Enhanced prefrontal nicotinic signaling as evidence of active compensation in Alzheimer's disease models

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Abstract

Background: Cognitive reserve allows for resilience to neuropathology, potentially through active compensation. Here, we examine electrophysiological evidence for active compensation in Alzheimer's disease (AD) focusing on the cholinergic signalling pathways in the prefrontal cortex. These pathways are vulnerable to neuropathology in AD and its preclinical models and are essential for attention and executive function.

Methods: We functionally interrogate aspects of the cholinergic system *ex vivo*, in brain slices of prefrontal cortex from two preclinical models: a compound transgenic AD mouse that permits optogenetically-triggered release of endogenous acetylcholine and a transgenic AD rat that closely recapitulates the human trajectory of AD. We then tested the impact of therapeutic interventions to further amplify the compensated responses and preserve the typical kinetic profile of cholinergic signaling.

Results: In two AD models, we find a potentially-compensatory upregulation of functional cholinergic responses above non-transgenic controls after onset of pathology. To identify the locus of this enhanced cholinergic signal, we dissect key pre- and post-synaptic components with pharmacological strategies. We identify a significant and selective increase in post-synaptic nicotinic receptor signalling on prefrontal cortical neurons. To probe the additional impact of therapeutic intervention on the adapted circuit, we test cholinergic and nicotinic-selective pro-cognitive treatments. The inhibition of acetylcholinesterase further enhances endogenous cholinergic responses but greatly distorts their kinetics. Positive allosteric modulation of nicotinic receptors, by contrast, enhances endogenous cholinergic responses and retains their rapid kinetics.

Conclusions: We demonstrate that functional nicotinic compensation occurs within the prefrontal cortex in two AD models. Promisingly, this compensated nicotinic signal can be boosted while preserving its rapid kinetic signature. Taken together, we conclude that compensatory mechanisms act within the prefrontal cholinergic pathway and reveal a new approach for cognitive treatment in AD neuropathology.

Abbreviations

ACh	acetylcholine
AD	Alzheimer's Disease
ChAT	choline acetyl transferase
ChR2	channelrhodopsin
DHβE	dihydro-β-erythroidine
gal	galantamine
hz	hertz
ms	millisecond
mV	millivolt
nTg	non-transgenic
opto-Ach	optogenetic release of acetylcholine
pA	pico-ampere
PAM	positive allosteric modulator
prl	prelimbic
Tg	transgenic

Introduction

Cognitive reserve denotes an individual's ability to withstand a higher degree of neurological decline before exhibiting cognitive impairment [1]. Lifestyle factors have been shown to promote cognitive reserve, decreasing risk of dementia and slowing cognitive decline in Alzheimer's disease (AD) [2–4]. The impact of these factors is not limited to disease onset but persists even as neuropathology worsens [5–9]. In fact, cognitive reserve is hypothesized to allow for compensation during neuropathology [10,11], generating a new or stronger response to sustain network recruitment [12,13]. In AD and its preclinical models, there are now several diverse examples of neuronal compensation leading to cognitive maintenance [14,15], but compensatory capacity in the cholinergic system has not been systematically evaluated.

Cholinergic pathways in prefrontal cortex are well positioned to contribute to mechanisms of cognitive reserve in AD [16,17]. This modulation is essential for attention, executive function, and working memory [18–22]. Pro-cholinergic treatments improve cognition preclinically [23–25] and slow cognitive decline clinically [26–29]. While the remodelling of the cholinergic system in AD has been extensively probed, key clinical [30–32] and preclinical studies [33–35] focus on cholinergic neurodegeneration and synapse loss. There has been relatively little functional investigation in early to mid-disease synaptic changes, except in the most swiftly-progressing genetic models of AD that preclude the use of littermate controls [36–45]. To detect and systematically investigate mechanisms of compensatory plasticity, it is essential to use a well-charted model with appropriately-matched non-transgenic controls.

To examine cholinergic signalling in AD, we use optogenetics and whole cell electrophysiology *ex vivo* to investigate prefrontal acetylcholine pathways. In models of AD from two different species, we find a strong and significant upregulation of prefrontal cholinergic responses above non-transgenic levels after onset of pathology. To probe the mechanisms underlying this functional upregulation, we systematically manipulated pre- and postsynaptic elements of the cholinergic synapse. We discovered the upregulation is specific to nicotinic receptor signalling. Lastly, we assessed the functional impact of therapeutic interventions on cholinergic responses, contrasting current standard AD treatment with a novel nicotinic treatment. Both manipulations improve endogenous cholinergic responses, but only the targeted nicotinic treatment preserves the typical rapid timing thought essential for cue detection. Overall, we demonstrate evidence for active cholinergic upregulation and put forward a mechanism of cognitive compensation that remains accessible to further potentiation with treatment.

Materials & methods

Animals

The University of Toronto Temerty Faculty of Medicine Animal Care Committee approved experiments in accordance with the guidelines of the Canadian Council on Animal Care (protocols #20011123, #20011621, #20011796). TgCRND8 transgenic mice expressing double human amyloid precursor protein Swedish and Indiana mutations (KM670/671NL/V717F) under the Prp gene promoter [46] on a C57BL/6 background were crossed with transgenic mice expressing channelrhodopsin in cholinergic afferents (ChATChR2; RRID:IMSR_JAX:014546, Jackson Laboratory [47]). Cholinergic neurons originating from the nucleus basalis project throughout the brain and densely innervate the deep layers of the prefrontal cortex [47,48]

where we optogenetically stimulate their afferents. This transgenic model expresses channelrhodopsin under the choline acetyltransferase promoter, localizing channelrhodopsin expression to neurons that are cholinergic at the time of recording. This approach avoids expression of channelrhodopsin in neurons that are only transiently cholinergic during development [49]. TgCRND8/ChATChR2 mice were compared to ChATChR2 littermates as controls. Male and female mice were weaned at postnatal day (P)21, separated by sex, and group housed (2-4 mice per cage) in plastic cages with corn cob bedding, houses for environmental enrichment, with *ad libitum* access to food and water on a 12hr light/dark cycle with lights on at 7:00AM. Mice were used at two age groups based on previously described progression [50–54]: an early to mid-disease group and controls, 3-6 months old (n = 30, mean 4.7 ± 0.2 months), and a later disease group and controls, 7 to 12 months (n = 26, mean 9.9 ± 0.3 months). Groups were balanced for sex and genotype.

TgF344 AD rats expressing the human amyloid precursor protein Swedish mutation (KM670/671NL) and presenilin 1 with exon 9 excised, under the mouse prion promoter [55] were outbred on a Fischer strain. TgF344 AD rats were compared to F344 littermates as controls. Rats were bred at Sunnybrook Research Institute (protocol #22655), and housed in plastic cages with corn cobb bedding, 2 animals per cage, with houses and toys for environmental enrichment, on a 12hr light/dark cycle with *ad libitum* access to food and water. Rats were transferred to the University of Toronto Division of Comparative Medicine and housed for a minimum of 6 weeks before experiments. Rats were used at three age groups based on stages described previously [56–59]:, an age group at 8 months for consideration of early AD and controls (n = 21, mean 8.4 ± 0.2 months), at 12 months for mid-AD and controls (n = 23, mean 12.4 ± 0.2 months), and 18 months for later AD and controls (n = 26, mean 17.6 ± 0.2 months). Groups were balanced for sex and genotype.

Electrophysiology and optogenetics

Animals were anaesthetized with an intraperitoneal injection of chloral hydrate (400mg/kg) and decapitated. The brain was rapidly removed in 4˚C sucrose ACSF (254 mM sucrose, 10 mM D-glucose, 26 mM $NaHCO_3$, 2 mM $CaCl_2$, 2 mM $MgSO_4$, 3 mM KCl, and 1.25 mM Na_2PO_4). The 400uM thick cortical slices of the prefrontal cortex (bregma 2.2-1.1) were obtained on a Dosaka linear slicer (SciMedia). Slices were transferred to a prechamber (automate Scientific) where they recovered for at least 2 Hr in oxygenated (95% O_2, 5% CO_2) ACSF (128 mM NaCl, 10 mM D-glucose, 26 mM $NaHCO_3$, 2 mM $CaCl_2$, 2 mM $MgSO_4$, 3 mM KCl, and 1.25 mM Na_2PO_4) at 30˚C before being used for electrophysiology.

For whole-cell patch-clamp electrophysiology, brain slices were transferred to a chamber mounted on the stage of a BX51WI (Olympus) microscope and perfused with 30 ˚C oxygenated ACSF at 3-4mL/min. Layer 6 pyramidal neurons in the prelimbic and anterior cingulate regions of the medial prefrontal cortex were identified by size, morphology, and proximity to white matter, visualized using infrared differential interference contrast microscopy. Recording electrodes were filled with patch solution containing 120 mM K-gluconate, 5 mM $MgCl_2$, 4 mM K-ATP, 0.4 mM Na_2-GTP, 10 Mm Na_2-phosphocreatine, and 10 mM HEPES buffer adjusted to pH 7.33 with KOH. Data were acquired and low-pass filtered at 20kHz with Axopatch 200b amplifier (Molecular Devices) and Digidata 1440 digitizer and pClamp10.3 acquisition software (Molecular Devices). Responses from a homogenous population of layer 6 regular spiking pyramidal neurons [60,61] were examined in voltage clamp at -75 mV and in current clamp.

To excite channelrhodopsin-containing cholinergic afferents optogenetically (opto-ACh), blue light (470 nm) was delivered in 5ms pulses with an LED (2mW; Thorlabs) through a 60x objective lens. This opto-ACh stimulus was delivered in a frequency-accommodating (50-10 Hz) eight pulse train to stimulate cholinergic axons [60,61] to mimic the activation pattern of cholinergic neurons [62–64]. This opto-ACh protocol elicits direct cholinergic inward current responses resilient to combined application of glutamatergic synaptic blockers [48,60,61,65] and sensitive to combined cholinergic receptor antagonists [60].

Experimental design, analysis, and statistics

Animals of both sexes were used in pharmacological interventions. All experiments draw on multiple rodents per interventions, and recordings were made from 1 to 3 neurons per brain slice, (brain slices of prefrontal cortex in mouse: 2-3 slices; rat: 3-4 slices). Pharmacological agents were pre-applied for 10 min and co-applied during optogenetic stimuli or exogenous acetylcholine bath application and recovery period. CNQX (50 µM) and D-APV (50 µM) were applied to block glutamatergic synaptic transmission; bicuculline (3 µM) and CGP55845 (1 µM) were applied to block GABA receptors; Atropine (200 nM; Sigma-Aldrich) was applied to block muscarinic receptors; dihydro-β-erythroidine (DHβE; 3 µM) to block β2-containing nicotinic receptors; AF-DX 116 (300 nM) to block M2 muscarinic receptors; galantamine hydrobromide (1 µM) to block acetylcholinesterase, and NS9283 (1 µM) to potentiate nicotinic responses. Compounds from Tocris Biosciences unless otherwise specified.

Data analysis was performed in Clampfit 10.3 (Molecular Devices) and Axograph and statistical analysis was performed with Graphpad Prism 10. To measure fast-onset kinetics, raw traces were used for calculating rising slope of current response within 50 ms of opto-ACh onset. To measure response magnitude, downsampled traces were used to fit triple exponentials to opto-ACh responses, from which the peak amplitude (pA) and decay constant (s), where applicable, were measured.

Firing rise is measured by the mean increase in firing frequency for the initial 0.5 s following the onset of the opto-ACh stimulus relative to the mean baseline firing frequency (calculated over 2 s before opto-ACh stimulus). Peak firing frequency is measured as the difference between the mean baseline firing frequency and fastest instantaneous firing frequency following opto-ACh stimulus. Genotype differences between opto-ACh responses were assessed with unpaired two-tailed *t*-tests.

To measure currents to exogenous ACh, 1mM ACh was bath-applied for 15 s. Genotype differences in acetylcholine current magnitude were measured by peak amplitude. Acetylcholine firing response was measured by the time from stimulus onset to peak firing. Both measures are graphed with a cumulative frequency distribution with 10 pA or 10 s bin width, allowing for direct comparison of each age group's genotype differences. Genotype differences in these measures are calculated with a nonparametric Kolmogorov Smirnov (KS) test. Pharmacological manipulations to assess synaptic components of the cholinergic response are calculated with unpaired, two-tailed *t*-tests. The effects of therapeutic interventions are assessed with paired, two-tailed *t*-tests.

Results

Increased opto-ACh responses in early to mid-disease in TgCRND8 AD mouse model

To measure functional changes in prefrontal cortex cholinergic signals in an AD model, we record whole-cell responses to endogenous acetylcholine released optogenetically (opto-ACh; Fig 1A.1, A.2) in littermate non-transgenic control and TgCRND8 AD mice during early to mid-AD (3 to 6 months) [50–54]. These mice were generated by crossing TgCRND8 transgenic AD model mice [46] with ChAT-ChR2 transgenic mice expressing channelrhodopsin in cholinergic afferents [47]. Cholinergic neurons from the nucleus basalis project throughout the brain and densely innervate the deep layers of the prefrontal cortex [47,66], where they respond to optogenetic stimulation. TgCRND8/ChATChR2 mice were compared to ChATChR2 littermates as controls. Optogenetic responses were recorded from pyramidal neurons in layer 6 of the prelimbic and anterior cingulate areas of the prefrontal cortex. Layer 6 receives dense innervation of cholinergic afferents [66] and shows strong excitatory responses [67]. Responses from a homogenous population of regular spiking pyramidal neurons [60,61] were examined in voltage clamp at -75mV. The brief opto-ACh protocol [60,61,65] elicits inward current responses resilient to combined application of glutamatergic synaptic blockers CNQX (20 μM) and D-APV (50 μM) in non-transgenic control (opto-ACh: 39.2 ± 14 pA, opto-ACh synaptic blockers: 40.5 ± 14.3 pA; paired *t*-test: t_5 = 0.3, *P* = 0.8) and TgCRND8 (opto-ACh: 82.7 ± 22 pA, opto-ACh synaptic blockers: 80.4 ± 19 pA; paired *t*-test: t_4 = 0.3, *P* = 0.8*)* and resilient to combined application of GABA receptor blockers BCC (3 μM) and CGP (1 μM) in non-transgenic control (opto-ACh: 28.2 ± 6.5 pA, opto-ACh GABA blockers: 24.8 ± 5.9 pA; paired *t*-test: t_5 = 2, *P* = 0.1) and TgCRND8 (opto-ACh: 45.4 ± 11.9 pA, opto-ACh synaptic blockers: 43.8 ± 11.5 pA; paired *t*-test: t_7 = 0.7, *P* = 0.5*)*.

We find a significant increase in opto-ACh current responses in early to mid AD mice (Fig 1B), as measured by a significantly greater rise slope (Fig 1C, unpaired, two-tailed *t*-test: *t* = 3.3, *P* = 0.002, df = 68) and peak amplitude (Fig 1D, unpaired, two-tailed *t*-test: *t* = 3, *P* = 0.004, df = 68) in AD responses.

This upregulation also can be detected in the change in the firing response elicited by opto-ACh (Fig 1E). Holding the neurons in current clamp and injecting current to elicit ~2-3 Hz action potential firing at baseline, opto-ACh elicits a significantly greater increase in the delta initial firing frequency or firing rise (1F, unpaired, two-tailed *t*-test: *t* = 4.2, *P* < 0.0001, df = 54) and the delta peak firing frequency (1G, unpaired, two-tailed *t*-test: *t* = 2.3, *P* = 0.02, df = 54) in AD compared to control.

These genotype differences are observed in the absence of corresponding genotype differences in passive properties (Supplemental Table 1).

To ask what happens to the AD cholinergic response as neuropathology progresses, we recorded from age- and sex-matched littermate non-transgenic control and TgCRND8 AD mice at a more advanced stage of AD. In this older group (7 to 12 months), opto-ACh current responses in AD mice are similar to the non-transgenic level (Fig 2A-C; unpaired, two-tailed *t*-test: rise slope *t* = 0.07, *P* = 0.9, df = 75; peak amplitude *t* = 0.5, *P* = 0.6, df = 75) as well as opto-ACh firing responses (Fig 2D-F; unpaired, two-tailed *t*-test: firing rise *t* = 0.6, *P* = 0.6, df = 60; peak firing *t* = 0.2, *P* = 0.8, df = 60). Cholinergic responses in the model are no longer significantly greater than controls at the later time point.

These results suggest that prefrontal endogenous cholinergic responses are upregulated in AD beyond WT levels in early/mid-pathology but that this high level is not maintained above non-transgenic controls when the AD model reaches later disease.

Increased cholinergic responses at mid disease in TgF344 AD rat model

To evaluate whether cholinergic upregulation in response to AD pathology is recapitulated across species, we consider the TgF344-AD rat model [55]. We compared TgF344-AD and littermate WT controls at three points in disease: early AD, mid AD, and later AD [56–59]. Strikingly, we again find an upregulation in cholinergic currents in TgF344-AD rats relative to controls (Fig 3A, 3B). This difference is specific to the mid-AD age group (KS test, $P = 0.005$, D = 0.4) (Fig 3C-E). It was not observed in the early AD group (KS test, $P = 0.7$, D = 0.2), nor in the later AD group (KS test, $P = 0.7$, D = 0.2).

A similar pattern is observed for changes in action potential firing in response to cholinergic stimulation (Fig 3F). The TgF344-AD rat model shows an upregulation in cholinergic firing, as measured by the reduced time taken to attain peak firing rate relative to controls at mid AD (Fig 3G-I, KS test, $P = 0.003$, D = 0.4). However, this difference was not observed at early AD (KS test, $P = 0.8$, D = 0.1) nor at later AD (KS test, $P = 1$, D = 0.1).

The differences in cholinergic responses occur in the absence of corresponding differences in intrinsic properties (Supplemental Table 2).

Together, this work shows the replication of the AD upregulation in cholinergic responses in a different species, a different model, and with a different method of cholinergic stimulation. This conserved property underscores the importance of understanding the receptor mechanisms responsible.

Upregulated responses arise from a selectively- increased nicotinic signal

Since we find that AD cholinergic responses are faster and greater amplitude than non-transgenic controls, we hypothesize that increased nicotinic responses underlie the genotype difference, as these ionotropic receptors impart these characteristics to the endogenous response [60,61,65]. To investigate pre-and post-synaptic elements in the intact prefrontal cholinergic synapse, we use the opto-TgCRND8 AD mouse. To investigate the nicotinic receptor contribution to this upregulated opto-ACh response in AD, we pharmacologically block these receptors using the antagonist DHβE (3 μM) (Fig 4A). DHBE changes the cholinergic responses in both genotypes (Fig 4B), significantly decreasing the rise speed (paired, two-tailed t-test: $t = 4.3$, $P = 0.0002$, df = 23) and the peak amplitude (paired, two-tailed t-test: $t = 3.5$, $P = 0.002$, df = 23). However, DHBE exerts a greater effect on the AD group, yielding a significantly greater change in rise slope (Fig 4C, unpaired, two-tailed *t*-test, $t = 2.3$, $P = 0.03$, df = 22) and peak amplitude (Fig 4D, unpaired, two-tailed *t*-test, $t = 2.6$, $P = 0.01$, df = 22). These results suggest that increased opto-ACh responses in this preclinical AD model include a prominent upregulation in nicotinic receptor signalling.

We next evaluate whether muscarinic components of the cholinergic synapse are also altered, since G-protein coupled muscarinic receptors contribute both pre- and post-synaptically

to prefrontal cholinergic synapses [60]. We block both pre- and postsynaptic muscarinic receptors with the antagonist atropine (200nM; Fig 4E). Atropine changes the cholinergic responses in both genotypes with blockade of presynaptic autoreceptors increasing opto-ACh responses (Fig 4F), without changing the rise slope (Fig 4G; paired, two-tailed *t*-test: $t = 1.1$, $P = 0.3$, df = 22) but increasing peak amplitude (Fig 4H; paired, two-tailed *t*-test: $t = 7.4$, $P < 0.0001$, df = 22). There was not a significant genotype difference in the effects of atropine, which blocks both pre- and post-synaptic muscarinic receptors. Furthermore, targeted block of presynaptic autoreceptors with AF-DX 116 (Fig 4I) also increases opto-ACh responses in both AD and control (Fig 4J), not changing the rise slope (Fig 4K; paired, two-tailed *t*-test: $t = 1.7$, $P = 0.1$, df = 18) but increasing the peak amplitude (Fig 4L; paired, two-tailed *t*-test: $t = 4.2$, $P = 0.005$, df = 18). These findings suggest that neither pre- nor post-synaptic muscarinic receptors are altered to the same degree as nicotinic receptors in this preclinical AD model.

Treatment strategies: acetylcholinesterase inhibition and nicotinic potentiation amplify cholinergic upregulation

To probe the impact of treatment intervention on this upregulated cholinergic signalling, we measure the effects of current standard of care treatments and a novel treatment strategy on the amplitude and kinetics of the AD neuron and non-transgenic control opto-ACh responses from early to mid and later disease in the TgCRND8 AD mouse.

The pro-cognitive standard-of-care treatment galantamine inhibits acetylcholinesterase (Fig 5A), allowing acetylcholine to remain longer at the synapse. Applying galantamine to opto-ACh AD responses trends towards increasing the rise speed (Fig 5C, paired, two-tailed *t*-test, $t = 2.3$, $P = 0.06$, df = 7) and significantly increases peak amplitude (Fig 5D, paired, two-tailed *t*-test, $t = 4.4$, $P = 0.003$, df = 7). However, its greatest impact is to significantly prolong the decay constant (Fig 5E, paired, two-tailed *t*-test, $t = 3.6$, $P = 0.008$, df = 7). This effect of galantamine is consistent across genotype, in TgCRND8 mice and non-transgenic controls (Fig S1, A-C) and consistent in TgCRND8 mice at early-to-mid AD as well as late AD (Fig S2, A-C). Galantamine modestly increases the peak response magnitude; however, it prolongs the overall kinetics of the usually brief cholinergic response.

To explore treatment interventions targeted to the specific nicotinic receptor upregulation seen in this AD model, we test the nicotinic-selective positive allosteric modulator (PAM), NS9283 to enhance endogenous cholinergic signalling (Fig 5F). We find NS9283 greatly boosts opto-ACh AD responses (Fig 5G), significantly increasing the rise speed (Fig 5H; paired, two-tailed *t*-test, $t = 2.7$, $P = 0.02$, df = 14) and the peak amplitude (Fig 5I; paired, two-tailed *t*-test, $t = 3.2$, $P = 0.007$, df = 14). Strikingly, these changes occur without changing the decay constant (Fig 5J; paired, two-tailed *t*-test, $t = 1.3$, $P = 0.2$, df = 14) of the opto-ACh response. The action of NS9283 is consistent across genotype, in TgCRND8 mice and non-transgenic controls (Fig S1, D-F) and consistent in TgCRND8 mice at early-to-mid AD as well as late AD (Fig S2, D-F). This intervention strongly amplifies peak response magnitude while retaining the typical rapid and brief response kinetics.

The current standard of care treatment galantamine significantly increases response amplitude (71% ± 16%) and trends towards a significant increase in rise speed (35% ± 16%), but at the cost of significantly slowed decay of the cholinergic response (2032% ± 993%). In comparison, the nicotinic specific NS9283 achieves a significant enhancement in rise speed

(210% ± 68%), a significant increase in amplitude (249% ± 87%) and modestly but not consistently prolongs response decay (77% ± 32%). NS9283 incites a greater increase in response magnitude and better conserves endogenous response timing and kinetics than the broad cholinergic standard of care treatment. We demonstrate it is possible to use a targeted treatment such as NS9283 to further enhance upregulation of this cognitively-crucial signalling pathway.

Discussion

We demonstrate a functional upregulation in prefrontal cholinergic signalling in two preclinical models of AD. Cholinergic upregulation occurs during early to mid-disease progression, in different species models with differing pathology trajectories. Elevated functional nicotinic signalling plays a dominant role, and the apparent compensation is sensitive to further enhancement via pharmacological manipulation. The AD treatment of AChE-inhibition modestly boosts the cholinergic response but distorts its time course. By contrast, targeted nicotinic positive allosteric modulation exerts a strong and significant potentiation with preserved kinetics. Taken together, our results illustrate an active potential mechanism of cognitive compensation and demonstrate an effective approach to amplify and potentially extend it further into the disease process.

Cognitive reserve and neural compensation in AD

Cognitive reserve, or the brain's ability to sustain neurological decline while maintaining cognitive processes, is well documented clinically in aging [12,13,68,69] and in AD [70,71]. The neurophysiological basis for this reserve, often discussed as cognitive resistance or resilience, is of great interest, with emerging work exploring compensatory plasticity in AD [15,72] including in the prefrontal cortex [73]. In preclinical models, this has been explored across synapses, where dendritic spine loss has been accompanied by potentially compensatory increases in size of remaining spines [74–77] or *de novo* spinogenesis [78–81]. Investigations into the GABAergic system show remodelling of GABAergic neurons [82] or increases in $GABA_B$ levels [83] to potentially compensate for hyperexcitability in AD [82,84]. In the TgF344 AD rat model used here, parvalbumin interneuron neuroplasticity is observed mid-pathology, with coinciding cognitive resilience in executive function and cognitive flexibility [14]. Interestingly, this emergence of neuroplasticity and cognitive resilience coincides with the same mid-disease timepoint as the cholinergic upregulation found here with the same model.

Prefrontal cholinergic signalling is crucial for many cognitive functions maintained by cognitive reserve, including attention, cue detection, and working memory [18–22]. It is well known that cholinergic neurons and synapses are sensitive and therefore responsive to AD. Development of the basal forebrain cholinergic system is important for developing and maintaining cognition [85–87]. Degeneration of the basal forebrain cholinergic neurons is an important predictor of cognitive outcome in AD [30,88], with great influence on an individual's trajectory of cognitive decline [89,90], and degeneration of these neurons can worsen amyloid-β accumulation [91]. This suggests that basal forebrain cholinergic neurotransmission contributes to adaptation to disease related damage [87]. Previous work has observed compensation in the cholinergic system in AD, with increases in spontaneous cholinergic transients in the visual cortex [92], and increases in pro-NGF in the precuneus [77]. In individuals pre-diagnosis with elevated amyloid-β and none to mild baseline cognitive deficits, cholinergic inhibition unmasks

otherwise undetectable cognitive deficits that correlate with amyloid-β load [93]. This supports that in pre-diagnosis or early AD, cholinergic signalling may be important in compensating for pathological decline and maintaining cognitive functions. This potential compensation, as well as the cholinergic system's importance as a pathway for cognitive enhancement and behavioural control positions it as a potentially significant locus of cognitive reserve [16,17,87]. This underscores the need to evaluate cholinergic compensation in AD and whether it can be further harnessed to improve cognitive outcomes. Our work builds on this phenomenon of active compensation, providing novel evidence for the involvement of the cholinergic system in these processes.

Cholinergic signalling and synapses in AD

Previous molecular investigations into cholinergic neurons and synapses in AD communicate a trajectory of cholinergic decline, with decreases in both pre- and post-synaptic markers resulting in eventual heterogenous loss of cholinergic neurons in advanced AD [30,31,88,94–103]. However, much of this characterization is performed later in disease progression, not capturing functional changes at earlier disease points preceding synapse loss [104,105]. Molecular and functional investigation that has been carried out in early to mid-disease mostly consists of swiftly-progressing genetic models of AD that preclude the use of littermate controls [36–42]. To detect and systematically investigate mechanisms of compensatory plasticity, it is essential to use a well-charted model with appropriately-matched non-transgenic controls.

There is, however, an important emerging body of work showing aspects of cholinergic upregulation arising with the onset of AD pathology, even coinciding with, and potentially compensating for, concurrent cholinergic dysregulation. Increases in spontaneous cholinergic transients in the visual cortex coincide with the accumulation of amyloid beta and the emergence in deficits in cholinergic release during outcome prediction [92]. Postmortem analysis of clinical AD reveals increases in proNGF, the precursor to neurotrophin NGF that is necessary for cholinergic neuron survival [77]. These findings, along with our work, give additional insight into potentially compensatory adaptations the cholinergic system undergoes during AD. These adaptations may be playing an unseen role in maintaining cognitive function in AD [93], where in the absence of such compensation, the onset of cognitive decline would be more rapid or severe.

Functional characterisation is vital for understanding synaptic transmission, as there are many elements regulating signalling that may not be captured otherwise. Changes to receptor localization, internalization, phosphorylation, or alternate forms of regulation may all affect signalling. Nicotinic receptors in particular are tightly regulated by the cell, undergoing desensitization by agonism [106,107] and active trafficking pathways [108,109]. Previous work has shown that they are functionally regulated by other synaptic elements such as lynx family proteins [65,110] or protein kinase C by way of muscarinic receptor agonism [60]. The diversity of elements regulating nicotinic receptor signalling provides many potential avenues for this signalling to be harnessed for compensation. This extends to therapeutic options, where flexibility of the functional nicotinic signal positions it as a powerful locus for further cognitive enhancement.

Here, we find an upregulation in cholinergic signalling that emerges after disease onset, at early to mid-disease in two different preclinical models of AD. Our use of models with littermate non-transgenic controls from early to late disease reveals unprecedented prefrontal cholinergic

upregulation and insight into compensation in AD. Strengths of our electrophysiological and opto-physiological approach include functional insight into cholinergic signalling upregulation, identification of this upregulation as specific to nicotinic receptors. We employ this finding to explore current cholinergic as well as nicotinic specific therapy to further enhance this upregulation and find that specific nicotinic therapy further amplifies cholinergic compensation.

While our work identifies nicotinic receptor upregulation as the mechanism underlying increased cholinergic responses, there are still outstanding questions as to how nicotinic responses are upregulated. Both the TgCRND8 AD mouse and the TgF344 AD rat used here employ human APP mutations [46,55], resulting in amyloid-driven AD pathologies. Amyloid-β directly interacts with nicotinic receptors, though the nature of this interaction is debated and may depend on factors such as concentration, cell type, and nicotinic receptor subunits [111–116] with some poised to confer neuroprotection [117,118]. Increases in nicotinic receptor availability may also arise secondary to changes in presynaptic cholinergic release via amyloid-β impairment of choline transport [119–121] or choline acetyltransferase [122,123]. Further investigation into the interaction between cholinergic vulnerability to AD pathology and the capacity of this system for compensation may allow us to further enhance and potentially amplify the compensation.

Caveats

An important caveat for our work is our interpretation of cholinergic upregulation as a pro-cognitive compensatory change. Cholinergic signalling has long been appreciated to improve cognition [66,124]. Additionally, upregulation in cholinergic signalling in AD emerges in early to mid-disease but does not continue to increase above non-transgenic levels as AD progresses. This supports that it is not contributing to disease worsening. Our interpretation of cholinergic upregulation as a form of compensation, as well as discussion of the possibility of this contributing to cognitive reserve, requires further investigation. Additional work investigating the vulnerability of cognitive performance in early AD to cholinergic challenge [93], potentially in individuals with varying degrees of cognitive reserve, will improve our understanding of the role of the cholinergic system in this process. We found compensation via nicotinic enhancement, but care must be taken in generalizing this receptor specificity across disease models. This insight was gained using the opto-TgCRND8 AD model mouse, as it engages the complete cholinergic synapse, allowing modulation of pre- and postsynaptic elements mediating cholinergic signalling. In the TgF344 AD rat model, we measure cholinergic responses to exogenous acetylcholine, recording postsynaptic cholinergic responses. Postsynaptic nicotinic receptor signalling mediates prefrontal cholinergic responses in both models used [125–128]. Despite the differences in cholinergic stimulation, nicotinic receptor upregulation is consistent with the similarity in upregulation observed in both models. However, species differences and differences in AD etiology between models may contribute to discrepancies in mechanisms of cholinergic upregulation. With the TgCRND8 AD mouse model's early onset and severe pathology, differences in disease etiology and progression may hinder our ability to compare stages in AD severity across models. This may contribute to differences in emergence of cholinergic upregulation in both models, with the TgCRND8 mouse presenting cholinergic upregulation at early-to-mid AD (3 to 6 months) whereas upregulation only emerges in the TgF344 AD rat model in mid AD (12 months). Tau pathology, which is seen in the TgF344 AD rat model but not in the TgCRND8 AD mouse, contributes to cholinergic loss [129] and cannot be ruled out from interacting with our identified mechanism. Both models used here employ human

APP mutations [46,55], resulting in amyloid-driven AD pathologies. Amyloid beta is known to interact with nicotinic receptors, but the nature of this interaction is unclear [111–116]. In our whole-cell recordings in slice, amyloid beta may not persist in the tissue to the same degree that it exists in the brain [130]. While we did not observe any relationship between time *ex vivo* and extent of nicotinic upregulation, it is possible we are underestimating the contribution of soluble amyloid beta to responses. Nevertheless, our investigation uncovers a nicotinic upregulation that may be a form of active compensation in response to AD.

Translational and clinical impact

Deficits in attention and executive function have consequences for other cognitive domains: if you can't attend, you can't encode [131]. It is therefore important to identify mechanisms through which we can improve attention and extend the maintenance of this cognitive domain as much as possible through AD progression. Nicotinic signalling is essential for attention and executive function and has long been a target for enhancing cognition, including in AD [132,133]. Direct stimulation of nicotinic receptors is pro-cognitive in AD [25], potentially protective against amyloid beta [134,135] but complicated by desensitization [106,107,136]. Nicotinic positive allosteric modulators, such as NS9283 used here, present less risk of desensitization [137], and are pro-cognitive preclinically [138,139]. Our results suggest that nicotinic positive allosteric modulation further enhances nicotinic signalling upregulation in AD, promoting pro-cognitive signalling through disease progression and potentially enhancing the effectiveness of existing cholinergic compensation.

Attention and cue-detection are mediated by cholinergic, and specifically nicotinic stimulation of the prefrontal cortex [19,20,140–144] and are timescale dependent [145–147]. Configurations of the fast ionotropic nicotinic receptor that include the α5 subunit lead to faster responses to endogenous acetylcholine [61] and contribute to better attentional performance [148]. Acetylcholinesterase inhibitor, a current and long-used AD treatment, enhances all cholinergic signaling: fast, ionotropic nicotinic signal and slower, longer-lasting metabotropic muscarinic signal shown above (Figure 5) and previously [60,61]. While acetylcholinesterase inhibitor imparts some increase in response amplitude, it profoundly slows response decay. Treatments that maintain the endogenous timing of responses, like the nicotinic positive allosteric modulator that increases the pro-attentional rise kinetics, largely amplifies response magnitude, and does not alter the decay might better enhance time-sensitive cognitive functions.

Understanding neural compensation and neurological changes at different disease stages is important for understanding the implications of clinical interventions. Differing levels of effectiveness of novel AD treatments may result from timing of intervention and the level of neurological changes already set in motion by AD. Adaptations that are pro-cognitive in the presence of AD may have altered outcomes if pathology is resolved. Therefore, it is important to take neurological changes into account when determining treatment strategies.

Conclusion

Overall, we uncover evidence for cholinergic compensation in two preclinical models of AD. In both models, functional upregulation in prefrontal cholinergic signalling occurs in early to mid-AD. Mechanistic investigation reveals increased nicotinic signalling, which is amenable to further upregulation, both by acetylcholinesterase inhibitor and by nicotinic positive allosteric modulation. Harnessing compensatory nicotinic upregulation may be an important treatment strategy to further enhance and preserve cognition in AD.

Declarations

Competing interest: The authors have no conflicts or competing interests to declare.

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Figure legends

Figure 1. Endogenous opto-ACh responses are upregulated in early to mid-AD

A.1 Image depicts compound transgenic mouse cross between TgCRND8 AD mouse model and ChAT-ChR2 mouse model expressing channelrhodopsin in cholinergic neurons. Image depicts coronal brain section from these mice, showing the recording electrode positioned over layer 6 of the prefrontal cortex. **A.2** Schematic adapted from Power et al., 2023, represents the cholinergic prefrontal synapse receiving optogenetic stimulus (0.5s pulse train of decreasing frequency). Afferents release endogenous acetylcholine (ACh) which binds to nicotinic and muscarinic receptors, exciting postsynaptic pyramidal neurons. **B** Example opto-ACh responses from non-transgenic (nTg) control (black) and TgCRND8 AD (grey) neurons measured in voltage clamp (Vm = -75 mV). Graphs show significant increase in **C** rise speed ($P < 0.01$) and **D** peak amplitude ($P < 0.01$) of opto-ACh currents in TgCRND8 early AD responses relative to age-matched controls (3-6 months old). **E** Example opto-ACh responses from WT control (black) and TgCRND8 AD (grey) neurons measured in current clamp. Graphs show significant increase in **F** firing rise ($P < 0.0001$) and **G** peak firing frequency ($P < 0.05$) of opto-ACh firing responses in TgCRND8 early/mid AD responses relative to age-matched controls. Mice aged 3 to 6 months (nTg: 4.5 ± 0.4 months, n = 10, TgCRND8: 4.8 ± 0.3 months, n = 10).

Figure 2. Cholinergic signaling not different from non-transgenic in late AD

A Example opto-ACh responses from non-transgenic (nTg) control (black) and TgCRND8 AD (grey) neurons later in disease measured in voltage clamp (Vm = -75 mV). Graphs show no difference in **B** rise speed and **C** peak amplitude of opto-ACh currents in TgCRND8 late AD responses relative to age-matched controls. **D** Example opto-ACh responses from WT control (black) and TgCRND8 AD (grey) neurons later in disease measured in current clamp. Graphs show no difference in **E** firing rise and **F** peak firing frequency of opto-ACh firing responses in TgCRND8 late AD responses relative to age-matched controls. Mice aged 7-12 months (nTg: 9.3 ± 0.5 months, n = 10, TgCRND8: 10.1 ± 0.6 months, n = 10).

Figure 3. Early cholinergic upregulation conserved in different species and AD model

A Image depicts TgF344 AD rat model and coronal brain section with the recording electrode positioned over layer 6 of the prefrontal cortex. **B** Example responses to exogenous bath-applied acetylcholine from F344 non-transgenic (nTg) control (black) and TgF344 AD (grey) neurons measured in voltage clamp (Vm = -75 mV). Graphs show cumulative frequency of peak amplitude of acetylcholine current is **C** not different at 8 months, **D** is significantly higher for TgF344 AD responses than controls at 12 months ($P < 0.01$), **E** and is not different at 18 months. Insets show the data in scattergram. **F** Example responses to exogenous bath-applied acetylcholine from F344 WT control (black) and TgF344 AD (grey) neurons measured in current clamp. Graphs show cumulative frequency of time to peak firing of acetylcholine response is **G** not different at 8 months, **H** is significantly faster for TgF344 AD responses than controls at 12 months ($P < 0.01$), **I** and is not different at 18 months. Insets show the data in scattergram. Rats aged in three cohorts: 8 months (nTg: 8.5 ± 0.2 months, n = 12, TgF344: 8.4 ± 0.2, n = 9), 12 months (nTg: 12.4 ± 0.2 months, n = 13, TgF344 12.5 ± 0.2 months , n = 10), and 18 months (nTg: 17.7 ± 0.3 months, n = 14, TgF344: 17.6 ± 0.2 months, n = 12).

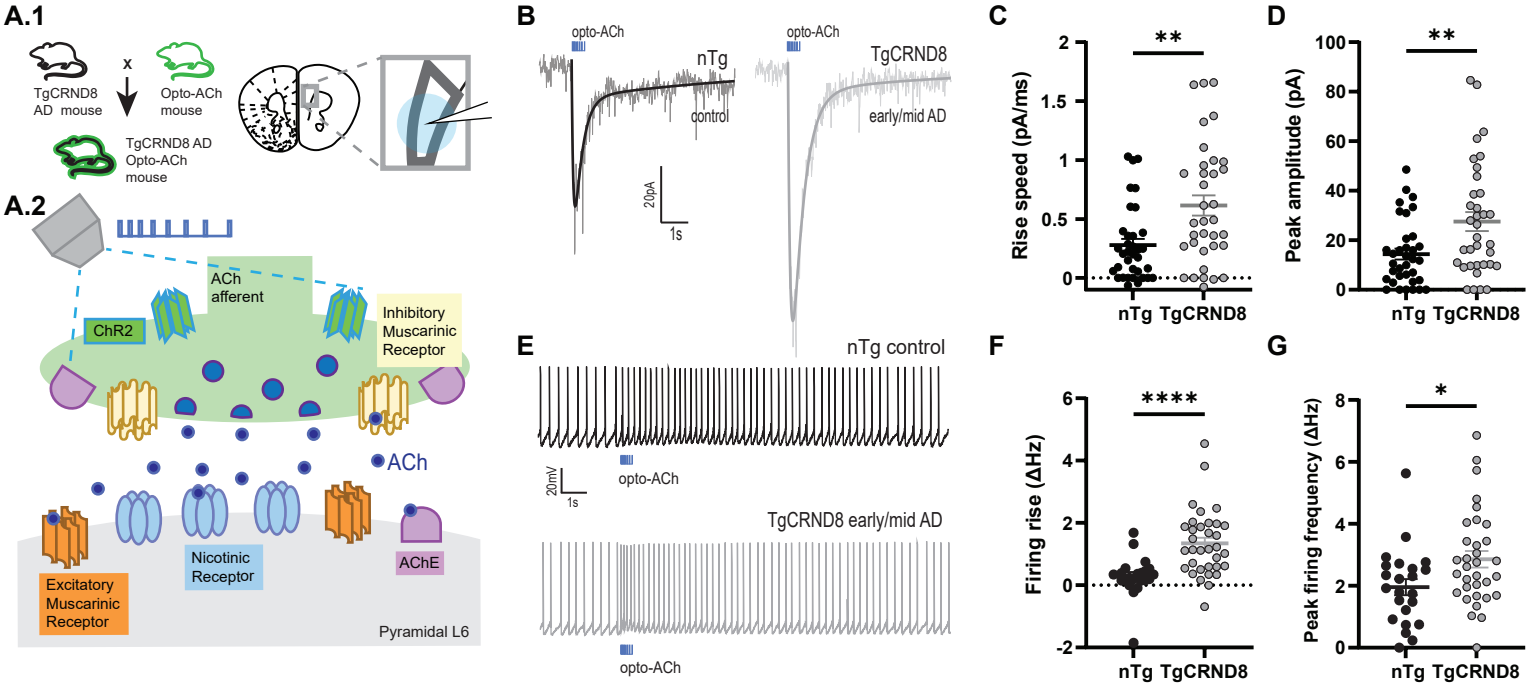
Figure 4. Early cholinergic upregulation in AD model is specific to nicotinic receptor signalling

A Schematic depicts cholinergic synapse in the presence of nicotinic receptor antagonist DHβE. **B** Paired example opto-ACh responses from non-transgenic (nTg) control (black) and

TgCRND8 AD (grey) neurons measured in voltage clamp (Vm = -75mV) before and after DHβE. Graphs show that DHβE causes a greater decline in **C** rise speed ($P < 0.05$) and **D** peak amplitude ($P < 0.05$) of opto-ACh currents in TgCRND8 AD responses relative to controls (age range: 4.5 to 12.2 months, mean = 7.9 ± 0.7 months, n = 14). **E** Schematic depicts cholinergic synapse in the presence of broad muscarinic receptor antagonist atropine. **F** Paired example opto-ACh responses from non-transgenic (nTg) control (black) and TgCRND8 AD (grey) neurons measured in voltage clamp before and after atropine. Graphs show that atropine elicits changes in **G** rise speed and **H** peak amplitude that are not different between TgCRND8 AD and control responses (age range: 3.1 to 12.2 months, mean = 6.4 ± 0.7 months, n = 20). **I** Schematic depicts cholinergic synapse in the presence of muscarinic M2 receptor antagonist AF-DX 116. **J** Paired example opto-ACh responses from non-transgenic (nTg) control (black) and TgCRND8 AD (grey) neurons measured in voltage clamp before and after AF-DX 116. Graphs show that AF-DX 116 elicits changes in **K** rise speed and **L** peak amplitude that are not different between TgCRND8 AD and control responses (age range: 4.2 to 12.2 months, mean = 7.8 ± 0.9 months, n = 13).

Figure 5. Galantamine and a novel nicotinic treatment strategy further enhances cholinergic upregulation in AD model.

A Schematic depicts cholinergic synapse in the presence of acetylcholinesterase inhibitor galantamine. Galantamine slows the degradation of acetylcholine, prolonging its availability at the synapse. **B** Paired example opto-ACh response from a TgCRND8 AD neuron before (grey) and after galantamine (purple). Graphs show that galantamine elicits **C** no change in rise speed but a significant increase in **D** peak amplitude ($P < 0.01$) and **E** response duration, as measured by the decay constant ($P < 0.01$) in TgCRND8 AD responses (age range 3-6 months: mean = 5.2 ± 0.6 months, n = 5). **F** Schematic depicts the activation of postsynaptic nicotinic receptors by acetylcholine and the action of nicotinic PAM NS9283 in increasing nicotinic receptor conductance. **G** Paired example opto-ACh responses from a TgCRND8 AD neuron before (grey) and after NS9283 (blue). Graphs show that NS9283 elicits an increase in **H** rise speed ($P < 0.05$) and **I** peak amplitude ($P < 0.001$) **J** with no change in the response duration (age range 3-6 months: mean = 4.7 ± 0.4 months, n = 6).



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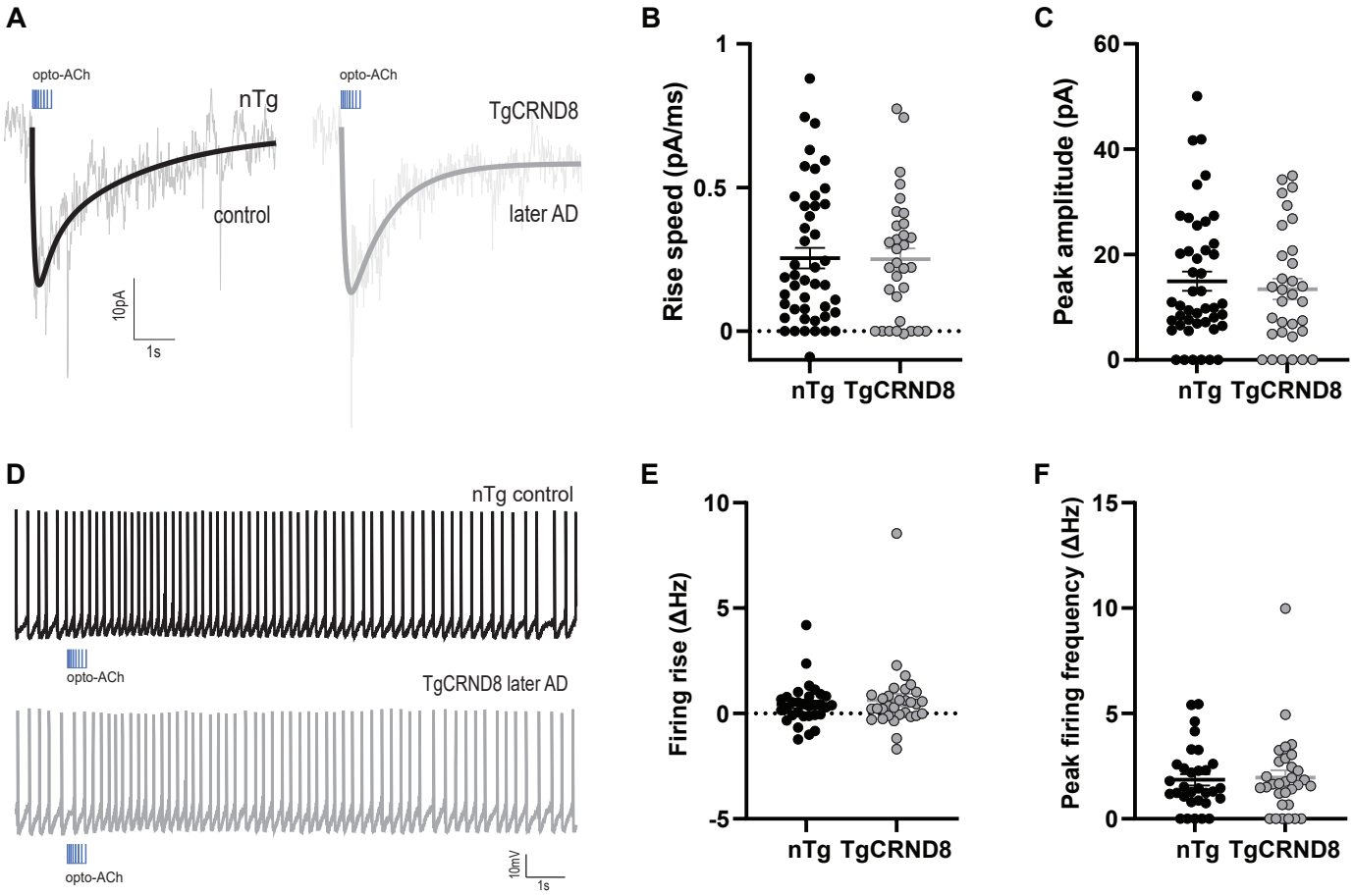

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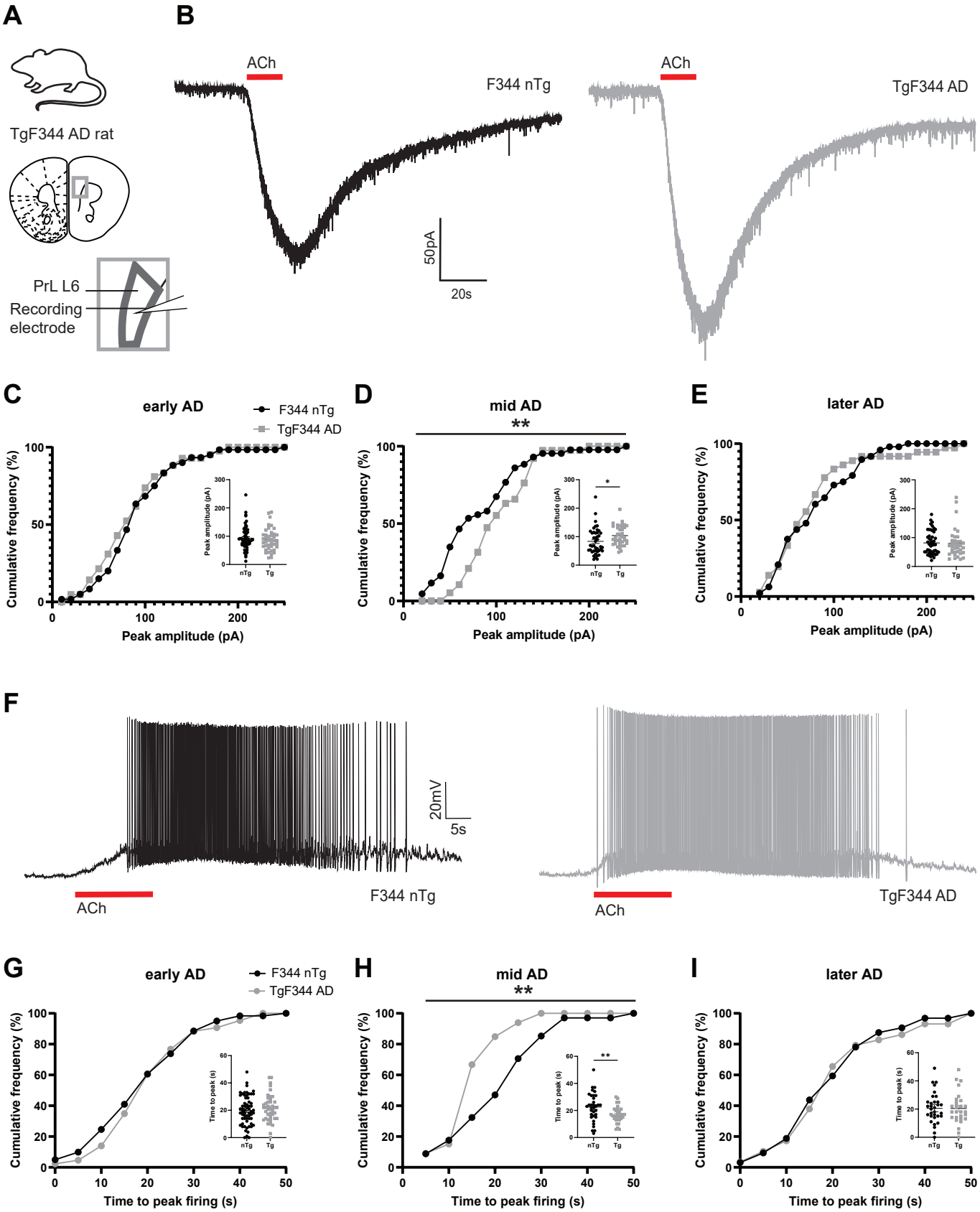

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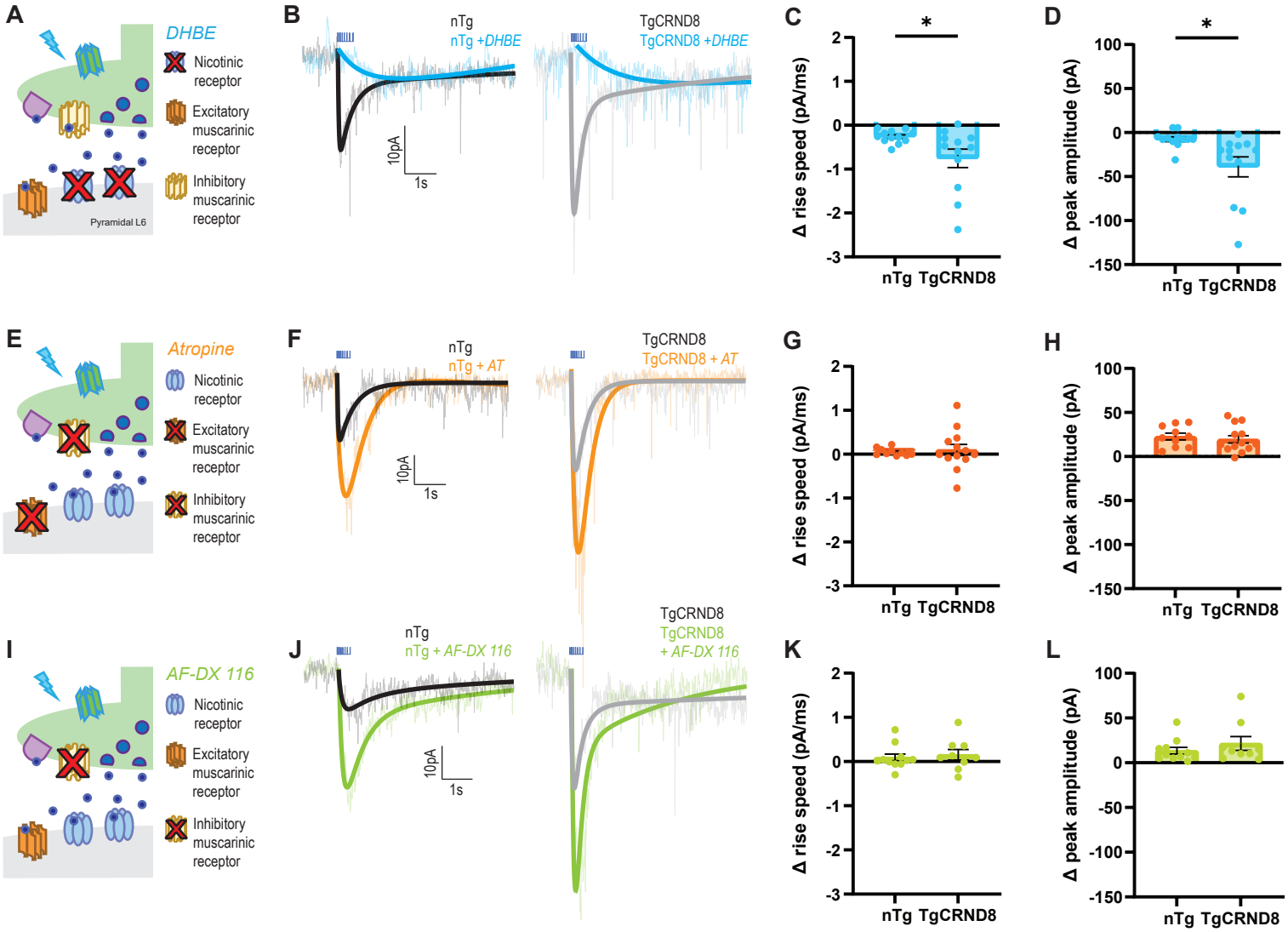

Figure 4. Early cholinergic upregulation in AD is specific to nicotinic receptor signalling

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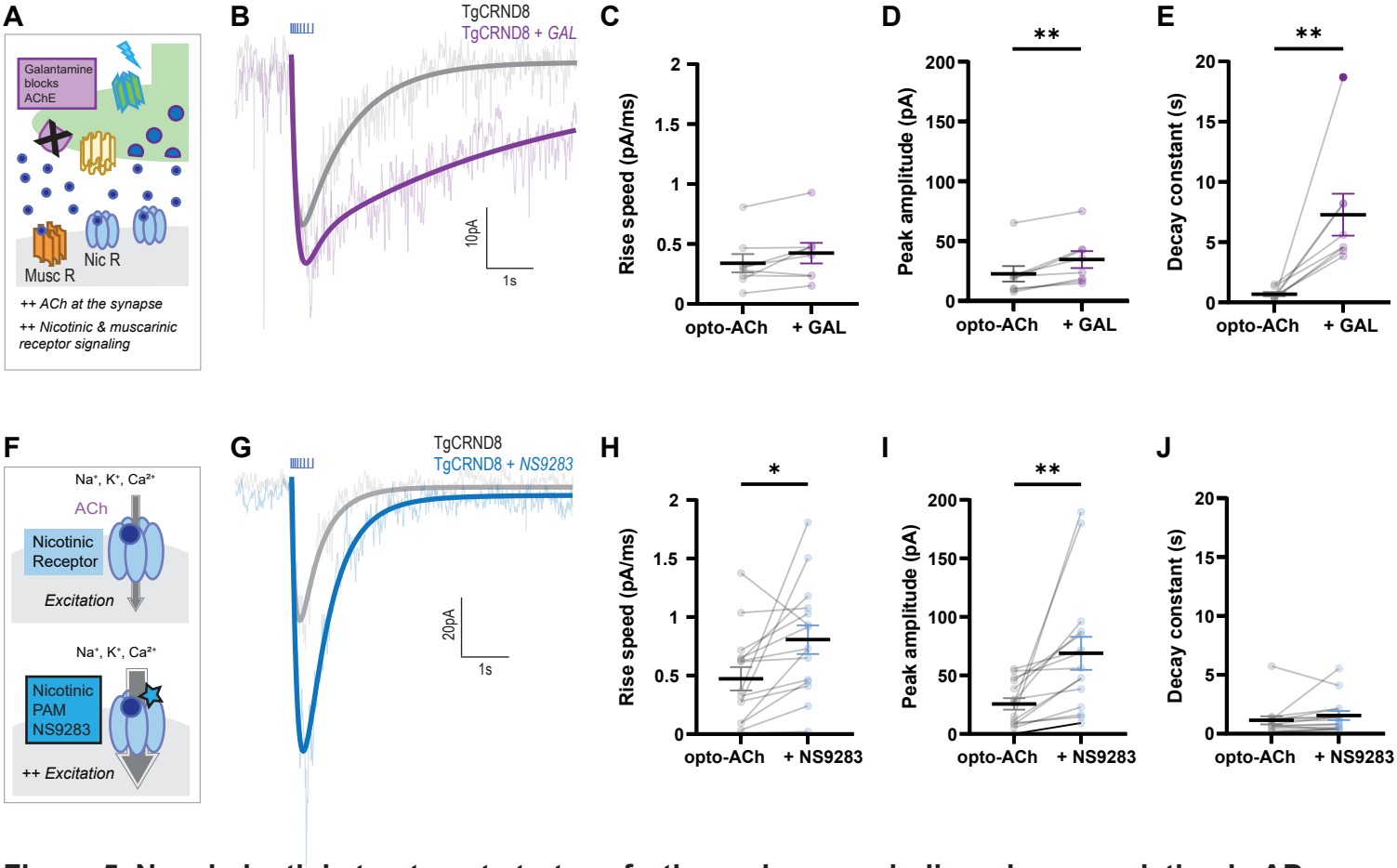

Figure 5. Novel nicotinic treatment strategy further enhances cholinergic upregulation in AD

A Schematic depicts cholinergic synapse in the presence of acetylcholinesterase inhibitor galantamine. Galantamine slows the degradation of acetylcholine, prolonging its availability at the synapse. **B** Paired example opto-ACh response from a TgCRND8 AD neuron before (grey) and after galantamine (purple). Graphs show that galantamine elicits **C** no change in rise speed but a significant increase in **D** peak amplitude ($P < 0.01$) and **E** response duration, as measured by the decay constant ($P < 0.01$) in TgCRND8 AD responses (age range 3-6 months: mean = 5.2 ± 0.6 months, n = 5). **F** Schematic depicts the activation of postsynaptic nicotinic receptors by acetylcholine and the action of nicotinic PAM NS9283 in increasing nicotinic receptor conductance. **G** Paired example opto-ACh responses from a TgCRND8 AD neuron before (grey) and after NS9283 (blue). Graphs show that NS9283 elicits an increase in **H** rise speed ($P < 0.05$) and I peak amplitude ($P < 0.001$) **J** with no change in the response duration (age range 3-6 months: mean = 4.7 ± 0.4 months, n = 6).