of ultrasonic irradiation time on Pg. Ultrasonic

366 irradiation time ranged from 2 to 10 min were used in combination with 40 μg/ml HMME

367 concentration and 3 W/cm^2 ultrasound intensity. Data represent mean values (n=10), and error bars

368 represent standard deviations. **P <0.01 compared with the control group.



369

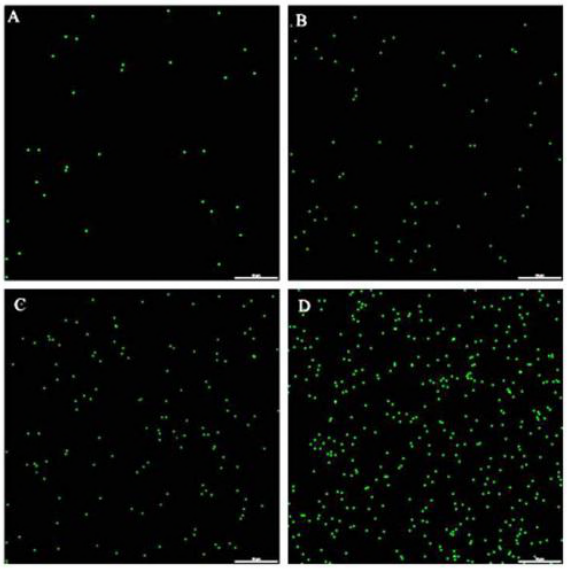
370 **Fig.3** Influence of HMME-mediated SDT on Pg growth. Groups consisted of samples incubated

371 with 40 μg/ml HMME in the absence of ultrasound (HMME), irradiated with 3 W/cm^2 ultrasound

372 intensity in the absence of HMME (Ultrasound), and without ultrasound and HMME treatment

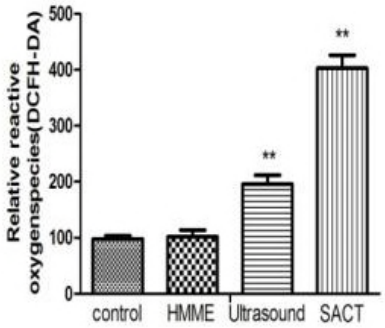
373 (Control), respectively. Data represent mean values (n=10), and error bars represent standard

374 deviations. **P <0.01 compared with the control group.



375

376 **Fig.4** Intracellular ROS production induced by SDT under a LSCM by DCFH-DA.



377

378 **Fig.5** Fluorescence intensity of ROS induced by SDT. Data represent mean values (n=3), and error

379 bars represent standard deviations. **P <0.01 compared with the control group.

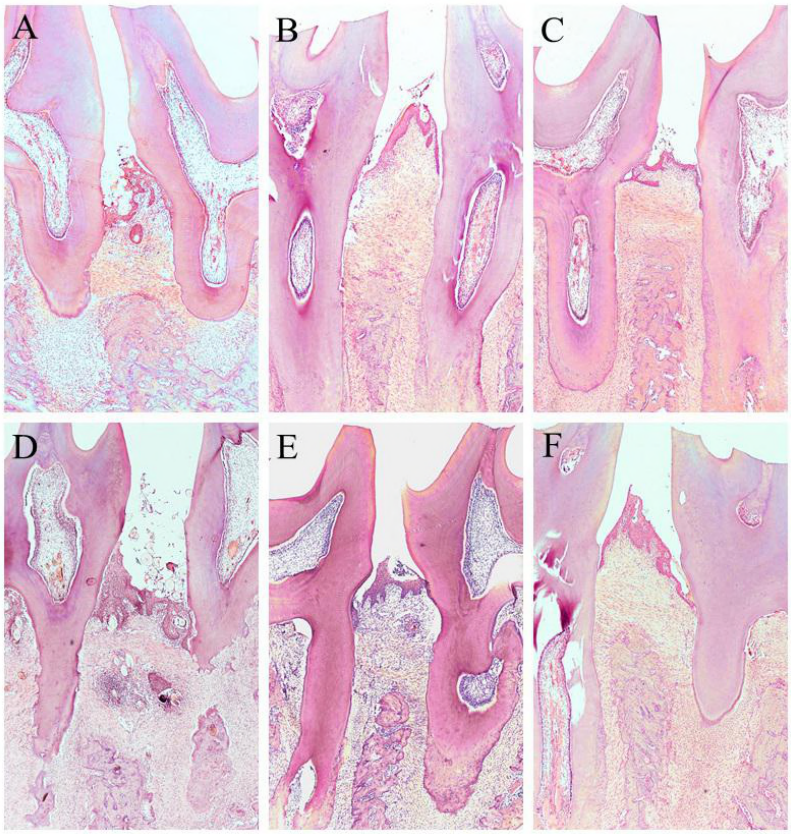


Fig.6 Photomicrographs of bone tissue in the alveolar bone region between the first and second maxillary molars with induced periodontitis.

Notes: (A) ND group: no treatment as control at 10 days. (B) ND group: SRP treatment at 10 days. (C) ND group: SRP+SDT treatment at 10 days. (D) D group: no treatment as control at 10 days. (E) D group: SRP treatment at 10 days. (F) D group: SRP+SDT treatment at 10 days. (H&E; original magnification ×4.)

Table

Table 1 Glycemic level (mg/dL; mean ± standard deviation) in different treatment and the distance between the CEJ and ABC (mm; mean ± standard deviation) in the alveolar bone region between the first and second maxillary molars.

	ND group	D group

Treatment	control	SRP	SRP+SDT	control	SRP	SRP+SDT
n	6	6	6	6	6	6
Initial blood glucose (mg/dL)	84.6±15.2	79.3±8.3	82.5±2.6	76.4±7.9	81.2±9.2	87.4±14.3
48 h blood glucose (mg/dL)	88.3±10.1	78.5±13.7	85.2±11.4	378.2±11.5*	388.3±7.7*	391.4±10.4*
Final blood glucose (mg/dL)	84.8±7.4	79.2±6.3	83.3±8.4	372.7±13.1*	390.8±10.5*	397.6±11.0*
CEJ-ABC (mm)	1.19±0.02$^{*\&}$	0.94±0.05$^{\&}$	0.56±0.01*†	1.31±0.03$^{*\&\dagger}$	1.01±0.07$^{\&}$	0.67±0.02*†

Notes: $^{\&}$Significant difference compared to SRP+SDT treatment ($P<0.05$; ANOVA and Tukey's tests).*Significant difference between groups in the same treatment ($P<0.05$; ANOVA and Tukey's tests).†Significant difference compared to SRP treatment ($P<0.05$; ANOVA and Tukey's tests). The data is shown as means ± standard deviation, unless otherwise specified.