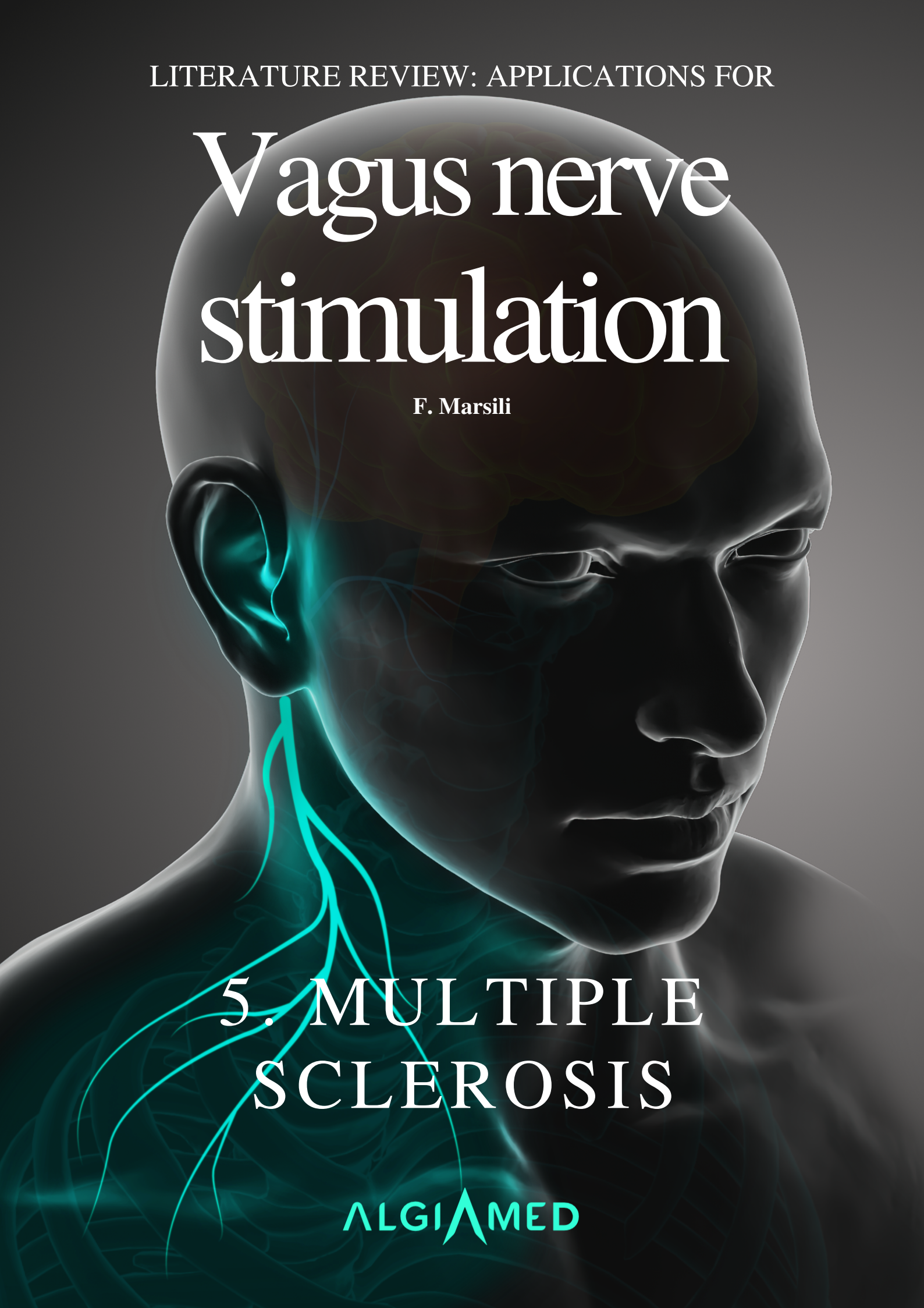
LITERATURE REVIEW: APPLICATIONS FOR

Vagus nerve stimulation

F. Marsili



5. MULTIPLE SCLEROSIS

ALGIAMED

Author's choice

The papers in this collection focus on the application of Vagus Nerve Stimulation (VNS) as established therapeutic solution for difficult-to-treat conditions.

The vagus nerve is the longest cranial nerve and is widely distributed throughout the body, traversing the neck, thorax and abdomen. It is composed by motor fibres and sensory fibres from sympathetic and parasympathetic branches. [1], [2]. Afferent branches of the vagus nerve innervate brain behavioural areas involved in depressive states, and it desynchronises cortical activity with anti epileptic effects [3], [4]. Efferent branches of the vagus nerve regulate gastrointestinal secretory and motor function [5]. Recent advances in the field, have unraveled an anti-inflammatory role of the efferent vagus nerve via the Cholinergic Anti-inflammatory Pathway (CAP), a known mechanism for neural inhibition of inflammation linked to the activation of the autonomic nervous system (ANS) [6], [7].

Electrical stimulation of the VN modulates the nervous system at central, peripheral, and autonomic levels without the need for pharmacological interventions. For decades, invasive techniques of VNS have demonstrated their clinical efficacy in VN-related diseases and, to these days, efforts have been made to create a more safe, effective, and non-invasive solution to VNS.

The auricular branch is the only peripheral branch of the VN on the human body, it is part of the afferent portion of the VN that directly connects to the brainstem. Thus, auricular VN has become the most favourable access point for non-invasive VNS. Neuroimaging studies on animal models and humans have confirmed the modulatory efficacy of auricular VNS (aVNS). For examples, fMRI studies show identical activation patterns in the brain between invasive and aVNS, with significant inhibitory and anti-inflammatory effects. Due to the existence of different control systems, the anti-inflammatory effects of aVNS (i.e., release of norepinephrine and noradrenaline, and neurotrophic factors) seem to occur immediately after intervention, while neuroplastic changes only occur as a consequence of sustained regenerative efforts [7].

Colleciton 1 and collection 2 are the most extensive selections, since VNS has been standard-of-care for epilepsy and depression for decades. Collection 3 explores the possibility of using VNS for the treatment of posttraumatic stress disorders. Collection 4 focuses on fibromyalgia and collection 5 on multiple sclerosis. Collection 6 and 7 corroborates the hypothesis that VNS can be used to activate the cholinergic anti-inflammatory pathway to treat inflammatory diseases, such as inflammatory bowel disease or rheumatoid arthritis. Collection 8 and 9 focus on the use of VNS for ameliorating pain sensitivity in chronic pain conditions and for rehabilitating upper limb motor fibres after ischemic strokes, respectively. In conclusion, collection 10 opens up other possibilities for clinical applications of VNS, ranging from cardiovascular diseases, through ADHD disorders, to tinnitus.

To summarise, VNS is a novel technology and its non-invasive configuration is still under investigation. Further clinical examinations are mandatory in order to understand the underlying mechanism of VNS and to open the door to new possible therapeutic applications. However, being a non-invasive, safe, and efficient therapeutic solution, VNS is an attractive tool for further implementation and new creative clinical applications.

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5. VNS and multiple sclerosis

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SHORT REPORT *Multiple Sclerosis* 2007; **13**: 1200–1202

Vagal nerve stimulation improves cerebellar tremor and dysphagia in multiple sclerosis

F Marrosu[1], A Maleci[1], E Cocco[1,2], M Puligheddu[1], L Barberini[1] and M G Marrosu[1,2]

Vagus nerve stimulation (VNS), an adjunctive approach for the treatment of epilepsy, was performed in three multiple sclerosis (MS) patients displaying postural cerebellar tremor (PCT) and dysphagia. Following VNS, improvement of PCT and dysphagia was manifested over a period of two and three months, respectively. In view of the involvement of the main brainstem visceral component of the vagus, the nucleus tractus solitarius (NTS), in modulating central pattern generators (CPGs) linked to both olive complex pathway and swallowing, improvement is likely to be VNS related. The results obtained suggest an additional therapeutic application for VNS and may represent a novel form of treatment in patients with severe MS. *Multiple Sclerosis* 2007; **13**: 1200–1202. http://msj.sagepub.com

Key words: Central Pattern Generators (CPGs); dysphagia; multiple sclerosis; postural cerebellar tremor; vagus nerve stimulation (VNS)

Introduction

In spite of the short term improvement registered in relapse rates for MS following the introduction of new treatments, the efficacy of the latter in ameliorating pre-existing overall disabilities has yet to be demonstrated. In particular, severe PCT and dysphagia, usually linked to brainstem impairment with high scores at EDSS, are not substantially modified. Recent studies have suggested that dysphagia and PCT might be produced by altered sequences in simple motor programmes regulated by brainstem microcircuits [1] throughout central pattern generators (CPGs) [2]. Moreover, it has been shown that deregulation of the CPG represented by the inferior olive (IO) complex cerebellar pathway induces PCT [3], while alterations of swallowing CPG produce dysphagia [4]. Stimulation of the vagus nerve modulates IO-cerebellar output via the NTS, its main visceral afferent, and improves experimentally-induced cerebellar tremor in rats [5]. Accordingly, in a preliminary report we proposed vagus nerve stimulation (VNS, Cyberonics, Houston, USA) as possible treatment for severe PCT in MS patients [6]. Moreover, in view of the role played by NTS stimulation in eliciting the CPG of swallowing [4], we hypothesize that VNS might produce an effect on the above CPG. The present study further extends a previous report published by the authors to assess the effect of VNS implant in three not previously described MS patients presenting severe brainstem impairment with PCT and permanent dysphagia.

Methods

Three males (mean age 32 years) affected by MS with PCT and dysphagia for an average of 8 years were enrolled in the study. All patients initially presented with RRMS treated by means of traditional and recently developed drugs (interferons 1b and 1a, IVIG, high doses of steroids). At the start of the study patients' general clinical symptomatology had been stable for at least 3 years, being characterized by severe head-neck tremor, dysarthria, internuclear gaze palsy, permanent dysphagia for liquids and solids. All subjects were confined to a wheelchair and unable to eat unaided. On the whole symptoms were considerably homogeneous with an EDSS score of 8.5. PCT was treated with Gabapentin, Primidone, Carbamazepine and Clonazepam, singly or in combination, while dysphagia was partially relieved by

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non-specific treatments, including dietary modifications (addition of thickeners to liquids) and improvement of swallowing techniques (eg, tilting head). PCT was scored using a modified version of the Klockgether Rating Scale (KRS) [7] (mild disability scored 1 point, maximum disability 5 points). Although application of the above rating scale is better suited to studies of primary cerebellar diseases, and *'ad hoc'* modifications might introduce possible measurement bias, its use in the present study was indicated for assessment of PCT tremor of the head and neck in a sitting position as subjects were confined to bed/wheelchair. Moreover, as the use of invasive and partially invasive examinations was prevented by the presence of permanent dysphagia, swallowing improvement was scored with the 50 mL water swallowing speed test, which estimates the ingestion of less than 10 mL/s an index of abnormal swallowing [8]. Our subjects swallowed 50 mL of water in a mean time of 18 s with nine pauses (pauses or 'piecemeal' deglutition periods, normally are 1–2/50 mL of liquid or ingested [8]).

Forty-five days after VNS implantation, 1.25 mA current was delivered by telemetry at 10 Hz (progression: 0.25 mA increase/week, 62 s stimulation 'on' alternated with 60 s 'off', 250 μsec pulse width). ECG and Holter-ECG were monitored every 3 months. Swallowing conditions and head-neck PCT were assessed separately by two groups of neurologists and one of physiatrists, while another team evaluated VNS-elicited improvement under blind conditions. The entire study lasted 26 months.

Results

Following VNS activation, dysphagia and head-neck PCT improved in all subjects over a period of 2–3 months, respectively. The latter showed a mean improvement of 67% (Figure 1A), while water intake and 'piecemeal' deglutition improved by 65% and 78% respectively (Figure 1B). Although difficulties in swallowing solids failed to improve (data not shown), with other brainstem dysfunctions and

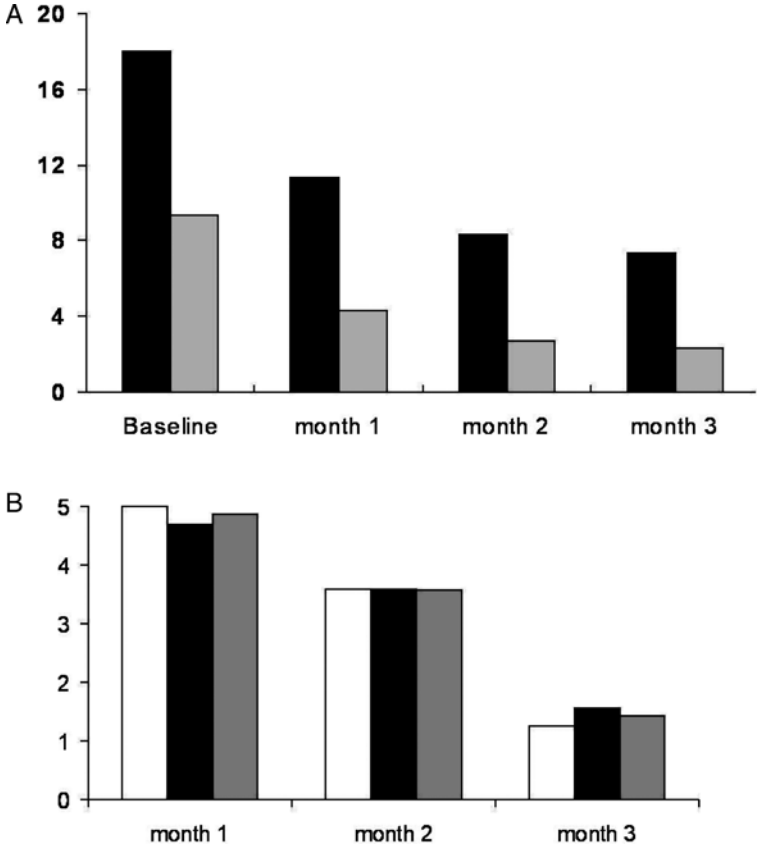

Figure 1 (A) Percentage improvement for the postural head-neck tremor. Y axis shows the disability score (5: maximum disability) according the Klockgether Rating Scale (KRS) modified as indicated in text. Each bar indicates a pwMS. (B) Timed test of swallowing capacity and piecemeal deglutition (50 mL water) at baseline and after 1, 2 and 3 months after VNS. Black bars: mean swallowing speed/seconds in pwMS. Gray bars: number of pauses of piecemeal deglutition during swallowing.

general MS symptoms remaining unchanged, the improvement of head-neck PCT and swallowing persisted throughout the 26 month follow-up period.

In line with these results, VNS parameters were maintained as reported and no serious side effects were referred. ECG and Holter-ECG monitoring yielded normal results.

Discussion

Several studies have suggested the possibility that VNS might affect cerebellar activity via NTS bilateral projections. It has been shown, for instance, that the inferior olive (IO) plays a crucial role in harmaline-induced experimental model via hypersynchronization of Purkinje cells (PC) propagated to deep cerebellar nuclei and vermis, such dysregulation being modulated by VNS [5]. As IO and cerebellar circuits oscillate in humans under 30 Hz [1] we hypothesize that low sub-harmonics of this frequency (eg, 10 Hz) might be used in an attempt to down-regulate the IO-cerebellar microcircuit, due to the fact that in experimental models the increase of IO firing rate induces cerebellar tremor [5]. Moreover, as swallowing and IO-cerebellar CPGs are both modulated by NTS, we deemed it likely that the same VNS parameters might prove capable of stimulating both CPGs via NTS.

As head-neck PCT and dysphagia improved following a slight delay, it seems likely that in accordance with other effects on neuroplasticity [9], VNS might affect both CPGs following a different temporal window. Indeed, the improvement of swallowing may occur more rapidly than amelioration of PCT in view of the fact that NTS is directly affected by VNS, acting indeed as the main synchronizer of the microcircuit containing pacemaker neurons mainly involved in triggering and timing the sequential phases of swallowing [4]. Severe bulbar symptoms, such as dysphagia, are among the most common causes of hospital admissions for frequent aspiration and PEG implants, constituting a heavy burden for patients, caregivers and institutions [10]. In spite of the need for additional instrumental data and the lack of a control population group, the present study emphasises how VNS might be taken into consideration as a possible alternative in the treatment of advanced MS in which PCT represents a highly distressing condition and dysphagia a potentially life threatening complication of the disease.

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REVIEW
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Vagus Nerve Stimulation in Rodent Models: An Overview of Technical Considerations

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Over the last several decades, vagus nerve stimulation (VNS) has evolved from a treatment for select neuropsychiatric disorders to one that holds promise in treating numerous inflammatory conditions. Growing interest has focused on the use of VNS for other indications, such as heart failure, rheumatoid arthritis, inflammatory bowel disease, ischemic stroke, and traumatic brain injury. As pre-clinical research often guides expansion into new clinical avenues, animal models of VNS have also increased in recent years. To advance this promising treatment, however, there are a number of experimental parameters that must be considered when planning a study, such as physiology of the vagus nerve, electrical stimulation parameters, electrode design, stimulation equipment, and microsurgical technique. In this review, we discuss these important considerations and how a combination of clinically relevant stimulation parameters can be used to achieve beneficial therapeutic results in pre-clinical studies of sub-acute to chronic VNS, and provide a practical guide for performing this work in rodent models. Finally, by integrating clinical and pre-clinical research, we present indeterminate issues as opportunities for future research.

Keywords: vagus nerve stimulation, vagus nerve, neuromodulation, nerve cuff electrode, electrical stimulation

INTRODUCTION

Vagus nerve stimulation (VNS) is an FDA-approved treatment for select neurological and psychiatric conditions including epilepsy, treatment-resistant depression, and cluster headache (Heck et al., 2002; Ruffoli et al., 2011; Conway et al., 2016; Pisapia and Baltuch, 2016; Lainez and Guillamon, 2017; Kumar et al., 2019). There is also growing interest in using VNS to treat other conditions, such as heart failure, rheumatoid arthritis, inflammatory bowel disease, ischemic stroke, and traumatic brain injury (Zhang et al., 2009; Bonaz et al., 2013; Cai et al., 2014; Levine et al., 2014a,b, Levine et al., 2018a,b; Dawson et al., 2016; Guiraud et al., 2016; Koopman et al., 2016; Pruitt et al., 2016; Kanashiro et al., 2018), many of which are characterized by inflammation. Extensive pre-clinical evidence has demonstrated the utility of VNS in treating inflammatory conditions (Huston et al., 2006, 2007; Rosas-Ballina et al., 2008; Levine et al., 2014a,b; Olofsson et al., 2015),

and a recent clinical study of rheumatoid arthritis (Koopman et al., 2016) further supports this treatment for widespread application. As VNS is applied to a broader range of conditions, it is important to recognize factors that influence study outcomes, such as stimulation settings, vagus nerve physiology, anatomical location of the target nerve branch, and electrode design. However, in many reports published thus far, these factors are often either not discussed, or are described as "customized" (i.e., as in the case of electrode design). A comprehensive discussion is therefore needed to inform the scientific design and reproducible execution of VNS studies.

The current review will provide a stepwise overview to inform the administration of VNS in rodent models, which often form the basis for higher-order study models. Key experimental conditions are discussed, including vagus nerve physiology, electrode design, stimulation equipment, microsurgical technique, and electrical stimulation parameters. Each step includes a detailed rationale to help inform modifications. Although a recent article outlined the surgical procedure for acute rodent VNS (Le Maitre et al., 2017), that method involved only a single stimulation and subsequent removal of the electrode. The current protocol will extend this work by outlining all of the steps necessary to conduct a full-scale sub-acute to chronic VNS study with an implanted cuff electrode. Here, we offer a practical guide to support pre-clinical VNS testing, anticipating the application of VNS for new clinical indications.

TARGETED STIMULATION OF THE VAGUS NERVE

Vagus Nerve Physiology

The vagus nerve is the tenth and longest cranial nerve and the primary mediator of the parasympathetic branch of the autonomic nervous system (Tracey, 2002; Bonaz et al., 2013). It also regulates immune system homeostasis through an intrinsic "cholinergic anti-inflammatory pathway" (Tracey, 2002; Bonaz et al., 2013). The vagus is a mixed nerve, largely composed of afferent sensory (∼80%) and efferent motor (∼20%) nerve fibers (George et al., 2003, 2004; Groves and Brown, 2005), the composition differing depending on the anatomical location of the nerve (Prechtl and Powley, 1990). The vagus nerve contains three main fiber types: A-, B-, and C-fibers, which are distinguished by fiber diameter, myelination, and activation thresholds (Heck et al., 2002; Groves and Brown, 2005; Ruffoli et al., 2011). A-fibers are large and myelinated (5–20 μm in diameter) and are activated by the lowest amount of current (0.01–0.2 mA) (Schnitzlein et al., 1958; Groves and Brown, 2005; Vuckovic et al., 2008; Ruffoli et al., 2011). B-fibers are mid-sized and myelinated (∼1–3 μm in diameter) and are also activated by low currents (0.04–0.6 mA) (Schnitzlein et al., 1958; Groves and Brown, 2005; Vuckovic et al., 2008; Ruffoli et al., 2011). C-fibers, which constitute the majority of vagus nerve fibers (∼65–80% of afferent fibers), are small and unmyelinated (0.4–2 μm in diameter) and require the highest activation currents (greater than 2.0 mA) (Schnitzlein et al., 1958; Heck et al., 2002; Groves and Brown, 2005; Vuckovic et al., 2008; Ruffoli et al., 2011; Yoo et al., 2013). Although the distribution of the vagus nerve has been shown to be comparable in some species (Mackay and Andrews, 1983; Asala and Bower, 1986), the morphology of the nerve changes depending on the anatomical location (Agostoni et al., 1957; Hoffman and Schnitzlein, 1961; McAllen and Spyer, 1978; Mei et al., 1980; Jammes et al., 1982; Powley et al., 1983; Prechtl and Powley, 1990; Henry, 2002; Ruffoli et al., 2011; Clancy et al., 2013; Hammer et al., 2015, 2018; Verlinden et al., 2015; Bonaz et al., 2016; Yuan and Silberstein, 2016; Planitzer et al., 2017).

Anatomical Considerations

Choosing an appropriate anatomical location to deliver stimulation is important when designing a VNS study. In most cases, VNS is delivered to the cervical vagus nerve (George et al., 2004; Howland, 2014) using an implanted electrode. Clinically, this anatomical location is the most common site for immune-modulation and treating epilepsy and depression (Lomarev et al., 2002; Nemeroff et al., 2006; Ben-Menachem et al., 2015; Koopman et al., 2016; Giordano et al., 2017). The left and right cervical branches differentially innervate the heart (O'Toole et al., 1986; Berthoud and Neuhuber, 2000; Ruffoli et al., 2011), where the right vagus nerve has more direct projections to the cardiac atria (Henry, 2002; Groves and Brown, 2005) and thus has a greater influence on heart rate. For this reason, left-sided VNS has been recommended to avoid adverse cardiovascular effects in humans (Henry, 2002; Groves and Brown, 2005; Van Leusden et al., 2015), even though equivalent anti-seizure effects are observed with either left, or right cervical VNS (Krahl et al., 2003; Navas et al., 2010). In rodent models, this lateral difference is not as clear and may differ depending on the stimulation parameters used (Stauss, 2017).

Anatomical differences in vagus innervation may be useful to help researchers adjust stimulation parameters to achieve specific, clinically relevant outcomes. Although most clinical applications target the left cervical vagus nerve, certain conditions may benefit from targeting different anatomical branches. For example, VNS applied to the right cervical vagus nerve is currently being explored to treat heart failure, where direct cardiac effects are desired (Li et al., 2004; Howland, 2014). Morphological differences in the right and left cervical vagus nerve branches (Verlinden et al., 2015) may also explain different clinical effects. Specifically, it was recently reported that both cervical nerve branches contain tyrosine hydroxylase- and dopamine β-hydroxylase-positive nerve fibers, but that the right cervical branch has a larger surface area and double the number of tyrosine hydroxylase-positive nerve fibers (Verlinden et al., 2015). These findings may inform the use of VNS for select cholinergic or adrenergic effects (Onkka et al., 2013; Seki et al., 2014; Verlinden et al., 2015).

Anatomical differences between the cervical vagus nerves may be less important in the treatment of other conditions, likely due to the abundant crossover of fibers between branches of the vagus nerve (Berthoud and Neuhuber, 2000). For example, in a recent study, no significant differences in inflammatory cytokines were found in animals receiving unilateral VNS to the left cervical

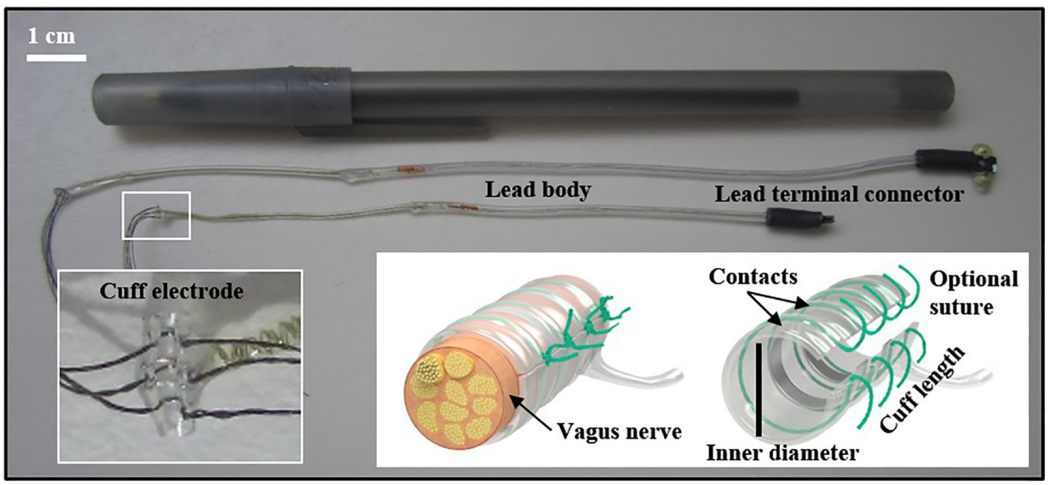

FIGURE 1 | Different sized (0.3 and 0.5 mm) cuff electrodes with connectors. Embedded sutures on the electrode can facilitate the surgical implant (inset). Other important electrode elements described in the text are identified. Cuff image reproduced with permission from MicroProbes for Life Science (Gaithersburg, MD).

vagus nerve compared to those receiving bilateral stimulation (VNS applied to the right and left nerve branches) (Olofsson et al., 2015). Laterality concerns may also be less pertinent for the emergent interest in transcutaneous VNS at the auricular or cervical branch (Howland, 2014; Ben-Menachem et al., 2015) and subdiaphragmatic VNS (Greenway and Zheng, 2007; de Lartigue, 2016). It remains to be determined whether the same stimulation parameters can be used for different vagus nerve branches or implanted vs. non-implanted modalities. Further research is needed to elucidate stimulation parameters for each clinical indication and comparative efficacy for implanted vs. non-implanted approaches. Here, the current review will focus on the most common clinical and pre-clinical stimulation site, the left cervical vagus nerve (Howland, 2014), using an implanted electrode. As rodents are commonly used in physiological studies with clinical relevance and form the basis for higher-order models, this overview will discuss specifications pertinent to mouse and rat models in a clinically relevant context, starting with electrode design and implantation, and concluding with stimulation parameters.

ELECTRODE DESIGN

The electrode design is an important factor to consider when planning a VNS study. In the most common clinical deployment using a can-and-lead system, the cervical vagus nerve is encircled with bipolar helical electrodes, and a pulse generator is implanted in the chest wall (Bonaz et al., 2013; Giordano et al., 2017). The electrode configuration consists of two spiral electrodes placed around the vagus nerve: the cathode is placed cranial and the anode caudal. A third helical tethering anchor is also placed around the nerve, directly caudal to the anode to provide strain relief (Pisapia and Baltuch, 2016; Giordano et al., 2017).

Electrodes used in rodents may differ, depending on the research objectives and study length (ranging from acute to chronic stimulation). The electrode configuration can include many designs (e.g., cuff or hook, and the inclusion of recording electrodes). A recent VNS methods paper described a needle electrode that was placed under the left cervical vagus nerve during a single stimulation (Le Maitre et al., 2017). For research involving multiple stimulation treatments, we implanted a bipolar cuff electrode with embedded sutures around the nerve (see **Figure 1**). Cuff electrodes are used in acute and chronic implantation to prevent current leakage into the surrounding tissue. We applied a strain-relieving suture close to the deployment site (detailed below), and the attached lead and pin connector was then tunneled under the skin and externalized at the base of the neck. **Figure 2** depicts the externalized connector and an awake animal receiving stimulation. Stimulation was delivered with a commercially available external pulse generator and current-controlled stimulus isolator (see **Figure 2**), described below.

For control conditions (unstimulated), a sham electrode can be made by implanting a silicon tube that is the same size as the electrode. This relatively inexpensive inactive design is helpful for feasibility testing, as it compensates for the mechanical stimulation that occurs when the nerve is manipulated (Huston et al., 2007). However, other variables (e.g., the weight of the electrode and tension from the connecting wire-embedded lead) may influence study outcomes, and it is best to have a control condition that consists of an identical implanted electrode that does not receive electricity or a cuff and lead constructed without wires.

In animal experimentation, placement of the cathode and anode are typically not reported. Animal research often includes study factors not relevant to clinical practice, such as stimulation of the distal nerve trunk of a vagotomized animal (Borovikova et al., 2000; de Jonge et al., 2005). In a recent rodent study, no significant differences in inflammatory cytokines were found with either rostral or caudal placement of the cathodic lead (Olofsson et al., 2015), likely because

FIGURE 2 | Left panel (top to bottom): Biphasic current-controlled stimulus isolator and biphasic pulse generator (BSI-1A, BPG-1P, respectively; Bak Electronics Incorporated, Umatilla, FL, United States). **Right panel** (top to bottom): Omnetics mating plug for the externalized connector and awake animal receiving stimulation. All procedures described and animal photography was performed with approval by the Institutional Animal Care and Use Committee (IACUC) at the University of Miami.

action potentials are generated in both directions when an axon is depolarized. Additional research is needed to understand how cathodic placement and pulse parameters can be modified for specific treatment indications, a topic that is currently being explored (Ardell et al., 2017; Patel et al., 2017; Stauss, 2017).

Electrode Specifications for Mice and Rats

Although many research groups construct their own electrodes, they can also be purchased and customized through commercial vendors. Nerve cuff electrodes can be made from several conductive materials, including platinum, platinum-iridium, and stainless steel. These electrodes are typically designed with monopolar, bipolar, or tripolar configurations, referring to the number of independent electrical contacts within the cuff. The tradeoff is generally increased control over current flow with a greater number of contacts, but also greater cost and cuff length. Monopolar electrodes are cheaper but require a return or ground, and current paths are less controllable. Bipolar electrodes are more expensive but allow better control over current flow than monopolar, as most of the current will flow directly between the two adjacent contacts. Bipolar cuff electrodes may be more practical and are widely used in pre-clinical research when the cost is a determining factor, especially in pilot studies. Tripolar electrodes may be connected in a pseudo-tripolar configuration (the two external electrodes linked together to form a common anode), which prevents current from leaking out of the cuff.

The size of the target nerve will determine the size of the electrode, as the inner diameter of the cuff should be approximately 1.4 times the outer diameter of the nerve. Use of a cuff that is too small could damage the nerve, and one that is too large could lead to insufficient surface contact or excessive current leakage (Agnew and McCreery, 1990; Yoshida and Riso, 2004). We used nerve cuffs with an inner diameter of 0.3 mm for both mice and small rats and 0.5 mm for larger rats. These sizes were informed by our experience and by published reports (Olofsson et al., 2015).

Besides inner diameter, other modifications include the number of contacts, the distance between contacts, and distance from the contacts to the end of the cuff. The number of contacts is determined by the stimulation paradigm desired. The distance between contacts ("inter-electrode spacing") we used was 0.5 mm for mice and small rats and 1 mm for larger rats. The distance from the last contact to the end of the cuff is typically three times the distance between contacts to prevent significant current leakage outside the cuff. This distance can be much smaller in pseudo-tripolar electrode configuration. Other custom modifications can be made to suit the research experiment, for example, using an angled cuff design, a multichannel omnetics connector on the externalized cuff lead, embedded suture material on the cuff for convenient closure, suture rings exiting from the base of the connector, and protective silicone tubing around the wiring. A deep review of electrode design is beyond the scope of the current article, but has been reviewed extensively elsewhere (Loeb and Peck, 1996; Merrill et al., 2005; Foldes et al., 2011; Dweiri et al., 2016; Caravaca et al., 2017).

Finally, stimulation conditions in acute vs. chronic studies may differ, as it has been shown that connective tissue forms around the cuff within the first 2 months of implantation (Agnew and McCreery, 1990; Helmers et al., 2012). While this scar tissue will bind the nerve and cuff together and prevent movement abrasion, it can also increase the impedance, causing an increase in the amount of stimulation voltage required to excite the nerve (Agnew and McCreery, 1990; Helmers et al., 2012). Furthermore, it was recently shown that chronic cuffing of the vagus nerve changes the integrity of the nerve fibers, likely due to the inflammatory response to the foreign material (Somann et al., 2018). Although the inflammatory response should resolve upon the formation of fibrous tissue, in some instances, it can negatively affect the integrity of the nerve, including demyelination (Tyler and Durand, 2003; Thil et al., 2007; Somann et al., 2018). It is currently unknown whether this process affects afferent and efferent vagus nerve fibers equally, but it is a potential source of study variability that should be considered when planning a chronic VNS study (Somann et al., 2018). Recent advancements in cuff design show promise in addressing some of these concerns (Caravaca et al., 2017).

STIMULATION EQUIPMENT

Commercially available equipment can be used to deliver a charge-balanced, biphasic square-wave pulse to a bipolar cuff electrode (Levine et al., 2014b; Olofsson et al., 2015). For investigators wanting readily available equipment, we have outlined the specifications related to one vendor, Bak Electronics Incorporated (Umatilla, FL, United States), but many of these specifications are also relevant to other vendors. For our studies, we delivered biphasic (cathodic-leading) stimulation (Levine et al., 2014b; Olofsson et al., 2015) using an external biphasic pulse generator and current-controlled biphasic stimulus isolator

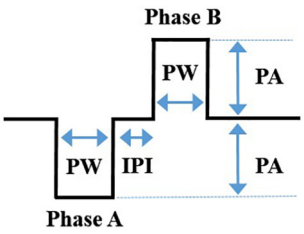

FIGURE 3 | A depiction of the waveform of one charge-balanced, biphasic, cathodic-leading square pulse cycle, showing pulse width (PW), inter-phase interval (IPI), and pulse amplitude (PA). These components have been explained in detail elsewhere (Merrill et al., 2005). Image adapted with permission (Levine et al., 2014b; Olofsson et al., 2015) under the Creative Commons Attribution License.

(BPG-1P and BSI-1A, respectively). Gently restrained rodents (without anesthesia) were connected to the equipment with a mating plug for stimulation delivery (De Herdt et al., 2009; Zhang et al., 2009). See **Figure 2** for equipment configuration and stimulation. Stimulation can be delivered for a specific period (e.g., 60 s) using the manual trigger or it can be digitally triggered or gated to a particular stimulus with a laptop configuration. The waveform design of one charge-balanced, biphasic, cathodic-leading square pulse cycle is represented in **Figure 3**.

The delivery specifications of each VNS "treatment" will depend on the physiological outcome measure to be studied. For example, in the context of anti-inflammatory effects, it has been shown that VNS delivered 24–48 h prior to endotoxin exposure resulted in a significant reduction in tumor necrosis factor (TNF) cytokine upon exposure (Huston et al., 2007). This period of therapeutic effects suggests that for certain indications (e.g., conditions characterized by an exaggerated inflammatory response to stimuli), VNS may be administered prophylactically or at specific intervals. As VNS treatment will likely be tailored to clinical symptoms, additional work is needed to determine the temporal response of VNS for other indications. Finally, it is important to include a measurable variable to determine stimulation effectiveness and rule out potential sources of study variability, such as incorrect placement or faulty electrodes, or mechanical damage to the nerve. One option is to record evoked potentials from the vagus nerve after VNS, for example, by stimulating the cervical branch and recording from the subdiaphragmatic branch (Olofsson et al., 2015). This approach can be taken just prior to euthanasia, or immediately after implantation; however, recording from the vagus nerve is technically challenging to perform in rodents (Silverman et al., 2018). To circumvent some of these challenges, investigators can record in a smaller cohort of animals, use electrodes that perform both stimulation and recording, or obtain electromyography (EMG) recordings of the laryngeal muscles that are innervated by the vagus. Another common option is to use heart rate to verify effective cuff placement, where stimulation is increased until a change in heart rate is observed (Levine et al., 2019). At a minimum, we recommend to visually inspect the nerve at euthanasia to ensure that it is still within the cuff and, when possible, to perform histology on the excised nerve to verify axon integrity.

MICROSURGICAL TECHNIQUE: ELECTRODE PLACEMENT

The stepwise surgical procedure detailed below involves the placement of an electrode on the LEFT cervical vagus nerve. The lateral configuration will change if implanting on the RIGHT nerve branch. All survival surgeries should be performed with aseptic technique while the animal is anesthetized, as recommended by the local Institutional Animal Care and Use Committee. Standard post-operative care should also be administered, including hydration and analgesia. With the animal lying prone, make a small opening (∼2 mm) in the skin at the craniovertebral junction, then place the animal in supine position. Palpate the sternal notch. Using scissors, carefully make a vertical incision at the neck, 3 mm caudal to the sternal notch. Dissect the subcutaneous space and extend the midline opening toward the jaw. Identify the inferior border of the thyroid tissue ("V" shaped distinct white line at the cervico-sternal junction). Blunt dissect the thyroid tissue along this line and reflect rostrally. Using a curved, narrow hemostat, create a subcutaneous tunnel toward the opening made at the craniovertebral junction. Bring the electrode through the tunnel and secure to the side of the incision site with tape or weighted instruments. Using blunt-tipped surgical hooks or modified needle syringes as hooks, reflect the thyroid superiorly and the left sternocleidomastoid inferiorly to expose the carotid fossa. No cutting of subcutaneous tissue should be done at any time.

Isolate the left carotid sheath from the connective tissue using pickup forceps and gentle opening-closing movements parallel to the vessels. Identify the nerve (white in appearance) located directly behind or adjacent to the carotid artery. Note, gentle dissection can be accomplished with small, blunt-tipped forceps, minimizing the risk of vessel puncture; however, sharp forceps can also be carefully used to separate the nerve from the carotid artery. Gently dissect the nerve circumferentially taking care not to damage the vessels or tug on the nerve, and place background material under the nerve (a small piece of sterile glove will serve this purpose). Feed the suture strings from the same side of the electrode cuff under the nerve. Advance the electrode cuff under the nerve. Open the cuff by pulling on the opposing sutures, allow the nerve to slide into the open cuff, and secure the cuff by tying the suture strings (see **Figure 4**). If the visualized nerve is very thin, it is also possible to encircle the entire carotid sheath in mice without isolating the nerve (Olofsson et al., 2015). Attach the lead body to the subcutaneous tissue with a non-absorbable suture (e.g., 4–0 Webcryl) placed approximately 5 mm away from the cuff. This suture will secure the electrode and provide strain relief. With the animal lying prone, feed the excess encased wires evenly into the subcutaneous space (if necessary, create a pocket with forceps by gentle opening-closing movements). Secure the connector to the skin with non-absorbable suture (using embedded suture rings or suture carefully placed through

FIGURE 4 | Surgical preparation of the electrode implant. Close up (inset), where the white dotted line lies parallel to the nerve lying inside the cuff. All procedures described and animal photography was performed with approval by the Institutional Animal Care and Use Committee (IACUC) at the University of Miami.

the rubber encasement) and close the skin opening. Before closing the neck incision, place the animal back in a supine position to inspect the electrode and ensure the cuff is encircling the nerve without twisting or pulling. Close the incision on the neck. During surgery, care should be taken to avoid excessive manipulation of the nerve to prevent axonal damage, and, as has been reported, mechanical activation of neuroimmune reflexes (Huston et al., 2007).

ELECTRICAL STIMULATION PARAMETERS

Current FDA-Approved Clinical VNS Guidelines

Many of the lessons learned in the application of VNS to treat epilepsy are generalizable to other VNS applications, although stimulation should be optimized to the specific treatment condition. Several important parameters can be adjusted when delivering stimulation to the vagus nerve: output current, pulse width, pulse frequency, and duty cycle (i.e., "ON" and "OFF" time) (Heck et al., 2002; Groves and Brown, 2005; Wheless et al., 2018). Collectively, these parameters determine the total amount of electrical energy delivered to the vagus nerve during treatment (Heck et al., 2002). Current guidelines in epilepsy include output currents between 0.25 and 3.5 mA and pulse frequencies ranging between 20 and 30 Hz (Heck et al., 2002; Groves and Brown, 2005; Ruffoli et al., 2011). Continuously applied, high-frequency (50–100 Hz) current leads to irreversible axonal injury, which can be avoided by reducing the frequency to 20 Hz (Agnew and McCreery, 1990). These findings and others showing optimal pulse frequencies for seizure reduction ranging from 10 to 30 Hz (Woodbury and Woodbury, 1990; Zabara, 1992) led to current FDA-approved guidelines (Groves and Brown, 2005). These settings also correspond with stimulation parameters reported in clinical trials of depression (Rush et al., 2000, 2005a,b) and a recent clinical study of rheumatoid arthritis (Koopman et al., 2016). Once a target fiber type is identified, stimulation can be adjusted within approved limits.

The output current is the stimulation parameter typically adjusted first (Heck et al., 2002). A tolerable range of current can be used to target specific nerve fibers and achieve clinical efficacy. Initially, VNS treatment for clinical epilepsy was thought to activate C-fibers, an approach that coincided with observations of progressive anti-epileptic effects with increasing current (Heck et al., 2002). This approach was not without consequence, as elevated currents are less tolerable and increase adverse effects, such as bradycardia, dyspnea, and throat tightness (Heck et al., 2002). The need to increase output current to achieve clinical efficacy (DeGiorgio et al., 2000, 2001) has been questioned and may have been influenced by the high currents used for non-responders (Heck et al., 2002). It has since been shown that C-fiber activation is not required for anticonvulsant effects (Krahl et al., 2001; Henry, 2002; Ruffoli et al., 2011) and that currents above 2 mA may be unnecessary for most patients (Heck et al., 2002).

The second parameter to consider is the pulse width, the duration of a single stimulation pulse (Labiner and Ahern, 2007), which can be adjusted to avoid the neural damage associated with continuous stimulation (Agnew and McCreery, 1990). Rodent seizure models report optimal pulse widths as high as 1,000 μs; however, the pulse width is inversely related to tolerance in people (Heck et al., 2002). Fortunately, this parameter can be adjusted to improve tolerance without loss of efficacy, for example, by shortening the pulse width from 500 μs to 250 μs (Heck et al., 2002). Pulse width is inversely related to the current required to stimulate a nerve (Heck et al., 2002; Labiner and Ahern, 2007; Levine et al., 2019), and together these two parameters determine the total charge per pulse (Labiner and Ahern, 2007; Levine et al., 2019). Although shorter and longer pulse durations may be preferred in different clinical applications (Agnew and McCreery, 1990), this is an area of active investigation (Mu et al., 2004; Kong et al., 2012; Aaronson et al., 2013; Loerwald et al., 2018). Thus, adjusting pulse width in concert with output current can meet stimulation requirements and reduce the risks of excessive stimulation current, while achieving a balance of clinical efficacy and tolerability.

A third parameter, pulse frequency (number of pulses per second), is less often varied in studies compared to other stimulation settings. Pulse frequencies that are generally used in rodent seizure models are similar to those used clinically, ranging from 10 to 30 Hz (Heck et al., 2002). For treatment indications besides epilepsy, the utility of specific pulse frequencies remains under investigation. In clinical practice, it may be helpful to use the natural firing rates of specific fiber types to guide pulse frequency (Bonaz et al., 2013). For example, it has been reported that the physiological firing frequency of A- and C-fibers is above and below 10 Hz, respectively (Binks et al., 2001). It is currently unclear whether pulse frequency can be used to preferentially stimulate afferent vs. efferent fibers without the use of chemical or electrical nerve block (Osharina et al., 2006; Bonaz et al., 2013; Olofsson et al., 2015; Patel et al., 2017; Patel and Butera, 2018), as generally, when an axon is depolarized beneath a cathodic electrode, action potentials travel in both directions.

To date, pulse frequencies that are responsible for specific clinical effects remain to be determined; however, as more studies are performed, we will better understand whether a combination of stimulation settings will be useful in targeting specific nerve fibers within efferent and afferent pathways [e.g., motor A-type or sensory group I, II, and III fibers (Yoo et al., 2013)]. The use of different stimulation paradigms to selectively target different fiber types remains an area of active investigation (Vuckovic et al., 2004, 2008; Howland, 2014; Peclin and Rozman, 2014; Guiraud et al., 2016; Patel et al., 2017; Nuntaphum et al., 2018; Patel and Butera, 2018).

A final parameter that affects stimulation is the duty cycle (ON/OFF cycle) (Heck et al., 2002; Labiner and Ahern, 2007). The standard duty cycle to treat persons with epilepsy is 30 s ON/5 min OFF (Heck et al., 2002). Although shorter OFF times can improve clinical efficacy, rapid cycling (i.e., very short duty cycles) is much more energy intensive and may not be necessary for effective treatment (Heck et al., 2002), at least for anti-seizure use. A more in-depth discussion on considerations regarding electrical stimulation can be found in previous reviews (Merrill et al., 2005; Mortimer and Bhadra, 2009; Cogan et al., 2018; Grill, 2018). As an example using our equipment setup (**Figure 2**), a stimulation "treatment" consisting of symmetrical biphasic square pulses with current intensity of 500 μA, 250 μs pulse width, and 50 μs inter-phase interval at 10 Hz for 60 s (Olofsson et al., 2015) can be delivered with the following settings. *Stimulus isolator*: 100 μA of constant current, AC coupling, continuous stimulation, and an input gain of 1. *Pulse generator*: 5.0 amplitude (5 × 100 μA × gain of 1), 250 μs pulse width, 100 ms period. It should be noted that the pulse period is the inverse of the desired frequency (i.e., 100 ms = 1/10 Hz × 1000 ms/s). To summarize, the stimulation "treatment" using the parameters from our previous example will consist of a 550 μs pulse (250 μs for each phase of the pulse, plus 50 μs inter-phase interval), and a 99,450 μs inter-pulse interval (total of 100,000 μs period).

Adverse Effects Associated With VNS

Commonly reported VNS adverse effects include cough, throat tightening or discomfort, shortness of breath, voice alterations, and cardiovascular symptoms, such as bradycardia (Ben-Menachem, 2001; Heck et al., 2002; Ben-Menachem et al., 2015; Jacobs et al., 2015). These transient effects are limited to when the device is actively stimulating and are proportional to increases in output current, pulse width, frequency, and duty cycle (Heck et al., 2002; Jacobs et al., 2015; Olofsson et al., 2015). Pulmonary effects are mainly associated with C-fiber activation (Banzett et al., 1999; Heck et al., 2002; Henry, 2002), which were previously associated with cardiovascular effects. However, it has been shown that cardioinhibitory effects can be attributed to activation of B-fibers (Jones et al., 1995; Banzett et al., 1999; Yoo et al., 2016; McAllen et al., 2018; Qing et al., 2018). Importantly, no evidence of "clinically relevant" bradycardia has been reported for stimulation within FDA-approved guidelines (Heck et al., 2002). It is also notable that anti-inflammatory and cardioinhibitory effects are separable (Huston et al., 2007), further indicating that stimulation parameters can be tailored for precise, clinically relevant outcomes.

Tailoring VNS for Specific Conditions

Early anti-epileptic work targeted C-fibers under the assumption that these abundant afferent fibers mediate the clinical effects of VNS (George et al., 2003, 2004; Groves and Brown, 2005; Yoo et al., 2013). As such, early VNS treatment utilized the high output currents needed to stimulate C-fibers (Heck et al., 2002). As A-, B-, and C-fibers are successively recruited with increased electrical current (Woodbury and Woodbury, 1990; Yoo et al., 2013), subsequent research demonstrated anticonvulsant effects without specifically targeting C-fibers, thus allowing for smaller amounts of current (Krahl et al., 2001; Henry, 2002; Ruffoli et al., 2011). The activation thresholds of A- and B-fibers overlap, but both require substantially less current than C-fibers (Groves and Brown, 2005; Castoro et al., 2011), which, when activated, are associated with most of the reported adverse effects (Heck et al., 2002; Henry, 2002).

As the field has progressed, this iterative process of associating specific fiber types with therapeutic effects has occurred in the use of VNS for other indications, where anti-inflammatory effects have been attributed to A-fibers (Huston et al., 2007) and B-fibers (Olofsson et al., 2015). Importantly, recent research shows that minimal stimulation can achieve beneficial therapeutic outcomes. A seminal pre-clinical study demonstrated that a minimal amount of current (0.5 mA) activated the inflammatory reflex in both mice and rats (Olofsson et al., 2015), effects of which were observed up to 2.5 mA. These output currents remain below FDA-approved levels (Heck et al., 2002) and are similar to currents used clinically for rheumatoid arthritis (Koopman et al., 2016). Thus, minimized stimulation may provide therapeutic benefits while avoiding the adverse effects associated with higher output currents (Heck et al., 2002).

CONCLUSION

Decades of research has brought extensive progress to the field of neuromodulation, and specifically to the clinical use of techniques such as VNS. Although VNS is a promising neuromodulation tool, it has been challenging to incorporate study findings from clinical and pre-clinical research. Pre-clinical VNS work often involves mechanistic study aspects not employed in clinical settings, such as the use of lidocaine to block efferent or afferent signaling or electrical stimulation of nerve stumps after vagotomy (Borovikova et al., 2000; de Jonge et al., 2005; Niederbichler et al., 2009; Olofsson et al., 2015). In clinical VNS application, decisions regarding stimulation parameters may not be explicitly defined, such as the number of treatment sessions; similarly, a clear rationale for pulse-design modifications are often not addressed. In addition to pulse frequencies, several other key stimulation parameters can influence study outcomes and reproducibility; however, selection of specific treatment parameters are often not detailed or are simply reported as "customized." Furthermore, as activation thresholds may differ depending on conditions of stimulation, it is critical that study conditions are outlined in ongoing research efforts.

These issues highlight the challenge of translating rodent work to clinical application. The inflammatory reflex appears to be conserved across species; where anti-inflammatory effects are observed with similar stimulation parameters in rodents with endotoxemia (Olofsson et al., 2015), rodents with collagen-induced arthritis (Levine et al., 2014b), and persons with rheumatoid arthritis (Koopman et al., 2016). However, it is unknown whether specific fiber types that mediate the reflex are similarly conserved. Additionally, as disease-related factors may influence VNS pathways, stimulation may be most effective if delivered at specific time points of disease progression. These and other questions remain to be determined and highlight the importance of translating pre-clinical findings to heterogeneous clinical populations.

The current review aims to advance VNS research by providing a comprehensive discussion on performing pre-clinical VNS studies in rodent models. We have provided a microsurgical technique, discussed stimulation equipment, and provided a rationale for choosing electrode design and electrical stimulation settings. We outlined how a combination of clinically relevant stimulation parameters can be adjusted to achieve selected therapeutic effects. Indeterminate issues are discussed and presented as avenues for future research.

AUTHOR CONTRIBUTIONS

CN, YL, TU, JA, and MN conceived, structured, and participated in writing and revising the review.

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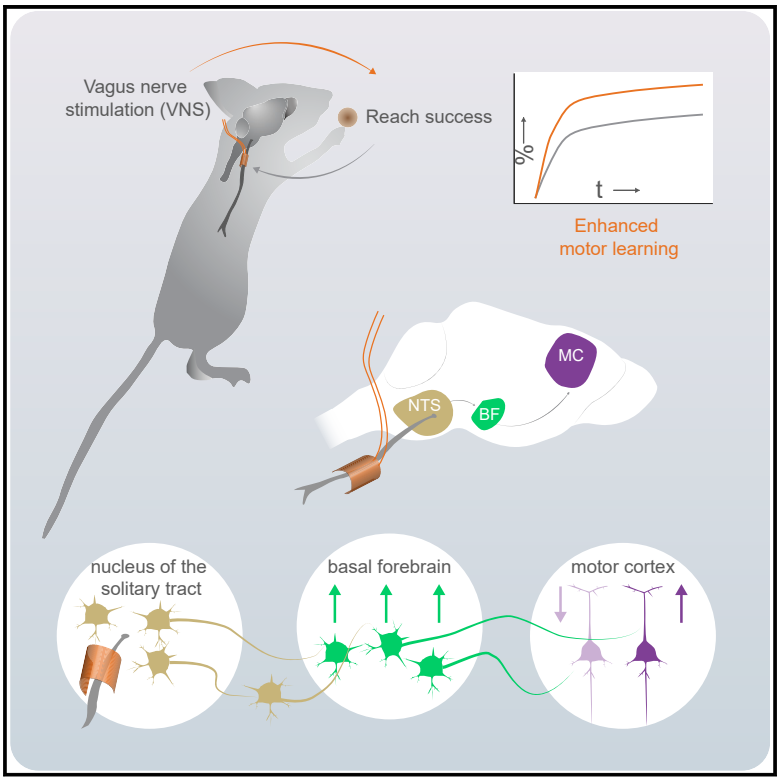
Conflict of Interest Statement: YL is an employee of SetPoint Medical Corporation, a company that is developing bioelectronic devices to target the vagus nerve in humans.

The remaining authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Neuron

Vagus nerve stimulation drives selective circuit modulation through cholinergic reinforcement

Graphical abstract



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In brief

Stimulation of the vagus nerve paired with behavior has been shown to enhance rehabilitation following neurologic injury, but the mechanism remains unknown. Bowles, Hickman, Peng et al. demonstrate that VNS applied after a successful reach improves skilled motor learning via a cholinergic reinforcement mechanism, resulting in selective modulation of M1 neurons.

Highlights

- VNS paired with success enhances skilled motor learning in healthy animals
- Enhanced motor performance is due to accelerated consolidation of an expert motor plan
- Enhanced motor learning depends on cholinergic neural activity in the basal forebrain
- In primary motor cortex, VNS specifically modulates outcome-activated neurons

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Article

Vagus nerve stimulation drives selective circuit modulation through cholinergic reinforcement

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SUMMARY

Vagus nerve stimulation (VNS) is a neuromodulation therapy for a broad and expanding set of neurologic conditions. However, the mechanism through which VNS influences central nervous system circuitry is not well described, limiting therapeutic optimization. VNS leads to widespread brain activation, but the effects on behavior are remarkably specific, indicating plasticity unique to behaviorally engaged neural circuits. To understand how VNS can lead to specific circuit modulation, we leveraged genetic tools including optogenetics and *in vivo* calcium imaging in mice learning a skilled reach task. We find that VNS enhances skilled motor learning in healthy animals via a cholinergic reinforcement mechanism, producing a rapid consolidation of an expert reach trajectory. In primary motor cortex (M1), VNS drives precise temporal modulation of neurons that respond to behavioral outcome. This suggests that VNS may accelerate motor refinement in M1 via cholinergic signaling, opening new avenues for optimizing VNS to target specific disease-relevant circuitry.

INTRODUCTION

Vagus nerve stimulation (VNS) is currently used in clinical care to treat epilepsy (Ben-Menachem et al., 1994; The Vagus Nerve Stimulation Study Group, 1995) and depression (Rush et al., 2005), but novel stimulation paradigms may treat a growing range of neurologic injuries (Dawson et al., 2021; Shi et al., 2013; Tyler et al., 2017). Recently, VNS paired with motor rehabilitation was approved by the Food and Drug Administration (FDA) for the treatment of motor deficits associated with stroke (Dawson et al., 2021). Preclinical and early clinical studies suggest that other paired-VNS paradigms can accelerate functional recovery from neurologic conditions including spinal cord injury, peripheral nerve injury, and traumatic brain injury (Ganzer et al., 2018; Meyers et al., 2019; Pruitt et al., 2016). Despite the wide-ranging etiology of these conditions, the therapeutic model is similar: VNS is paired with a relevant rehabilitation protocol. It is hypothesized that precise timing of stimulation drives targeted circuit plasticity for recovery (Kimberley et al., 2018; Tyler et al., 2017). However, the lack of a clear circuit mechanism limits optimization of VNS therapy to treat neurologic injury.

The circuitry that mediates the effects of VNS on central nervous system plasticity remains poorly understood. Vagus nerve afferents terminate in the brainstem nucleus tractus solitarius (NTS) (Krahl et al., 1998), and NTS projects to subcortical and cortical brain regions, including neuromodulatory nuclei (Beaumont et al., 2017; Collins et al., 2021; Hulsey et al., 2017). Lesions of neuromodulatory centers, including the cholinergic basal forebrain (BF), limit both VNS-driven cortical map plasticity (Hulsey et al., 2016, 2019) and functional rehabilitation after peripheral nerve damage (Meyers et al., 2019). In addition, the cholinergic BF has been indicated as necessary for motor learning (Conner et al., 2010), and phasic cholinergic signals are thought to play critical roles in reinforcement learning and outcome representation (Hangya et al., 2015; Zhang et al., 2019). Together, these data suggest a possible role for phasic cholinergic signaling in mediating the effects of VNS-driven learning.

Paired-VNS drives expansion of the cortical map for the associated sensory(Borland et al., 2016) or motor representation (Porter et al., 2012). However, map expansion is delayed relative to changes in behavior and does not always correlate to improved performance (Reed et al., 2011). To achieve the improvements in motor and sensory learning, VNS must also influence neural activity and plasticity on shorter, behaviorally relevant timescales. Electrophysiological (Chase et al., 1966; Fraschini et al., 2013; Usami et al., 2013) and *in vivo* imaging studies (Collins et al., 2021) have identified broad, excitatory effects of VNS across multiple cortical regions. However, this

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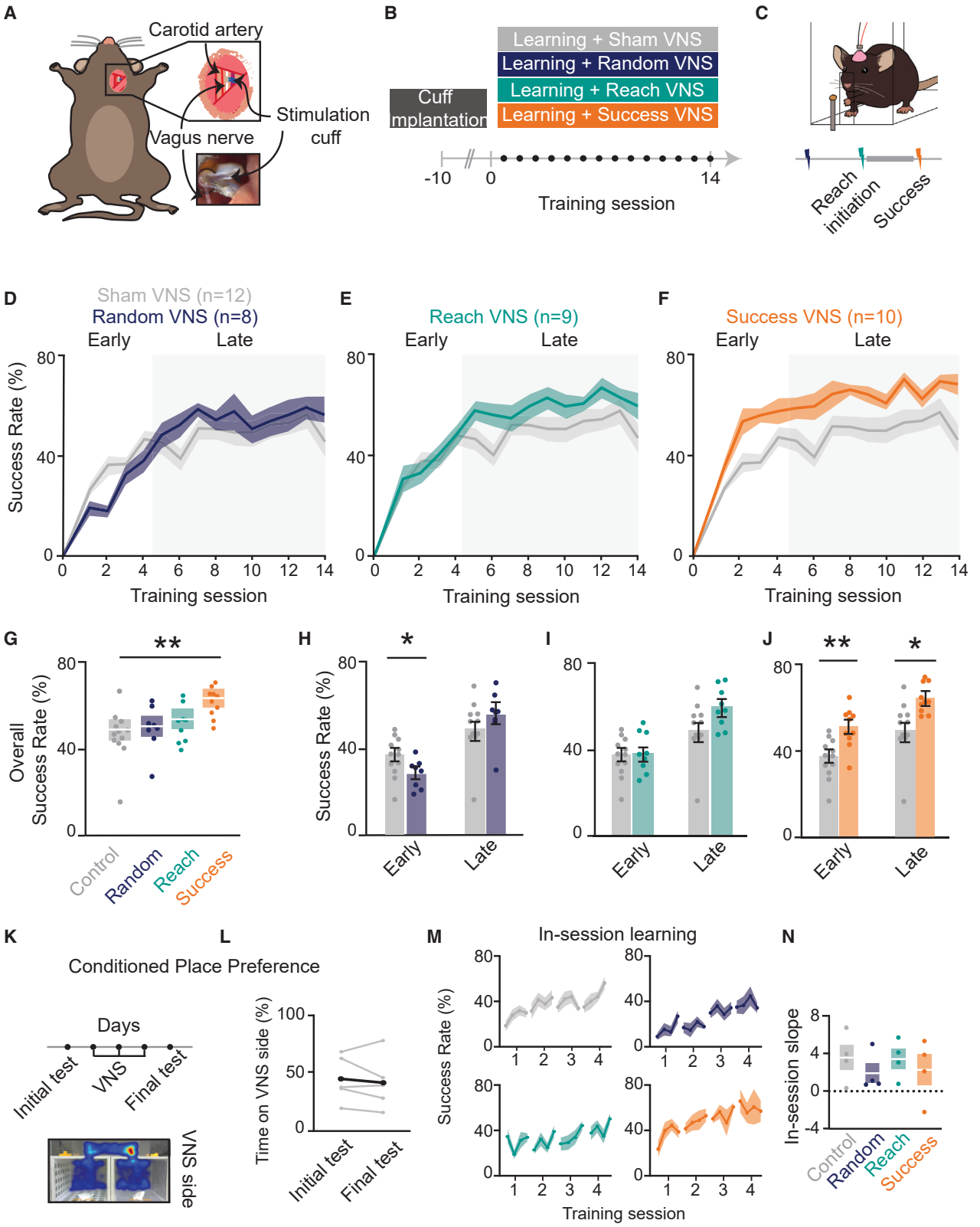

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non-specific alteration in excitatory drive cannot account for the selectivity of paired-VNS stimulation, which requires a specific refinement of relevant cortical circuits (Ganzer et al., 2018).

To understand the mechanism by which VNS selectively modulates neural circuits to optimally enhance motor behavior, we compared the effect of VNS timing on skilled reach learning in mice and probed the underlying circuit using optogenetic cholinergic circuit manipulation, kinematic analysis, and *in vivo* calcium imaging in the motor cortex. Paired-VNS-enhanced skilled reach learning, but only when applied after a successful reach (Success VNS). Improved reach performance was explained by accelerated consolidation of reach trajectory onto an expert trajectory, indicating earlier and more effective motor learning. Cholinergic neural activity in the BF was required for the effects of VNS on motor learning and reach kinematics. VNS altered specific neural populations relevant to outcome representation in the primary motor cortex, and the effects of VNS in M1 were mitigated by cholinergic antagonists. These results indicate that VNS enhances motor learning through precisely timed phasic cholinergic signaling to reinforce outcome, resulting in the recruitment of specific, behaviorally relevant cortical circuits.

RESULTS

VNS enhances skilled motor learning when paired with successful task outcome

To induce motor rehabilitation and cortical plasticity, VNS must be paired with movement (Engineer et al., 2011; Porter et al., 2012); however, an optimal pairing protocol has not been identified (Ganzer et al., 2018). To determine the optimal timing of VNS during skilled motor learning, we applied multiple VNS pairing protocols as mice learned a skilled forelimb reaching task (Whishaw et al., 2008). Using a newly developed chronic VNS approach for mice (Mughrabi et al., 2021), we implanted a microfabricated stimulation cuff on the left cervical vagus nerve (Figure 1A), connected to a skull-mounted headcap. Mice were trained to perform the skilled reach task, where they learn to reach through a slit to grab a food pellet off a post, for 14 days (Figures 1B and 1C).

We explored three possible mechanisms by which VNS could influence motor learning: arousal, spike-timing dependent plasticity, and reinforcement (Figures 1B and 1C; see STAR Methods). To test if VNS drives plasticity by increasing widespread cortical excitation and arousal (Collins et al., 2021; Groves and Brown, 2005; Narayanan et al., 2002), VNS was applied at pseudo-random intervals (Random VNS) during the 20-min training session. To determine if VNS acts through modulation of short-term attention or by influencing spike-timing-dependent plasticity (Feldman, 2012), VNS was applied at the initiation of a subset of reach movements (Reach VNS). To explore if VNS may augment reward or reinforcement related to movement outcome (Dayan and Balleine, 2002; Leong et al., 2017), VNS was applied after successful reach completion (Success VNS). The surgical control cohort was implanted with stimulation cuffs and connected to a stimulation isolation unit that was turned "off" (Sham VNS). To ensure that each VNS group received a similar number of stimulation pulses, the mean stimulation pulse number per session was calculated for a small cohort of Success VNS animals, and then applied to the experimental design of the Random and Reach VNS groups (STAR Methods). A post-hoc analysis of stimulation pulse number demonstrated that Random VNS received ~2 additional stimulation pulses per session (17.90 ± 0.92) than Reach VNS (15.75 ± 1.75) and Success VNS (15.96 ± 1.68) (Random-Reach: $p = 0.021$, Random-Success: $p = 0.005$, Tukey honestly significant difference; Figure S1A). However, the amount of stimulation delivered did not correlate with success across groups (Figure S1B) or within groups (Figure S1C), suggesting that the additional pulses did not influence reach learning or performance. Animals in all cohorts learned to perform the skilled reach task (Sham VNS: $p = 0.0001$, Random VNS: $p = 0.0001$, Reach VNS: $p = 0.0002$, Success VNS: $p = 0.001$; Figure S2B). Neither Random nor Reach VNS altered the success rate of the animals relative to Sham VNS (Random VNS: 47.4% ± 3.9%; Reach VNS: 53.6% ± 3.5%; Sham VNS: 46.3% ± 3.2%; Figures 1D, 1E, and 1G). However, Success VNS improved the overall success rate compared with Sham VNS (59.2% ± 3.1% versus 46.3% ± 3.2%; Figures 1F and 1G), demonstrating that paired VNS can enhance motor learning in healthy animals.

Prior work on learning of a skilled reach suggests a multiphasic approach to learning, with distinct early and late learning phases (Padmashri and Dunaevsky, 2019; Peters et al., 2017). However, the timing of early to late transition has not been empirically demonstrated. Using a Weibull growth curve nonlinear model of the control learning curve, we identified an inflection point (55.49% ± 6.81%) to determine early learning (days 1–4) and late learning (days 5–14; Figure S2A). We next examined if VNS exerted distinct effects during different learning stages. Despite

Figure 1. VNS modulates forelimb reach learning and requires temporally specific stimulation

(A) VNS surgical approach.

(B) Behavior timeline.

(C) Stimulation protocol, with Reach and Success VNS applied before and after reach, respectively.

(D–F) Random VNS, Reach VNS, and Success VNS success rate across 14 sessions of training.

(G) Comparison of mean performance across all days between control and stimulated groups (Success VNS: $p = 0.0065$, $f = 9.24$, Random VNS: $p > 0.05$, Reach VNS: $p > 0.05$, REML). Shaded boxes denote SEM.

(H) Comparison of mean success rate for control and Random VNS mice during early ($p = 0.028$, $f = 7.07$, Student t test) and late learning ($p > 0.05$).

(I) Comparison of mean success rate for control and Reach VNS mice during early and late learning ($p > 0.05$).

(J) Comparison of mean success rate for control and Success VNS mice during early ($p = 0.0031$) and late learning ($p = 0.0126$).

(K and L) VNS mice performed a conditioned place preference test after 3 days being stimulated in one of two distinct rooms.

(M) In-session learning trajectories for each group.

(N) Comparison of within-session learning between all groups across 4 days of learning.

In all figures, *$p < 0.05$, **$p < 0.01$, ***$p < 0.001$ bars and error bars represent the mean ± SEM.

having no effect on the overall success rate, Random VNS impaired early learning (27.3% ± 7.3% versus 37.4% ± 8.9%), but performance recovered during late learning (Figure 1H). Reach VNS had no influence on success rates at any phase of learning (Figure 1I). Success VNS increased success rates during the early and late phases (Early: 50.6% ± 9.4% versus 37.4% ± 8.9%; Late: 63.6% ± 6.9% versus 49.6% ± 13.2%; Figure 1J). To determine if Success VNS improved learning above the other stimulation protocols (Random or Reach VNS) we compared these groups during early and late learning. During early learning, Success VNS increases success rate compared with Random and Reach VNS, and Random VNS has a lower success rate than Reach VNS (Random VNS: 27.3% ± 7.3%, Reach VNS: 38.0% ± 9.3%, Success VNS: 50.6% ± 9.4%; Figure S2C). In contrast, during late learning, there were no differences across stimulation groups (Figure S2C). These data suggest that VNS paired with a successful outcome accelerates learning, whereas random VNS temporarily impairs early learning. Moreover, during early learning, Success VNS outperforms Reach and Random VNS, whereas in late learning, differences between VNS protocols are not significant, suggesting the timing of VNS is critical during early learning but more flexible in late learning.

Only Success VNS enhanced motor learning, indicating a mechanism contingent on successful outcomes, likely reward or reinforcement. To determine if VNS serves as a rewarding or aversive stimulus (Wickens et al., 2003), we used the conditioned place preference (CPP) test (Figure 1K). Implanted mice were introduced to two rooms with distinct visual and olfactory cues, with VNS applied in only one room for several days. On the final day probe session, mice spent equal time in the conditioned room as they did in their initial naive session (44.8% ± 2.0% and 41.4% ± 2.3%; Figure 1L), indicating that VNS is not inherently rewarding or aversive. Together, these results suggest that Success VNS may act by augmenting reinforcement cues but not serve as a rewarding stimulus.

To determine if VNS alters within-session learning or between-session learning (Censor et al., 2012), training session data were grouped into 4 blocks of 5 trials each (Figures 1M and 1N), and the within-session learning slope was quantified over the first 4 days (Figure 1O). The within-session learning slope was not significantly different between conditions, suggesting that Success VNS likely enhances between-session learning.

VNS confers short-term performance benefits during the execution of learned tasks

To further confirm the behavioral results were due to learning and not short-term modulation of attention, we compared the success rate of trials that immediately follow a stimulation (post-success) with those immediately prior (pre-success). We found no effect of VNS on the success rate of trials following stimulation (Figures 2A and 2B). We next compared the response to Success VNS with an unstimulated probe trial block included on days 7 and 14 (Figure 2C). On day 14, the success rate for unstimulated trials was greater than Sham VNS (61.9% ± 6.3% versus 46.6% ± 9.2%; Figure 2D), suggesting that Success VNS led to stimulation-independent, lasting learning. However, success rate during stimulated blocks was greater than unstimulated blocks on day 14 (69.7% ± 10.2% and 61.9% ± 6.3%), but not day 7 (Figure 2E), implying an additional short-term performance benefit that emerges during late learning.

To further explore potential short-term benefits of VNS, we performed subgroup analysis of only stimulated or unstimulated reaches in the Reach VNS group (Figure 2F). During late learning, the success rate of stimulated trials, but not unstimulated trials, is greater than sham (64.0% ± 9.4% versus 50.8% ± 13.7%; Figure 2H; Figure S2D). Paired analysis for individual animals shows a higher success rate for stimulated trials compared with unstimulated trials in both the early and late phases (Early: 41.9% ± 10.2% versus 35.3% ± 9.7%; Late: 64.0% ± 9.4% versus 53.7% ± 9.5%; Figure 2I). Taken together, Reach VNS provides a short-term performance boost for stimulated trials throughout learning. Similar to Success VNS (Figure 2E), Reach VNS most effectively modulates short-term performance for during late learning.

To explore if this generalizes to tasks that are already known (learned without VNS), we applied paired VNS to animals already proficient in the skilled reaching task (Figure 2J). Both Success VNS (Figures 2L and 2M) and Reach VNS (Figures 2K and 2M), delivered on alternate days for 10 days, improved performance over trial blocks without VNS (Success VNS: 46.0% ± 8.5% versus 40.8% ± 8.9%; Reach VNS: 49.0% ± 10.2% versus 38.8% ± 9.5%), confirming that either pairing protocol is sufficient to modulate the short-term performance of a known task. This demonstrates that VNS confers short-term enhancement to performance of known motor skills.

VNS drives neural activity in the BF

Cholinergic neuromodulation is associated with reinforcement-driven plasticity (Guo et al., 2019; Hangya et al., 2015) and is required for motor learning (Kucinski et al., 2019; Ramanathan et al., 2009, 2015). The BF is the source of cortically projecting cholinergic neurons (Gielow and Zaborszky, 2017); however, it was unknown if BF neurons respond to VNS. To address this question, we implanted tetrodes into the BF of mice with implanted VNS cuffs (Figure 3A). Extracellular activity was recorded during VNS in awake animals in their home cage (30 Hz, 0.6 mA, 100-μs pulse, 500-ms train). VNS modulated the firing rate of BF neurons (Figures 3B and 3C), with altered activity in 43% of recorded units, and increased activity in 61% of those units (Figure 3D). On average, the firing rate modulation of activated neurons began during the stimulation train (200 ms after stim onset) and persisted for ∼1 s after stimulation ended (Figure 3E).

To identify cholinergic neurons from the multiple cells types found within the BF (Do et al., 2016), we used an opto-tagging approach (Lima et al., 2009) combined with tetrode recordings to interrogate their response to VNS. Acute recordings were performed in anesthetized *ChAT-ChR2* transgenic mice (B6.Cg-Tg(Chat-COP4*H134R/EYFP,Slc18a3)6Gfng/J; Figure 3F). Cholinergic neurons were identified by their rapid response to light (Figures 3G and 3H) and confirmed using stimulus-associated latency test (SALT) analysis (Hangya et al., 2015) (latency 5.2 ± 1.3 ms; Figure 3I). Cholinergic neurons exhibited a lower baseline firing rate (3.4 ± 2.1 Hz) than the non-cholinergic population (6.8 ± 6.2 Hz; Figure 3J). Of 76 units, roughly

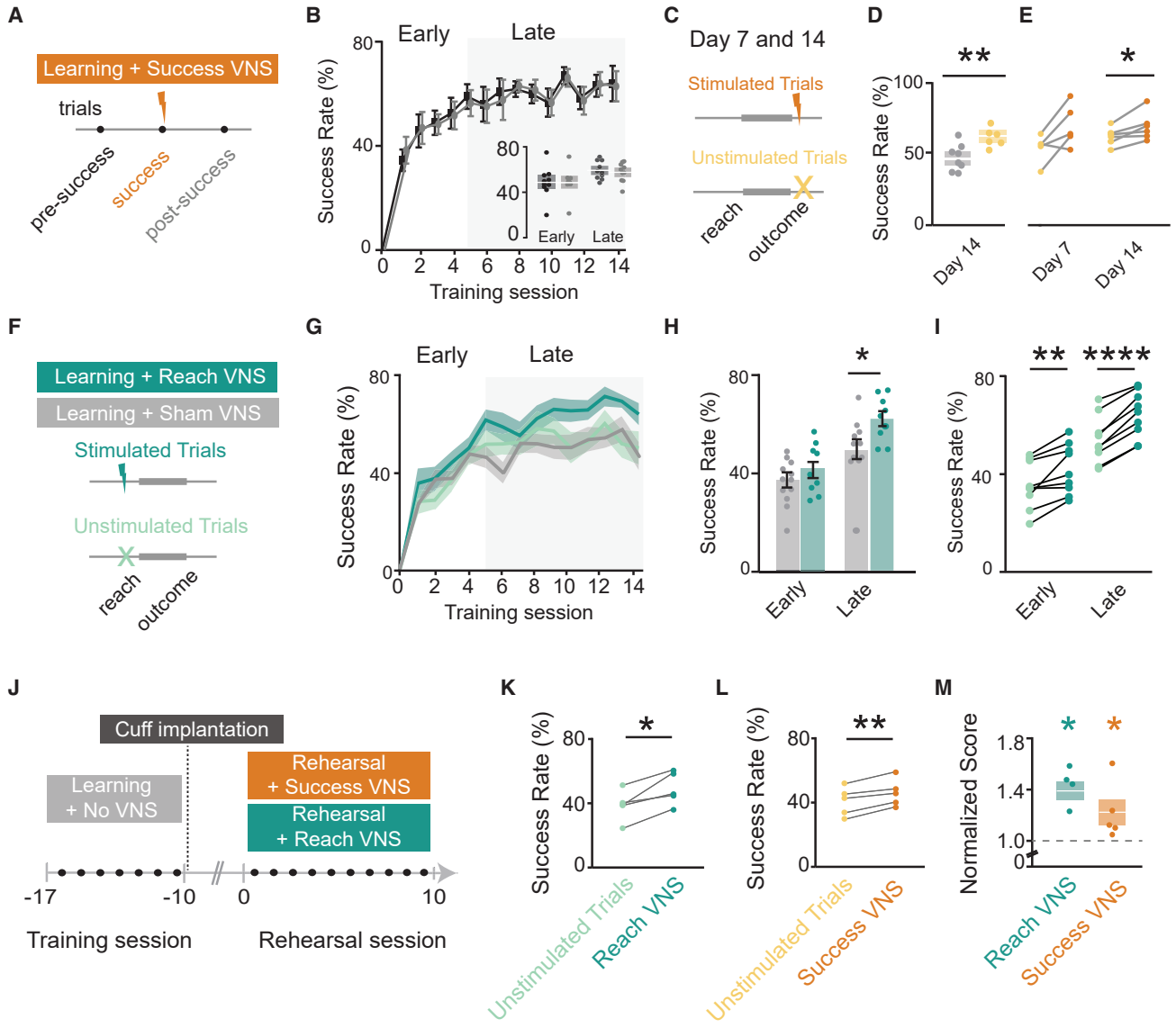


Figure 2. VNS improves success rate within sessions and in learned mouse during rehearsal of forelimb reach task

(A) Trials before and after a stimulated success are investigated in Success VNS.

(B) Comparison of success rate for reaches preceding or following stimulated reach.

(C) For Success VNS, days 7 and 14 trials are divided into equal blocks of unstimulated and stimulated trials.

(D) Comparison of unstimulated (light orange) and sham (gray) trials on day 14 ($p = 0.0059$, $t = 3.34$, Student's t test).

(E) Comparison of stimulated (dark orange) and unstimulated (light orange) trials on days 7 and 14 (day 7: $p > 0.05$; day 14: $p = 0.0499$, $t = 2.57$, ratio paired t test).

(F) Reach VNS schematic.

(G) Success rates across training sessions for sham (gray), stimulated Reach VNS (dark green), and unstimulated Reach VNS (light green).

(H) Comparison of stimulated Reach VNS and Sham VNS trials in early ($p > 0.05$) and late learning ($p = 0.024$, $t = 2.47$, Student's t test).

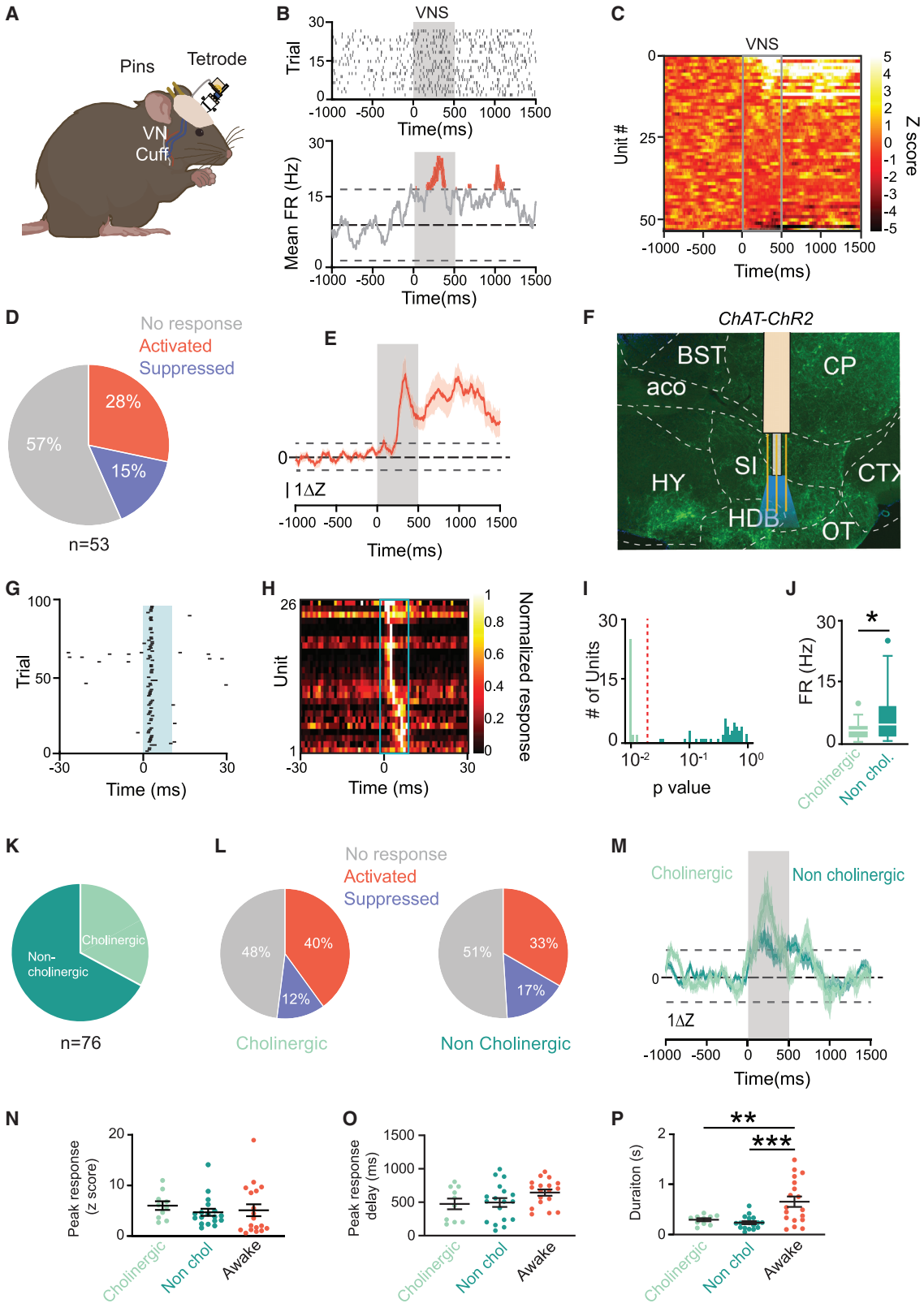
(I) Comparison between stimulated Reach VNS and unstimulated Reach VNS trails in early ($p = 0.004$, $t = 3.98$, paired t test) and late learning ($p < 0.0001$, $t = 10.08$, paired t test).

(J) Success VNS and Reach VNS applied during rehearsal of reach task in trained mice.

(K) Stimulated Reach VNS trials improve success rate during rehearsal ($p = 0.015$, $t = 4.058$, paired t test).

(L) Stimulated Success VNS trials improve success rate during rehearsal ($p = 0.005$, $t = 5.62$, paired t test).

(M) Normalized improvement of stimulated Reach VNS ($p = 0.047$, $t = 3.56$) and stimulated Success VNS trials ($p = 0.028$, $t = 4.16$) compared with unstimulated trials (Sidak's multiple comparison's test in RM one-way ANOVA).



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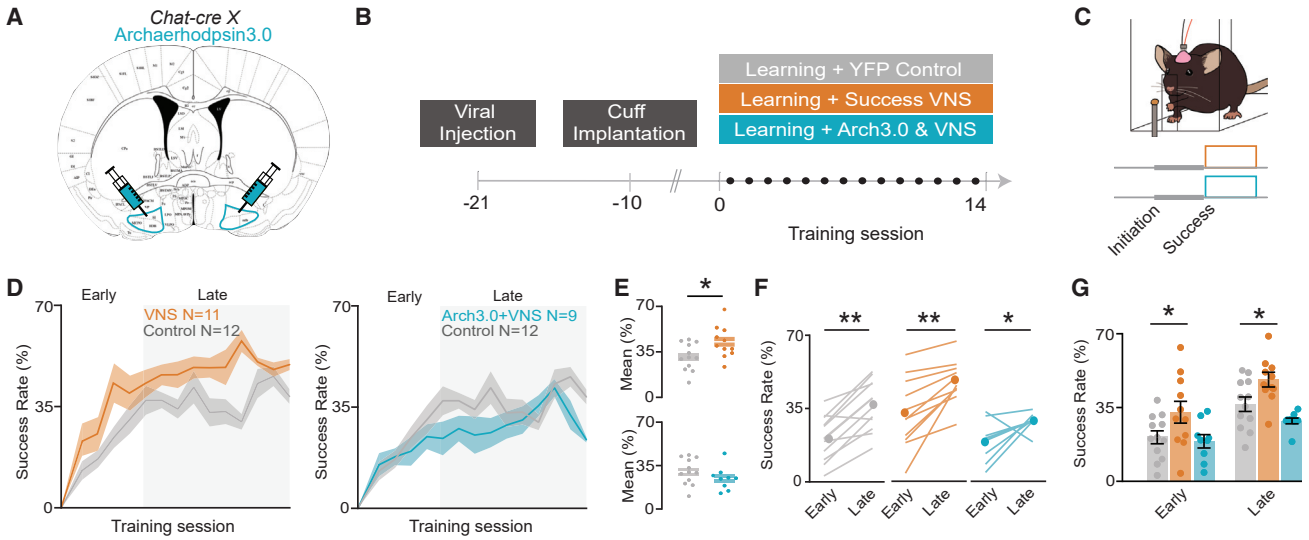


Figure 4. Success-paired VNS motor learning enhancement requires cholinergic neuromodulation

(A) A subset of VNS-implanted *ChAT-Cre* transgenic mice received injections of viral constructs containing Archaerhodpsin3.0 in the BF.

(B) Timeline of experimental setup and training. Each training session lasts for 20 min.

(C) Depending on cohort, mice receive VNS, or continuous 532 nm light and VNS simultaneously, after successful reach attempts.

(D) Average success rate for all mice over the course of learning (VNS N = 11, Arch+VNS N = 9, control N = 12).

(E) Mean performance across all days between VNS and control ($p = 0.0409$, top) and Arch+VNS and control ($p > 0.05$, bottom).

(F) Mean success rate of all groups between early and late phases (control $p = 0.0001$, VNS $p = 0.0009$, Arch VNS $p = 0.0379$).

(G) Mean success rate for control and VNS mice during early ($p = 0.0458$) and late ($p = 0.0001$) learning phases and control and Arch+VNS mice ($p > 0.05$).

1/3 were cholinergic (Figure 3K) and half of both neuron populations were VNS-responsive (52% of cholinergic, 49% of non-cholinergic; Figure 3L). Of the VNS-responsive units, most cholinergic units and non-cholinergic units showed increased activity (Figure 3M), suggesting that VNS increases activity in cholinergic and non-cholinergic BF neurons.

A comparison of VNS-driven activation in anesthetized and awake recordings suggests that VNS response depends on arousal state (Figures 3E and 3M), consistent with prior findings (Collins et al., 2021). Although the peak response magnitude and timing to VNS do not change between awake and anesthetized animals (Figures 3N and 3O), awake animals have a longer response than anesthetized animals (awake: 652.7 ± 439 ms; cholinergic: 293.7 ± 94 ms; non-cholinergic: 235.8 ± 127 ms; Figure 3P).

Optogenetic cholinergic inhibition prevents VNS-enhanced motor learning

Having established that VNS can drive BF cholinergic neurons, we next wanted to determine if these neurons mediate the effects of VNS on enhanced motor learning. To do so, we used optogenetic control to silence cholinergic neurons during VNS. An inhibitory opsin (AAV-EF1a-DIO-eArch3.0-EYFP) was injected into the BF of *ChAT-Cre* transgenic mice, followed by implanted optical fibers and VNS cuffs (see STAR Methods; Figure 4A). Mice then learned to perform the skilled reach task (Figure 4B) and either

Figure 3. VNS drives BF neural activity in anesthetized and awake mice

(A) Schematic of experimental setup.

(B) Example raster (top) and average firing rate from a response to VNS. Gray box denotes stimulus delivery.

(C) Average responses of all recorded neurons to VNS (gray box).

(D) Percent of neurons that respond to VNS (N = 5 mice, n = 53 neurons).

(E) Average activity of all "activated" neurons in response to VNS. Dashed lines mark significance, shading represents SE.

(F) Recordings with optrodes were targeted at the horizontal diagonal band of Broca (HDB) in *ChAT-ChR2* transgenic mice under light anesthesia. Green fluorescence denotes the presence of ChR2.

(G) Example cholinergic neuron responding consistently to pulses of 488 nm light.

(H) Average activity of all cholinergic neurons during opto-tagging. Each row represents a neuron.

(I) Stimulus-associated latency tests (SALTs) separate light responsive neurons from non-light responsive neurons.

(J) Mean baseline FR of cholinergic and non-cholinergic neurons ($p = 0.013$, N = 5 mice, 53 neurons).

(K) Percent of neurons categorized as cholinergic (light green) and non-cholinergic (dark green) (N = 6 mice, n = 76 neurons).

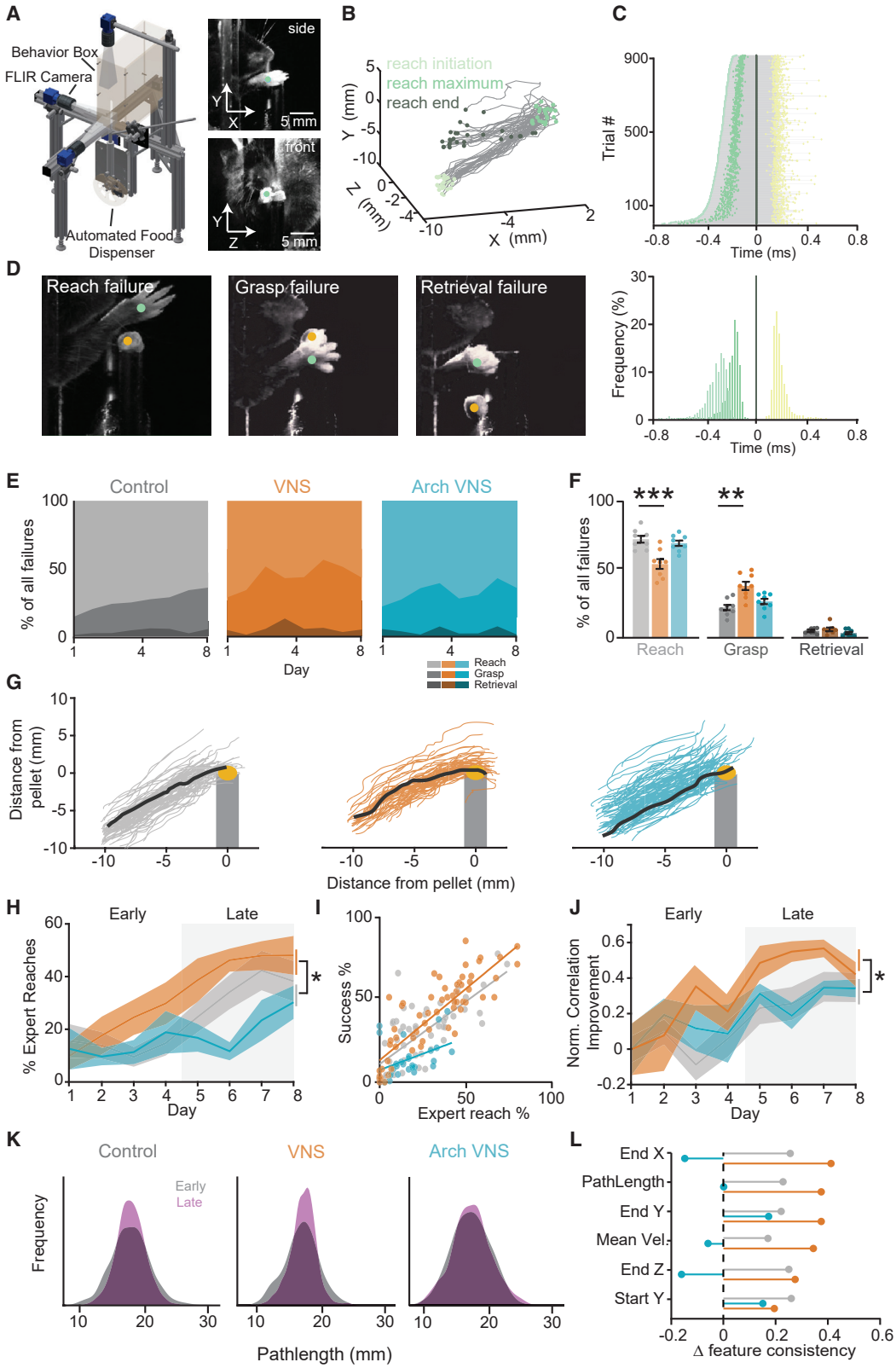
(L) Percent of units that are VNS-responsive in cholinergic (left) and non-cholinergic (right) populations.

(M) Average response to VNS for all "activated" neurons.

(N) Mean peak activation during VNS.

(O) Average delay of peak activation from VNS onset.

(P) Mean duration of significantly elevated activity after VNS (cholinergic versus awake, $p = 0.0087$, non-cholinergic versus awake, $p = 0.0003$).



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received Success VNS, Success VNS with simultaneous optical inhibition cholinergic neurons (Arch+VNS) or no stimulation (Figure 4C). VNS animals (40.55% ± 7.1%) performed significantly better than controls (31.23% ± 10.4%), whereas Arch+VNS animals performed at control levels (25.59% ± 9. 3%; Figures 4D and 4E). Although all cohorts learned the task (Figure 4F), cholinergic inhibition prevented VNS-driven performance increases in both learning phases (Early: 19.02% ± 9.5%; Late: 28.66% ± 4.1%) compared with VNS mice (Early: 32.81% ± 17.1%; Late: 48.28% ± 11.6%; Figure 4G), demonstrating that phasic cholinergic signaling is necessary for VNS-enhanced motor learning.

VNS reduces off-target failures through increased reach consistency

To further explore how VNS influences skilled reach, we measured the kinematic features of the reach across learning and conditions. To obtain accurate kinematic measures, we designed a custom closed-loop automated reaching apparatus (CLARA) (Bowles et al., 2021; Figures 5A–5C). Individual reach trial outcomes were categorized into one of four categories: success, reach failures, grasp failures, and retrieval failures (Figure 5D). Of all errors, Success-VNS mice made fewer reach failure errors than control and Arch+VNS mice (VNS: 54.14% ± 10.4%; Control: 72.16% ± 7.0%; Arch+VNS: 71.66% ± 4.5%), and more on-target grasp errors (VNS: 38.19% ± 9.2%, Arch+VNS: 24.00% ± 4.8%, Control: 22.14% ± 6.0%; Figures 5E and 5F), implying an improved accuracy in reach trajectory. Therefore, we explored if VNS drives a speed/accuracy trade-off (Shmuelof et al., 2012). We measured reach endpoint accuracy and outward reach velocity (see STAR Methods; Figures S3A and S3B) but found that Success VNS does not alter endpoint accuracy or speed of reach attempts (Figure S3C).

As animals learn the skilled reach task, their reach trajectories become more similar to their final expert reach trajectory (Kawai et al., 2015; Peters et al., 2017) as they learn a successful motor plan. To determine if VNS can influence motor plan selection, an expert trajectory was defined for each mouse based on the average successful reach trajectory over the last 2 days of training (see STAR Methods; Figure 5G). Expert reaches were identified by having a >0.95 correlation with the expert trajectory. On day 1 of training, all cohorts have similar percentage of expert reaches (Figure 5I; Figure S3D), but during late learning, VNS mice made more expert reaches compared with control mice (VNS: 45.22% ± 4.4%; Control: 34.22% ± 6.6%), whereas cholinergic inhibition prevented this increase in expert reach selection (23.58% ± 6.2%; Figure 5H). Expert reach attempts correlate strongly with behavioral performance ($p = 0.0001$, $R^2 = 0.621$; Figure 5I). VNS also shapes the trajectory of reaches that end in failure. Although reach failures rarely qualify as expert reaches (Figure S5E), VNS increases the correlation of reach failures to the expert trajectory during late learning to a greater degree than control mice, and cholinergic inhibition prevents this increase (VNS: 50.18 ± 16.6; Control: 29.65 ± 19.9; Arch+VNS: 33.19 ± 11.6; Figure 5J). Additional kinematic features also show a VNS-driven increase of the consolidation between early and late phases (Figures 5K and 5L), indicating increased stereotypy in the VNS cohort reach. These data suggest that VNS drives all reaches closer to the expert reach trajectory, enhancing the selection of a successful motor plan, and this is mediated by cholinergic signaling.

VNS drives acute neural suppression and activation in motor cortex

VNS paired with forelimb movement alters motor cortical map plasticity (Porter et al., 2012), but the effect of VNS on neuronal function in motor cortex is unknown. Given that neural activity in M1 is required for both motor skill learning and execution (Guo et al., 2015; Kawai et al., 2015; Figure S4A), we hypothesize that VNS will modulate the neural activity and movement representation in M1. To investigate the effects of VNS on M1 neural activity, we imaged activity in neurons expressing the calcium indicator GCaMP6m using a head-mounted miniature microscope (UCLA miniscope V3, http://miniscope.org; Figure 6A).

In response to VNS applied in the homecage, some neurons demonstrated either activation (red, cell 25; Figure 6B) or suppression (blue, cell 36; Figure 6B), without a change in the overall firing rate of the neuron population (Figures S5A and S5B). Approximately 30% of all neurons showed acute response to a VNS delivery, with similar percentages of neurons showing activation and suppression (activation: 13.8% ± 5.8%; suppression: 18.1% ± 15.8%; Figure 6D), and only a small fraction (0.7% ± 1.4%) showing bidirectional modulation (Figure 6D). The

Figure 5. VNS improves performance through improved consolidation of reach trajectory

(A) The closed-loop automated reaching apparatus (CLARA) provides 3D tracking of the paw and pellet.

(B) Example trajectories and automatically generated reach events (one control session).

(C) Top: duration of all stimulated control trials, yellow dot denotes stimulus delivery (180 ± 5 ms). Bottom: a histogram of reach timepoints normalized to reach end.

(D) Example images of the subcategories of failed reaches (see STAR Methods).

(E) Breakdown of failure outcomes for each group over 8 days of learning. Light colors: reach failures; intermediate: grasp failures; dark: retrieval failures.

(F) A comparison of types of failed attempts between control and VNS (reach errors: $p = 0.0005$; grasp errors: $p = 0.0035$) and between control and Arch+VNS mice ($p > 0.05$, VNS N = 8, Arch+VNS N = 8, control N = 8).

(G) Examples outward trajectories during a session on day 8. Black lines represent each mouse's "expert reach."

(H) Percent of expert reaches. Comparisons were made for the mean "expert" reaches in the late learning phase (gray box) between control and VNS mice ($p = 0.0142$) and control and Arch+VNS mice ($p > 0.05$, VNS N = 8, Arch+VNS N = 6, control N = 8).

(I) Correlation of expert reaches and task performance for all mice, $R^2 = 0.62$.

(J) Improvement in reach failures toward an expert trajectory (normalized to day 1). Comparisons were made during late learning between control and VNS mice ($p = 0.0455$) and control and Arch+VNS mice ($p > 0.05$).

(K) Distribution of trajectory lengths from all failure attempts during early (gray) and late (purple) learning phases.

(L) Normalized improvement in reach features from early to late learning phases.

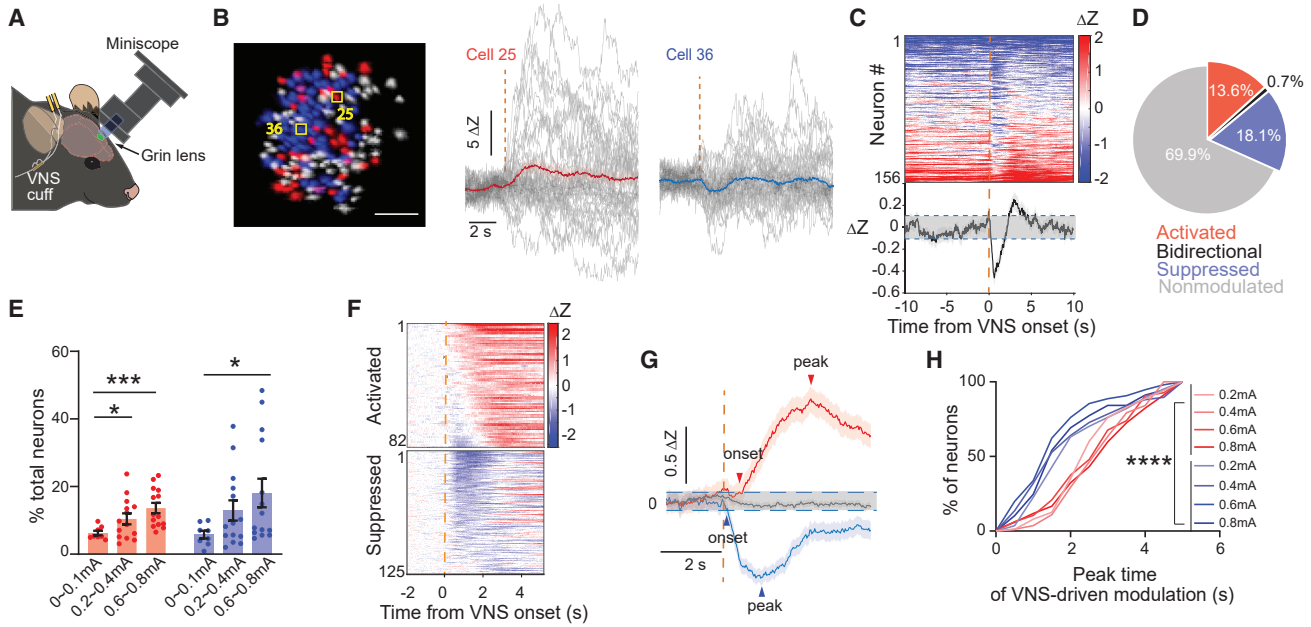


Figure 6. VNS drives acute neural suppression and activation in forelimb motor cortex

(A) Schematic of experiment design.

(B) Left: representative neural ROIs from the field of view of one mouse M1 (n = 156 neurons): VNS-activated (red) and suppressed (blue), scale bars, 100 μm. Middle and right: representative neurons' Ca^{2+} responses aligned by VNS onset (gray: individual trials; red: VNS-activated; blue: VNS-suppressed).

(C) Top: individual neurons' average response *Z* scored to inactive phases of all neurons from the representative mouse in (B); bottom: average neural responses of all neurons from the same mouse.

(D) Average percent of total neurons activated, suppressed, bidirectionally modulated after 0.6–0.8 mA VNS delivery (N = 7 mice, 767 neurons).

(E) Percent of total neurons that are activated or suppressed by VNS across different current amplitudes. (N = 7 mice, n = 747–807 neurons, one-way ANOVA and multiple group comparison to 0–0.1-mA group).

(F) Neural response heatmap of all activated neurons and all suppressed neurons aligned at VNS onset.

(G) Average neural activity of all activated neurons and all suppressed neurons aligned at VNS onset (N = 7 mice, 82 activated, 125 suppressed, 0.6 mA VNS).

(H) Cumulative distribution of neural response peak time of activated and suppressed neurons (see STAR Methods, 82–151 neurons from each group, Kruskal-Wallis test followed by Dunn's multiple comparisons test, $p < 0.0001$).

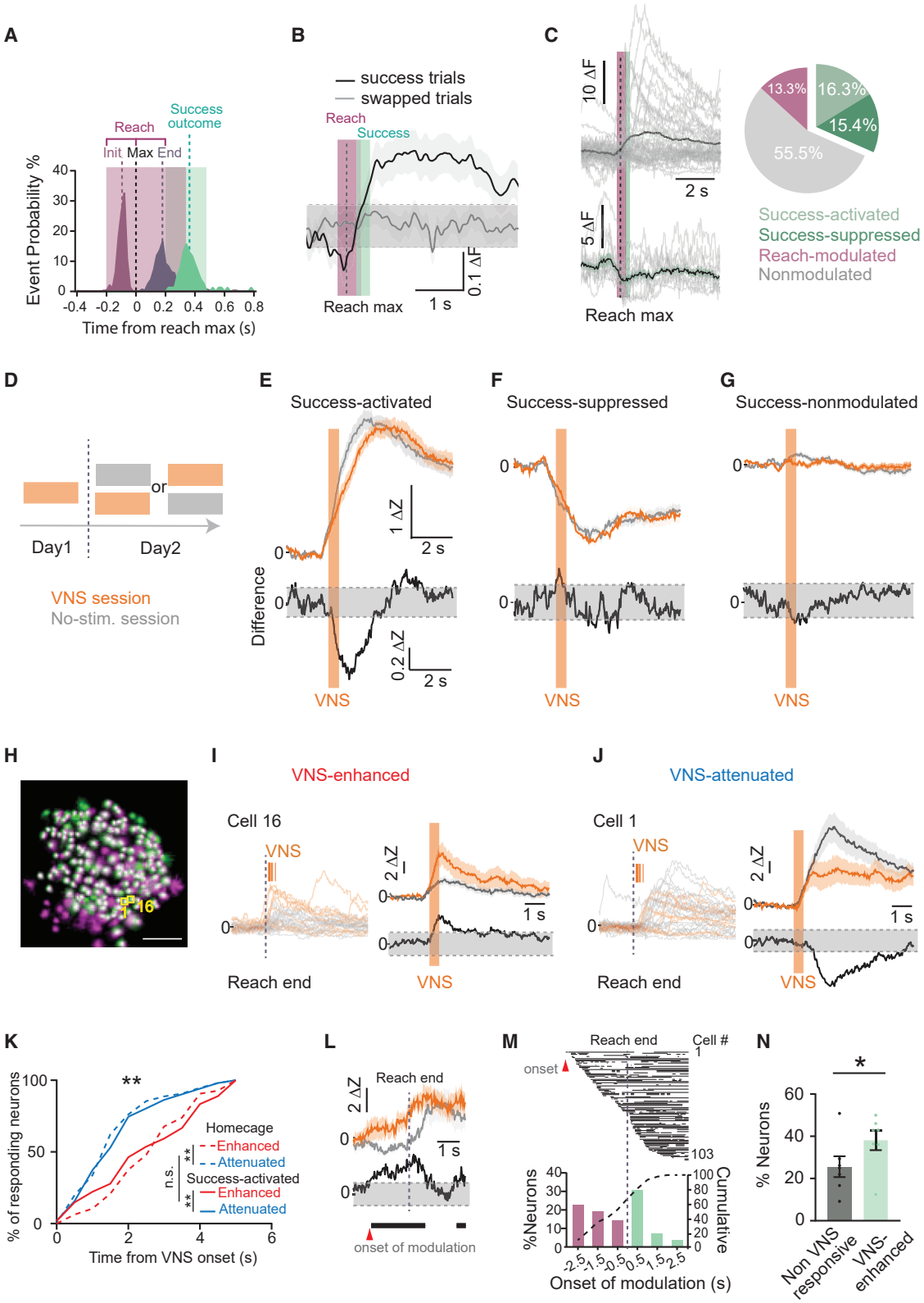
percentage of neurons modulated depended on stimulation intensity (Figure 6E).

Across the population of VNS-responsive neurons, we observed a temporal relationship between activation and suppression (Figures 6C and 6F). The mean peak timing of the suppression precedes the activation by 1.2 s (Suppression: 1.6 s from VNS onset; Activation: 2.8 s; Figure 6G), a relationship consistent across a range of stimulation intensities (Figure 6H). Similarly, the onset of suppression preceding activation by 0.6 s (Figure S5C). These together suggest that in primary motor cortex, VNS first drives acute neural suppression, followed by activation in two separate subpopulation of neurons, without altering the mean population firing rate.

Success VNS modifies the neural representation of reach outcome

We next examined the influence of Success VNS on movement representation during early learning. The neural activity in M1 was measured by miniscope imaging in mice as they learned the skilled reach task. Each reach was subdivided into a reach and an outcome phase using post hoc analysis (Figure 7A). The reach phase includes the outward paw movement (~100 ms) and the return movement (~200 ms). Reach outcome was typically detected 200 ms after reach end. As anticipated (Donoghue and Sanes, 1994; Levy et al., 2020; Peters et al., 2014; Sanes and Donoghue, 2000), the average population activity was significantly modulated during movement (Figure 7B). Nearly half of all neurons were movement modulated, with 13.3% of neurons modulated during reach and 31.7% modulated during success outcome. For success outcome-modulated neurons, roughly half were activated, and half were suppressed (success-activated: 16.3% ± 6.4%; success-suppressed: 15.4% ± 10.2%; Figure 7C). The outcome representation of success differs from failure, both at the level of the population average response (Figures S6A and S6B) and individual neural responses (Figures S6C and S6D).

During Success VNS, stimulation is delivered at reach outcome, and hence, the acute neural response to VNS is likely to overlap with the intrinsic response to success outcome. To accurately detect VNS-related neural activity, mice participated in two daily sessions of training, one with VNS and one without. These sessions were administered on a pseudo-randomized schedule (Figure 7D), and the average neural response was compared between the same day VNS and no-stimulation sessions. During VNS sessions, the success-activated neurons' average response was first attenuated, then slightly enhanced



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(Figure 7E). In contrast, success-suppressed (Figure 7F), non-modulated (Figure 7G), and failure-activated neural (Figure S6F) responses did not differ between sessions. Moreover, in VNS sessions, the percentage of success activated and suppressed neurons were not different from no-stimulation sessions (Figure S6E), suggesting that VNS modulates neurons that already represent success outcomes. These together suggest that Success VNS specifically modulates neurons already activated by success outcome.

To track the response of individual neurons to VNS, we cross-registered neuronal ROIs between the VNS and no-stimulation sessions (Figure 7H; STAR Methods, cross-registered neurons are a subset of neurons from Figures 7C–7G). We found that VNS did not change the percentage of neurons in each category of task representation. To determine if VNS alters the temporal structure of suppression and activation during reach outcome, as seen in homecage conditions (Figures 6G and 6H), we examined the temporal dynamics of the VNS response. Indeed, VNS produced a similar temporal dynamic as seen during homecage stimulation. VNS peak attenuation occurred with similar post-stimulation latency to VNS suppression in the homecage (1.85 ± 1.20 s versus 1.78 ± 1.10 s after VNS onset; Figure 7K), followed by peak enhancement at a similar latency to peak activation in the homecage (2.65 ± 1.50 s versus 2.74 ± 1.20 s after VNS onset; Figure 7K). During outcome and homecage VNS, neural suppression precedes activation (Homecage: $p = 0.001$, Success-activated: $p = 0.033$, Kruskal-Wallis Test, Figure 7K; Figure S6H). This difference was not present in success-activated neurons in trials without VNS ($p = 0.99$, Kruskal-Wallis test, Figure S6I) or in any other neural population (success-suppressed, reach-activated, reach-suppressed, and non-task; $p = 0.99$, Kruskal-Wallis test, data not shown). This suggests that VNS alters the temporal structure of neural suppression and activation selectively for success-activated neurons in a manner unique from other neural populations.

Having established that the majority of success-activated neurons are acutely modulated by VNS during success outcome, we explored if the activity of these neurons is altered beyond the acute response to VNS. Neural activity was normalized to a pre-reach baseline epoch, and movement related activity was compared between the Success VNS and no-stimulation sessions. Neural activity during the VNS session often differed across the reach phase (Figure 7L), with an onset of modulation occurring prior to VNS in nearly 60% of success-activated, VNS-modulated neurons (Figure 7M). During the VNS session, all VNS-enhanced neurons are more likely to be active during the reach phase than VNS-nonmodulated neurons (38.1% ± 4.7% versus 25.6% ± 4.9%; Figure 7N). This suggests that VNS effects on neural activity persist beyond those seen during acute modulation.

VNS-driven acute neural modulation is mediated through AChRs

Because the effects of VNS on motor learning are mediated by cholinergic signaling, we next set out to determine if the effects of VNS on neural activity in M1 likewise depend on acetylcholine. To test this, we injected awake, freely moving animals with a systemic acetylcholine receptor (AChR) antagonist cocktail and measured the acute neural response to VNS in M1. The baseline acute VNS response in M1 was first measured in the homecage, then 15 min following administration of AChR antagonist cocktail, and finally in a washout session ~24 h later (Figure 8A). The percentage of VNS-modulated neurons was not changed by AChR antagonism (Figure S7A). However, the average response amplitude of VNS modulated neurons, both activated and suppressed, was reduced by administration of cholinergic antagonists (Figures 8B–8E), but not saline control (Figures S7B and S7C). This demonstrates that AchR-mediated signaling is required for VNS-driven acute neural activation and suppression.

DISCUSSION

VNS paired with rehabilitation is proposed as a therapeutic treatment for a wide range of neurologic conditions; however, the mechanism by which VNS may alter neuronal activity to influence behavior remains relatively unexplored. In this study, we establish that VNS enhances motor learning when paired with successful reach attempts, suggesting a reinforcement learning mechanism. Optogenetic inhibition of cholinergic neurons in the BF is sufficient to eliminate both the enhanced motor learning and the reach trajectory consolidation, consistent with a role

Figure 7. Success VNS selectively modulates activities of a subpopulation of task-activated M1 neurons in the reach task

(A) Peri-event histogram of the task related events aligned at reach max (N = 6 control mice, day 4, n = 278 success trials). Magenta indicates full reaches, green success recognition.

(B) Average neural activity of success trials (black) and random control trials (gray, n = 488 neurons). Gray-dashed line indicates 2 SD from the baseline mean.

(C) Left, representative neural responses; top, success-activated; bottom, success-suppressed; gray, individual trials. Right, percent of neurons modulated in the task (903 neurons; 16.3% ± 6.4% success-activated, 15.4% ± 10.2% success-suppressed, 13.3% ± 5.5% preparation/reach modulated).

(D) Assignment of VNS or no-stimulation sessions.

(E–G) Top: average responses of success-activated (D, n = 115 and 101), success-suppressed (E, n = 122 and 92) and success-nonmodulated neurons (F, n = 383 and 394) in VNS (orange) and in no-stimulation session (gray). Bottom: the difference trace.

(H) Registered neurons (white) in VNS (green) and no-stimulation session (magenta).

(I and J) Left: trial responses of success-activated neurons in no-stimulation and VNS session (orange ticks: VNS onset). Right: the average and difference responses aligned by VNS onset.

(K) Cumulative distribution of neural response onset (see STAR Methods) of VNS-enhanced or attenuated neurons in homecage and success-activated populations (homecage $p = 0.0001$, success-activated $p = 0.033$, Kruskal-Wallis test).

(L) Example success-activated neuron modulated by VNS (Figure S6H) also have higher neural activity before reach end in VNS session. Arrowhead: onset of increased activity.

(M) Onset timing histogram of VNS-driven modulation of success-activated neurons.

(N) Percent of neurons modulated in reach in VNS-nonmodulated versus VNS-enhanced neurons.

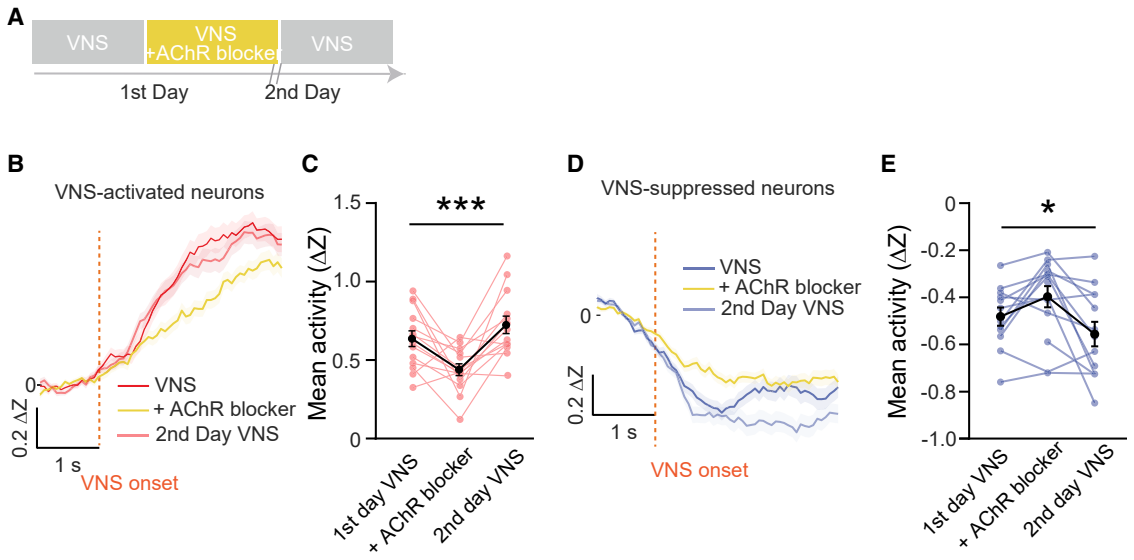

Figure 8. VNS-driven acute neural modulation is mediated through AChRs

(A) Diagram of experimental design.

(B and D) Average neural activity of VNS-activated neurons (B, n = 104–116 neurons) or VNS-suppressed neurons (D, n = 124–143 neurons) in control VNS session, VNS session with AChR blocker, and the second day recovery VNS session.

(C) Average neural activity comparison of VNS-activated neurons quantified from 0.8 to 2.8 s after VNS onset (see STAR Methods, N = 7 mice × two repeats each mouse, repeated measures ANOVA, $p < 0.001$).

(E) Average neural activities comparison of VNS-suppressed-neurons quantified from 0.2 to 1.6 s from VNS onset (N = 7 mice × two repeats each mouse, repeated measures ANOVA, $p = 0.02$).

for cholinergic signaling in VNS-driven learning. Calcium imaging of neurons in M1 shows that VNS selectively modulates neurons that represent reach outcome, and the effects of VNS on M1 neural activity depend on cholinergic signaling. Together, these results demonstrate that VNS accelerates motor learning through cholinergic reinforcement, mediated by selective modulation of motor cortical outcome representation.

VNS paired with reach success optimally enhances motor learning

To our knowledge, we are the first to demonstrate the importance of pairing VNS to movement outcome to enhance motor learning. We find that VNS paired with a successful reach, but not reach initiation, enhances motor learning, indicating a role for VNS in reinforcement signaling. Endogenous activity of the vagal nerve has been linked to reward and motivation (Han et al., 2018), and VNS in human subjects drives motivation toward reward (Neuser et al., 2020) and improves reinforcement learning (Weber et al., 2021). However, VNS does not seem to activate the classical dopaminergic reward pathway (Wickens et al., 2003), as CPP test results indicate that VNS is not inherently rewarding or aversive. Instead, VNS may augment reinforcement cues, leading to improved selection of the expert trajectory (Pekny et al., 2015; Uehara et al., 2019) and the neural ensembles that underlie those movements (Athalye et al., 2018; Oby et al., 2019; Wolpert et al., 2011). By augmenting reinforcement cues, VNS may help to select the appropriate neural circuits, strengthening those connections for lasting improvements in functional outcome.

The importance of VNS timing appears to differ among learning phases, such that VNS must be paired with reach outcome during early learning, but there is more flexibility in the timing of VNS pairing during the rehearsal of a known task. How might success-paired VNS contribute to early skilled motor learning? Motor learning travels along an exploration-exploitation axis, with early exploration, expressed as motor variability, reducing as the motor behavior consolidates onto an expert solution (Aronov et al., 2008; Dhawale et al., 2017; Garst-Orozco et al., 2014), and predicting improved later performance of the expert motor solution (Athalye et al., 2017; Uehara et al., 2019; Wu et al., 2014). This is generally thought to reflect error-driven learning, in which increased exploration allows for faster identification of the expert solution. Reinforcement processes also shape motor learning, where increased reward frequency increases consolidation of movement trajectory onto an optimal motor solution (Dhawale et al., 2019, 2017; Pekny et al., 2015). Our results show that paired VNS does not increase variability in early learning but instead improves kinematic consolidation onto an expert reach. This leads us to believe that in this context, VNS acts via reinforcement-driven learning to increase the exploitation of the expert solution, without increasing early motor variability. Future experiments are needed to explore if VNS can reinforce movements without association to a food reward.

Improved kinematic consistency has been shown to correlate with consistency of neural activity in motor cortex (Cao et al., 2015; Churchland et al., 2012; Peters et al., 2014). Selection of neuronal activity patterns can result from sensory-error learning (Scott, 2016), neural reinforcement (Athalye et al., 2020), or from

unsupervised learning processes (Doya, 1999; Makino et al., 2016). We hypothesize that VNS-modified outcome signals lead to more consistent patterns of neural activity in motor cortex, producing more consistent reach behavior (Athalye et al., 2017; Chen et al., 2015; Mawase et al., 2017). Alternatively, VNS could influence subcortical motor structures, such as basal ganglia or cerebellum, leading to altered thalamocortical input to cortex. To explore this further, future work will examine the possible role of VNS on thalamic motor activity.

Success VNS could bias neural activity to set an appropriate initial state for re-entrance into the neural patterns that lead to a successful reach (Athalye et al., 2020; Levy et al., 2020). More consistent re-entry into these patterns can drive long-term plasticity toward reactivation of these patterns, resulting in improved learning. In this scenario, we predict that reaches following Success VNS would be more likely to be successful. However, this is not consistent with Figure 2B, where we find the same success rate for reaches before or after Success VNS. Further analysis of the dynamics of neural populations in motor cortex could determine if VNS does modify the initial conditions prior to a reach.

Another option is that VNS may act to enhance sensory-error motor learning, where incoming sensory cues are compared with an internal model of expected sensory information (Scott, 2016) and used to refine neural encoding of the reach. In this case, Reach VNS should be as effective as Success VNS to enhance learning. In our data, Reach VNS does not enhance overall learning rates (Figure 1I). However, trial-by-trial analysis of the data shows that Reach VNS improves the success of reaches that follow VNS compared with those reaches +without VNS (Figures 2F–2I). This effect strengthens over learning and is present during the rehearsal of a known task (Figure 2K). This suggests that VNS may play a role in sensory-error learning, particularly during late learning refinement or rehearsal.

VNS-driven motor learning is mediated by cholinergic signaling

VNS activates multiple neuromodulatory systems in the central nervous system (Farrand et al., 2017; Hulsey et al., 2019; Perez et al., 2014), including the locus coeruleus (LC), raphe nucleus, and the cholinergic BF (Hulsey et al., 2016, 2019). Although each of these neuromodulators play a role in learning, cholinergic neuromodulatory sytems are critical for use-dependent plasticity (Jiang et al., 2016; Kang et al., 2014; Ramanathan et al., 2009; Sawaki et al., 2002; Shinoe et al., 2005). They are closely associated with reinforcement signaling (Guo et al., 2019; Hangya et al., 2015), encode task outcome (Lin and Nicolelis, 2008; Zhang et al., 2019), and link learned neural activity to temporally delayed outcomes (Tu et al., 2022). Lesion (Conner et al., 2003, 2010) or pharmacological inhibition (Puzerey et al., 2018) of cholinergic neurons is detrimental to motor learning and VNS-enhanced motor rehabilitation (Meyers et al., 2019). Early motor learning depends on elevated cholinergic signaling (Ren et al., 2022), consistent with the unique role for cholinergic-mediated VNS enhancement during early learning. We find that a brief cholinergic inhibition is sufficient to prevent VNS-driven enhancement in motor learning. This suggests that the effects of Success VNS are mediated through phasic cholinergic signaling in the BF.

Only limited evidence exists demonstrating an anatomical or functional connection between the vagus nerve and the cholinergic BF (Détári et al., 1983). We were able to demonstrate robust functional connectivity between the BF and the vagus nerve. Stimulation of the vagus nerve elicited robust responses in nearly half of the cholinergic and non-cholinergic units recorded under anesthesia and more than 40% of the units recorded in awake animals. The variable timing of BF neuronal responses to VNS suggests the involvement of a multi-synaptic pathway, possibly through the LC, which is known to send direct projections to the BF (Schwarz and Luo, 2015; Smiley et al., 1999; Zaborszky et al., 2004) and is activated by VNS (Groves et al., 2005; Hulsey et al., 2017).

Motor cortical neurons are modulated by VNS via cholinergic activity

Neurons in the primary motor cortex represent movement preparation and execution for dexterous movements (Guo et al., 2015; Lemon, 2008; Whishaw et al., 1986). During motor learning, these neural representations are updated to improve motor output (Adler et al., 2019; Biane et al., 2019; Peters et al., 2014) by incorporating feedback from error and reinforcement signals generated throughout multiple regions of the central nervous system (Heffley et al., 2018; Hosp et al., 2011; Luft and Schwarz, 2009; Wolpert et al., 2011). Recent work demonstrated that in addition to movement preparation and execution, M1 pyramidal neurons also report movement outcome (Levy et al., 2020). Our data demonstrate that Success VNS attenuates the population representation of a success outcome by selectively modulating the temporal dynamics of success-outcome responsive neurons. This neural population is more likely to have altered representation of movement preparation and reach execution, suggesting that VNS modulates neural activity beyond the acute response to stimulation. The specificity of the population of neurons that are modulated by Success VNS may indicate that VNS adds selectivity to outcome representation, which optimizes outcome signals for enhanced learning.

The selectivity of the effects of Success VNS on movement representation are somewhat in contrast to recent observations of widespread, long-lasting excitatory responses to VNS (Collins et al., 2021). However, in the previous study, VNS elicited locomotion and whisking, both of which correlate to increased general arousal and widespread cortical activation (Eggermann et al., 2014; Musall et al., 2019; Reimer et al., 2016). This makes it difficult to disentangle direct VNS effects from changes in arousal. In contrast, another recent work demonstrated a VNS-driven suppression of neural response to an auditory tone that persisted even after arousal state was regressed from the neural response (Lai and David, 2021). Our trial design controls for movement state, and VNS did not produce any noticeable acute motor response. By eliminating the confound of behavioral states such as locomotion or quiet resting, we can detect that VNS produces an initial suppression of the outcome response followed by excitation. This acute effect is seen only in neurons that respond to outcome, indicating that when applied during a reach, VNS quickly acts on a specific population of neurons that are already engaged in the representation of reach outcome. Further analysis of neural activity patterns over the course of

learning may help to understand if altered temporal dynamics of outcome-related neurons influence patterns of neural activity during reach learning.

Optimizing VNS to treat neurological conditions

An improved understanding of the mechanisms of VNS is important to best utilize the therapy to treat a range of neurological conditions. For example, pairing VNS with success criterion in rehabilitative tasks may improve outcomes. In addition, our results point to a concern that improperly paired VNS could lead to maladaptive plasticity, suggesting a potential for harm. Understanding how VNS interacts with neural circuits may identify new targets for stimulation. For instance, models that can predict how stimulation protocols will engage specific vagal fiber types (Chang et al., 2020; Pelot et al., 2017; Settell et al., 2020) could be used to test differential target engagement in the brain. Alternatively, direct brain stimulation of targets, such as the BF, could be used to provide more specific neuromodulation to achieve key therapeutic results. Finally, less invasive techniques, such as auricular VNS, might still be able to convey therapeutic benefits if their stimulation protocols and target activation within the central nervous system is optimized (Redgrave et al., 2018; Wu et al., 2020). The data presented here provide a framework for dissecting the role of VNS within specific therapeutic indications, with the ultimate goal of improving therapeutic delivery and patient outcomes.

Conclusions

In conclusion, we demonstrated that VNS augments reinforcement cues to enhance skilled motor learning and accelerate kinematic consolidation on an optimal motor plan in healthy animals. VNS alters neural coding of outcome in a select neural population in motor cortex and modulates neuronal activity of this population across the entire reach. The behavioral, kinematic, and motor representation effects of VNS are mediated by phasic cholinergic activity. Understanding the behavioral and circuit mechanisms of VNS allows for future optimization of rehabilitation protocols and new avenues for the use of cholinergic manipulation to treat neurologic conditions.

STAR★METHODS

Detailed methods are provided in the online version of this paper and include the following:

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SUPPLEMENTAL INFORMATION

Supplemental information can be found online at https://doi.org/10.1016/j.neuron.2022.06.017.

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AUTHOR CONTRIBUTIONS

S.B., J.H., X.P., and C.G.W. contributed to the text of the manuscript. J.H., S.B., and C.G.W. designed and conducted behavioral tests. S.B., J.H., D.D., and C.G.W. designed and conducted electrophysiological recordings. X.P. and C.G.W. designed and conducted calcium imaging experiments. X.P. and C.G.W. designed and conducted pharmacological experiments. W.R.W. and S.B. constructed and tested the CLARA behavioral system. K.W. conducted CPP tests. S.B., J.H., X.P., and R.H. performed surgeries for the experiments. S.B., J.H., X.P., and C.G.W. analyzed experimental data and performed statistical tests.

DECLARATION OF INTERESTS

The authors declare no competing interests.

INCLUSION AND DIVERSITY

We worked to ensure sex balance in the selection of non-human subjects. One or more of the authors of this paper self-identifies as an underrepresented ethnic minority in science. While citing references scientifically relevant for this work, we also actively worked to promote gender balance in our reference list.

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STAR★METHODS

KEY RESOURCES TABLE

REAGENT or RESOURCE	SOURCE	IDENTIFIER
Bacterial and virus strains		
AAV-EF1a-DIO-eArch3.0-EYFP	Deisseroth Lab	UNC, cat#AV4881E
AAV-EF1a-DIO-EYFP-WPRE-pA	Deisseroth Lab	UNC, cat#AV4842E
AAV1.Syn.GCaMP6m.WPRE.SV40	Chen et al., 2013	Addgene, plasmid #100841. RRID:Addgene_100841
Chemicals, peptides, and recombinant proteins		
Muscimol	Sigma-Aldrich	Cat# M1523
(−)-Scopolamine hydrobromide trihydrate	Sigma-Aldrich	Cat# S1875
Mecamylamine hydrochloride	Sigma-Aldrich	Cat# M9020
Experimental models: Organisms/strains		
Mouse: ChAT-ChR2(H134R)-EYFP	Zhao et al., 2011	Jackson Lab, Stock No: 014546. RRID:IMSR_JAX:014546
Mouse: ChAT-IRES-Cre	Rossi et al., 2011	Jackson Lab, Stock No: 006410. RRID:IMSR_JAX:006410
Software and algorithms		
Python version 3.7	Python Software Foundation	https://www.python.org
Matlab 2021a	MathWorks	https://www.mathworks.com
CLARA software package	Bowles et al., 2021	https://github.com/wryanw/CLARA_DLC
SpikeSort3D 2.5.4	Neuralynx	https://neuralynx.com
Cheetah 6.4.2	Neuralynx	https://neuralynx.com
NoRMCorre	Pnevmatikakis and Giovannucci, 2017	https://github.com/flatironinstitute/NoRMCorre
CNMF-E	Zhou et al., 2018	https://github.com/zhoupc/CNMF_E
CellReg	Shintuch et al., 2017	https://github.com/zivlab/CellReg
Graphpad Prism 9	Graphpad Software Inc.	https://www.graphpad.com
JMP Statistical Software	SAS Software	https://www.jmp.com/en_us/home.html
Other		
Miniscope Version 3	Optogenetetics and Neural Engineering Core	https://optogeneticsandneuralengineeringcore.gitlab.io/ONECoreSite/
CLARA Behavioral System	Bowles et al., 2021	https://medschool.cuanschutz.edu/neurotechnologycenter/Cores/IdeaCore

RESOURCE AVAILABILITY

Lead contact

Further information and requests for resources and reagents should be directed to and will be fulfilled by the lead contact, Cristin G. Welle, at cristin.welle@cuanschutz.edu.

Materials availability

This study did not generate new unique reagents or mouse lines.

Data and code availability

All original code has been deposited at GitHub and is publicly available as of the date of publication. Links are listed in the key resources table. Any additional information required to reanalyze the data reported in this paper is available from the lead contact upon request.

METHOD DETAILS

Animal care

All animal procedures and experiments were performed in accordance with protocols approved by the Institutional Animal Care and Use Committee at the University of Colorado Anschutz Medical Campus. Male and female adult C57BL/6 wild-type mice between the

age of 2 and 10 months old were used for all experiments unless otherwise noted. Mice were group-housed before surgery and single-housed following surgery and throughout behavior training. Mice were kept on 14 hr light/10 hr dark schedule with ad libitum access to food and water with exception from behavior-related food restriction (Forelimb Reach training).

Surgery

Vagus nerve stimulating cuff implantations

Commercial cuffs from Micro-leads (150um cuffs) and Cortec (100 um microsling cuffs), soldered to gold pins or Plastics1 connectors, were implanted on the cervical vagus nerve (Mughrabi et al., 2021). Mice were anesthetized with 4.5% isoflurane anesthesia for induction and maintained with 1.5%. 1% injectable lidocaine was used locally at incision sites. Eye ointment was applied to the eye to prevent corneal drying. Temperature was regulated at 37°C with a thermostat-controlled heating pad. The vagus nerve was accessed with an incision in the ventral cervical region, and the nerve was bluntly dissected from the carotid sheath. The cuff was tunneled subcutaneously to the ventral cervical incision from an incision at the base of the dorsal skull. The vagus nerve was placed in the cuff. The ventral cervical incision was sutured using 6-0 absorbable sutures. The dorsal skull was cleaned using saline and ethanol, and electrical connectors were fixed to the skull using dental cement (C&B Metabond). GLUture (WPI) was used to seal the skin around the dental cemented headcap. Stimulation efficacy was measured using peripheral biomarkers such as breathing rate changes and heart rate reduction (Mughrabi et al., 2021) on the day of surgery and weekly until the end of experiments with a paw sensor (Mouse Stat Jr., Kent Scientific). Mice received sub-cutaneous lactated ringers (∼100 μL as necessary), intramuscular gentamicin (3 mg/kg), and intraperitoneal meloxicam (5 mg/kg) following surgery and as needed in cases of dehydration, infection, or pain. Mice were monitored for 7days to ensure proper recovery from surgery before any subsequent experiments were conducted.

Viral injections and optical fiber implantation

All surgeries were performed on mice expressing Cre recombinase driven by the ChAT promoter (ChAT-IRES-Cre, Jackson Labs stock #0064100; Rossi et al., 2011). Animals were prepared for surgery as described above, and the hair was removed prior to an incision over the dorsal skull. 200 μm diameter fiber optics with 1 cm ceramic cannulas were fabricated in-house using ONECore facilities. The skull at the dorsal incision was cleaned using sterile saline and ethanol. Two craniotomies were opened above the basal forebrain in each hemisphere (0.35 mm posterior, ±1.6 mm lateral of bregma) using a dental drill. Glass pipettes containing a floxed inhibitory archaerhodopsin (AAV-EF1a-DIO-eArch3.0-EYFP, UNC) or yellow fluorescent protein (YFP) control (AAV-EF1a-DIO-EYFP-WPRE-pA, UNC) were then inserted bilaterally into the basal forebrain using a stereotaxic device (-4.75 mm from dorsal surface of the brain). Approx. 210 nL of viral construct was injected over 5 minutes. The pipettes were removed and 200 μm fiber optic cannulas were inserted above each injection site (-4.65 mm from the dorsal surface of the brain). The craniotomies were then sealed using a surgical silicone (Kwik-Sil). The cannulas were fixed to the skull using dental cement (C&B Metabond). GLUture was used to seal the skin around the headcap. Mice received intramuscular gentamicin (3 mg/kg), and intraperitoneal meloxicam (5 mg/kg) following surgery and as needed in cases of infection, or pain. Mice were monitored for 7 days to ensure proper recovery. After 14 days, mice underwent VNS implantation described above (see vagus nerve stimulating cuff implantations).

Electrode implantation

Chronic tetrodes. Custom twisted wire tetrodes, built in-house, were implanted into the left basal forebrain of mice. Surgical preparation was as described above. Two craniotomies were opened using a dental drill: one above the left basal forebrain (0.35 mm posterior, 1.6 mm lateral of bregma) and one above the cerebellum (∼1 mm posterior of lambda, midline). A tetrode was then inserted into the basal forebrain craniotomy using a stereotaxic device (-4.75 mm from the dorsal surface of the brain). A gold ground pin was inserted into the second craniotomy. Both craniotomies were sealed with surgical silicone (Kwik-Sil) and the tetrode was fixed to the skull using dental cement (C&B Metabond). GLUture was used to seal the skin around the dental cemented headcap. Mice received intramuscular gentamicin (3 mg/kg), and intra-peritoneal meloxicam (5 mg/kg) following surgery and as needed in cases of infection, or pain. Mice were monitored for 7 days to ensure proper recovery after which they underwent VNS implantation described above (see vagus nerve stimulating cuff implantations).

Acute Optrodes. Vagus nerve cuffs were implanted in transgenic mice expressing channelrhodopsin2 in cholinergic neurons (ChAT-ChR2; Zhao et al., 2011) using the protocol described above (see vagus nerve stimulating cuff implantations). After cuff implantation, while mice were still under anesthesia (1.5% isoflurane), mice were moved to a stereotaxic apparatus and a cranial window (2.5x2.5 mm) was opened above the left BF (0.35 mm posterior, 1.6 mm lateral of bregma). The stereotaxic apparatus was placed in a Faraday cage and single shank Optrodes from Neuronexus (A1x32-Edge-10mm-20-177-OA32LP) were inserted into the BF (-4.75 mm from the dorsal surface of the brain). Extracellular recordings were then performed while mice then underwent VNS (see neural classification of BF response) and opto-tagging (see opto-tagging) protocols. Mice were sacrificed at the end of the experiment and the cuff and optrode were recovered.

Cranial window surgery for miniscope objective lens and baseplate installation

Mice were anesthetized with isoflurane and maintained similarly as described above until skull was exposed. A round cranial window (∼1.8 mm diameter, ML 1.5 mm, AP 0.3 mm for center) was made above M1 contralateral to the reaching paw using a dental drill. A viral vector (AAV1.Syn.GCaMP6m.WPRE.SV40) was infused at $2x10^{12}$ titer to 200 ∼300 μm beneath brain surface at 3∼4 sites in the cranial window around the center, with ∼200 nL at each site. Objective grin lenses (Edmund Optics, #64520, 1.8 mm, 0.23 mm WD) were lowered through the cranial window and pressed against the brain surface. The lens' side was sealed by surgical silicone (Kwik-Sil) and secured by dental cement. The exposed part of the lens above the skull was further coated with black nail polish. 3∼4 weeks

later, a metal baseplate was mounted to the skull over the lens with Loctite glue (Loctite 454 prism), guided by a miniscope for optimal field of view while the mice were anesthetized with isoflurane (1.5%). After the baseplate was securely mounted, the miniscope was taken off, a cap was attached to the baseplate and the mouse was returned to the home cage.

Muscimol cannula surgery and infusion

Using the same craniotomy surgery procedure described above, a round cranial window (~1.8 mm diameter, ML 1.5 mm, AP 0.3 mm for center) was made above the contralateral M1 and a plastic cannula (2~3 mm long pipet tip) was inserted into the window right above the brain surface. Then the pipet tip was secured by Kwik-Sil and dental cement. The top of the cannula was sealed with Kwik-Sil if the mouse was not undergoing behavior tests within a couple of hours. Before behavior tests, the mice were briefly anesthetized with isofluorane, the seal was removed and 1~2 μL of muscimol at a concentration of 1 mg/mL was infused into the pipet tip.

Behavior

Manual training of skilled forelimb reach task

Mice were trained and scored on a skilled reach task (Whishaw et al., 2008). Mice were food restricted and maintained at 85-90% of their free feeding weight throughout training. Following food restriction, mice were habituated to the training box for 20 minutes where mice were given 20 mg food pellets (BIO-serv) near the window of the box where reaching occurs. The training box is a custom-built plexiglass box with a 1 cm wide opening that provides access to a post with a divot to hold a pellet located approximately 1 cm away, with a left offset from the center of the opening to force right forepaw reaching. Learning sessions then occurred for 14 consecutive days where mice perform a reach to grasp task with the right forepaw for food pellets. Rehearsal sessions occurred 7-10 days after training and featured stimulated and unstimulated trials. For both training and rehearsal sessions, mice were scored on a per trial basis until 20 successful attempts or 20 minutes passed. A trial terminates in a success, or the pellet being knocked off the pellet holder by the mouse. Trial outcomes were recorded by the trainer in real time. A success was defined by when the mouse grabbed the pellet and returned it into the cage. Errors were subcategorized into: "reach error" (failure to correctly target), "grasp error" (failure to grasp the pellet), and "retrieval error" (successful grasp of pellet, but failure to return it into the box).

VNS experiment groups

Experiment groups for training were based on stimulation protocols. Mice were assigned into experiment groups in cohorts of 4-8 mice at a time interleaved to achieve a similar number of mice per group. Investigators were not blinded to mice designations. To ensure that each VNS group received a similar number of stimulation pulses, we first ran a cohort of Success VNS animals, and calculated the average number of stimulation pulses for each day of training (equivalent to the number of successful reaches per day). We used this calibration value to titrate the stimulation number for the Reach VNS and Random VNS groups. Average stimulation pulses are similar between groups, with some variability due to small subset of initial measurements (Figures S1A–S1C). Sham VNS cohort were implanted with a cuff but were not stimulated at any point during learning. Success VNS were manually stimulated following every successful trial – days 7 and 14 featured designated blocks without stimulation to track baseline learning levels versus trial-to-trial performance. Random VNS received stimulation at random intervals as generated by an Arduino board to achieve between 15-20 stimulations per day, matching stimulation rates to other groups. Reach VNS received manual stimulation prior to movement onset on a pseudo-random 50% subset of trials to normalize VNS trains delivered. Reach VNS occurred rapidly (0.003±0.263s) after reach initiation, defined as when the paw exits the behavior box (Figure S1D). All groups were trained on the forelimb reach task for 14 days. For performance measurements in animals trained without VNS (Figures 2K–2N), Reach VNS and Success VNS were applied during daily behavioral sessions. All animals received both Reach and Success VNS sessions on different days, with randomized order of session assignments across animals.

CLARA skilled reach training and behavior data acquisition

Mice were food restricted and habituated identically to manually trained animals. Dimensions of the behavior box were also identical in manual and CLARA cohorts. Behavior box used for miniscope recording was modified so that the front panel had an alcove above the height of the mouse head to accommodate the miniscope when the mouse was close to the slit to reach. On day 1, the mice were primed to have one success before CLARA training session started. Learning sessions then occurred for 14 consecutive days (or specified otherwise in results), where mice perform a reach to grasp task with the right forepaw for food pellets. Each trial started as the automated dispenser placing a food pellet on the post, as the mouse reached to successfully retrieve it or knocked it off, the CLARA would mark success or failure as the trial outcome as the end of this trial. Each session lasted for 20 minutes, and mice were scored on a per attempt basis. Using the CLARA behavior system, high speed (150 Hz) video data was recorded from three FLIR Blackfly® S (model BFS-U3-16S2M-CS, Edmund Optics) cameras placed in front of the box, lateral to the box, and at a 45° angle above the box from the opposite side from the lateral camera (Figure 6A). A neural network was trained prior to experiment sessions using manually annotated frames of the skilled reach behavior labeling the hand center and the pellet. Video frames from all cameras were sent through this network in real time to identify the location and state of the hand and pellet. This information was used to initiate trials via pellet placement, and to categorize attempt outcomes as either success or failure so that stimulation could be delivered in a closed-loop manner (for additional details, see Bowles et al., 2021). The timing of pellet placement, success or failure outcome, VNS delivery, and optogenetic light delivery was recorded through CLARA. In the miniscope cohort, the timing of miniscope neural recording was cross registered with behavior video frames through a CLARA-controlled Arduino board.

Optogenetic+VNS experiment groups

Experiment groups for training were based on stimulation type. The control cohort was injected with a floxed YFP construct that did not contain an opsin and received light stimulation (see *light stimulation parameters*), the Success VNS cohort was electrically stimulated (see VNS stimulation parameters), and the Arch+VNS cohort received both light and electrical stimulation. All groups received stimulation following every successful trial automatically through the CLARA system.

Light stimulation parameters

For all light-stimulated groups, 488 nm light was delivered as a 500 ms train at 20 Hz with a 10 ms phase duration. Light was delivered through a 200 nm fiber-optic cable from a class IIIb diode pumped solid-state laser (Cobalt) at 0.5 mW (calculated based on output efficiency from the bottom of the optical fiber). Stimulation parameters were controlled and delivered using a PulsePal or a CLARA+-Arduino system connected directly to the laser.

Miniscope groups

Mice wore miniscopes for 5∼10 minutes a few times in their home cages or the CLARA training box to habituate the weight. When recording VNS response in home cage, mice wearing miniscopes and VNS wires were put in home cage. About 4 minutes spontaneous neural activity were recorded as mice freely moved in the home cage, then 30∼40 VNS were delivered every 20∼30 s. Afterward, another ∼4 minutes spontaneous activity was recorded. In sessions with AChR antagonists, scopolamine (1 mg/kg body weight) and mecamylamine (10 mg/kg body weight) were dissolved in saline and delivered to mice through intraperitoneal (IP) injection. The concentration of scopolamine and mecamylamine cocktail was chosen to have effects in brain circuits related to memory and learning without debilitating effects, according to previous studies (Riekkinen et al., 1993, 1990). 15 minutes after cocktail administration, the neural response was recorded during a home cage session.

For reach training recordings, food restricted mice were mounted with a miniscope and VNS wires and put in the training box to start a CLARA training session. The minisope acquisition was turned on immediately as the CLARA training session started and each frame of the video was cross registered with the CLARA video frames. All mice were primed without VNS to have one success reach before the first session started. On the first day, VNS mice participated in one 20-minute Success VNS session. From day 2 to day 4, each VNS mouse participated in two sessions of training, with one of them being a Success VNS session and the other a no-stimulation session in which VNS was not delivered, which was given on a pseudorandomized schedule (Figure 7D). Control mice also received two training sessions without VNS each day. On days when mice receive two sessions of training, the two sessions are 1∼3 hours apart.

Place preference test

We used a standard conditioned place preference test to examine if VNS is rewarding or aversive. The behavior apparatus contained two compartments separated by a gate. Mice were tested for baseline preference in an initial 20-minute session where mice can freely navigate between compartments. Mice then were trained for three days with two 20-minute sessions each day where they received stimulation in only one compartment. Stimulation was delivered pseudo-randomly approximately once per minute. On the day of testing, no stimulation was given, and mice were allowed to freely navigate between compartments to see which compartment they spent more time in Prus et al. (2009). The amount of time spent in each compartment was compared between the baseline and testing day. Experiments were conducted with assistance from CU Anschutz Behavior Core.

Stimulation parameters

VNS stimulation parameters. For all VNS experiment groups, VNS was delivered as a 500 ms train of 15 pulses, with 100 μs phase duration at 30 Hz. Current amplitudes were 0.4-0.6 mA. Stimulation parameters were controlled and delivered using Master8, PulsePal, or a CLARA+Arduino system, which were connected to a stimulation isolation unit (A-M Systems, Model 2200 Analog Stimulus Isolator) to control amperage.

Light inhibition parameters. For all light stimulated groups, 561 nm light was delivered continuously for 500 ms. Light was delivered through a 200 nm fiber-optic cable from a class IIIb diode pumped solid-state laser (Cobalt) at 0.5 mW (calculated based on output efficiency from the bottom of the optical fiber). Stimulation parameters were controlled and delivered using a PulsePal, or a CLARA+Arduino system connected directly to the laser.

Behavior and kinematic analysis

Manual behavior analysis

A success percentage was generated for each session of each animal by determining the number of trials that resulted in a successful retrieval out of all trials initiated. Success percentages were compared between stimulation groups across all days of training, as well as by early and late learning phases. Early learning phase refers to days 1-4 of training, while the late phase refers to days 5-14, which were defined using a Weibull growth curve (See quantification and statistical analysis). On days where animals received blocks of stimulation, such as rehearsal groups, stimulated and unstimulated trials were compared on a per mouse basis within days. To determine a trial-level effect for the Success VNS group, we divided all trials to three categories, pre-success trials that occur immediately before each success trial, success trials and post-success trials that occur immediately after each success trial. We then compared the success rate between pre-success and post-success trials.

Behavior curator analysis

Videos acquired during CLARA training sessions were processed by custom Python scripts overnight to extract key reach timepoints: reach initiation (ReachInit), when the hand leaves the box; reach max (ReachMax), the outward point of maximum distance

from reach initiation; reach end (ReachEnd), when the hand returns to the cage; and stimulation onset (stim), when a trial received a trigger pulse for VNS or light stimulation. The stamps of reachInit, reachMax and reachEnd were further manually screened for consistency. The accuracy of CLARA trial outcome classifications were verified, and failures were subcategorized *post-hoc* into reach, grasp and retrieval failures (see manual training of skilled forelimb reach task for failure definitions).

Kinematic analysis

3D location of the center of the paw and pellet were tracked during reach attempts (between reach initiation and reach end). Tracking data was extracted using custom MATLAB scripts (MATLAB Simulink) and documented as 3D data arrays for kinematic analysis. Positional data for gross targeting analysis was determined by selecting the 3D location of the hand and pellet at the reach max timepoint. Points were normalized such that the pellet center was 0,0,0. Euclidean distance between the hand center and pellet center was then calculated using the norm function from MATLAB. The mean distance from the pellet was compared in early and late phases and between stimulation groups. Reach velocity was obtained by measuring the absolute velocity between reach initiation and reach end, and then averaging the velocity over that period. The mean velocity was compared in early and late phases of training and between stimulation groups.

Reach consistency and expert reach

Positional data between reachInit and reachEnd were normalized such that the pellet center was 0,0,0. Reach trajectory was defined as the time between reach initiation and reach end. Each trajectory was then temporally warped to be the same arbitrary 'length' of time using dynamic time warping (Li et al., 2017). An expert trajectory was constructed for each mouse by averaging the trajectories of all successful reach attempts made on each mouse's last two days of training. Reach consistency was determined through comparison of reach trajectories to each mouse's expert trajectory. Reach trajectories were compared to the expert trajectory through a correlation coefficient to obtain the mean correlation coefficient for each mouse in each training session. Additionally, any individual reach that had a correlation of 0.95 or higher with the expert trajectory was defined as an 'expert reach', and the percent of expert reaches were also recorded for each day. The number of expert reaches and mean correlation coefficients were then compared between VNS, Arch+VNS and control groups in early and late phases.

Feature consistency

Several reach features were extracted from each reach attempt: start location (X, Y, Z), end location (X, Y, Z), mean absolute velocity, max absolute velocity, pathlength (length of full trajectory), and reach consistency (defined above in *reach consistency and expert reach*). The distribution of each feature was calculated for the early and late learning phases based on the stimulation group. The distribution of each early-late pair was normalized using the interquartile range of the early phase distribution. The normalized late interquartile range was subtracted from the normalized early range and the difference was defined as 'delta feature consistency'. A positive delta means that the distribution was more constrained during the late phase compared to the early phase.

Electrophysiology recording and analysis

VNS electrophysiological recording in BF

While mice were either under maintained anesthesia (1.5% isoflurane), or awake in a home cage, VNS was repeatedly delivered while recording from the left basal forebrain (see electrode implantation). No behavioral task was performed during recording. Mice received several (10-20) trains of VNS (0.5 s, 30 Hz, 100 μs pulse-width, 0.6 mA), delivered approximately 90 s apart. Data was recorded with Cheetah acquisition software at 30 kHz using a Digital Lynx SX (Neuralynx). TTL pulses were sent from the Master-8 (A.M.P.I.) to the Digital Lynx SX for each pulse of a light or electric stimulation train. In acute experiments, mice were opto-tagged after all VNS trains were delivered to identify cholinergic units.

Opto-tagging protocol

While mice were under maintained anesthesia (1.5% isoflurane), recordings were performed in the left BF (see *optrode implantation*). Light was delivered using a class IIIb diode pumped solid state laser (Cobalt) attached to the optrode through a ceramic ferule. Opto-tagging stimulus consisted of several (10-20) trains of 5 mW, 488 nm light delivered just above the BF through a 105 μm diameter fiber optic spaced ~30 s apart. Trains consisted of 10 pulses of light at 20 Hz with a 10 ms pulse duration.

Neural classification of BF response

After recording, units were clustered manually using clustering software SpikeSort 3D (Neuralynx) and imported into MATLAB. Isolation distance and L-ratio were used to quantify cluster quality and noise contamination (Schmitzer-Torbert et al., 2005). The start of each stimulation train was identified *post-hoc* using custom scripts (Mathworks) and defined as a trial. The trial window, referred to as the 'VNS stimulation window,' was defined as: 1 s baseline before stimulation (-1 to 0 s), VNS delivery (0 to 0.5 s), and 1 s after the end of VNS (0.5 to 1.5 s). Firing rate during the trial window was calculated using a 100 ms moving average, shifted by 1 ms from the start of the trial window to 100 ms after the end of the trial window. Baseline firing rate was defined as the mean firing rate during the baseline period (-1 to 0 s). Units were screened, and any unit with a mean firing rate below 0.5 Hz in anesthetized recordings or below 1 Hz in awake recordings were removed from the pool. ±1 ms around each stimulation pulse was removed to account for electrical noise. Firing rate was converted into a Z-score normalized to the mean firing rate and standard deviation of baseline activity. If a unit's normalized firing rate was ±2.56 s.d. from the baseline firing rate for >100 ms during VNS delivery (0 to 0.5 s), the unit was defined as VNS responsive. If the change in firing rate was 2.56 s.d. above baseline it was further subclassified as activated, and if it was 2.56 s.d. below baseline, it was subclassified as Suppressed. A unit that met both criteria was classified based on which occurred first. Peak response, peak delay and response duration were compared between cholinergic and non-cholinergic units in

anesthetized mice, and units recorded in awake mice. Peak response refers to the maximum normalized firing rate of VNS activated units after stimulation onset (0 to 1.5 s). Peak response delay refers to the amount of time, in ms, from train onset (0 s) to peak response. Duration refers to the total amount of time that a VNS activated unit had normalized activity <2.56 s.d. above baseline after stimulation onset (0 to 1.5s).

Neural classification of opto-tagging in BF

After recording, units were clustered manually using clustering software SpikeSort 3D (Neuralynx). Each pulse was identified *post-hoc* using custom MATLAB scripts (Mathworks) and defined as a trial. Tagged units were identified using a stimulus-associated latency test (SALT; Hangya et al., 2015). This test compares the distribution of onset time of the first spike recorded during light delivery trials (10 ms) to the onset time of spikes during control windows of similar length (10 ms). Units whose p-value from the SALT test was <0.05 were defined as cholinergic, all other units were defined as non-cholinergic. Firing rates of cholinergic and non-cholinergic units were calculated using the baseline firing rate of the unit from the VNS session.

Calcium imaging and analysis

Data acquisition

Miniscope components and DAQ board were purchased and assembled by Optogenetics and Neural Engineering (ONE) Core according to UCLA miniscope (http://miniscope.org/) V3 guidelines. The objective GRIN lens used were Edmund optics #64-520 and achromatic lens were #45-407. Images were acquired at 30 Hz with Miniscope Control data acquisition package (affiliated with UCLA miniscope). Each imaging session was 15∼20 minutes. The calcium signal images were saved as TIFF stacks through USB3.0 port to an SSD hard drive to reduce frame drops. For some home cage sessions, the mice behavior was recorded simultaneously by a LG webcam controlled by MiniscopeControl. For CLARA reach training sessions, behaviors were recorded by the CLARA system and the timing of miniscope frames and behavior camera frames were coordinated.

Imaging analysis

Neural signal preprocessing. Image stacks that were acquired through the miniscope were motion corrected using MATLAB-based NoRMCorre packages (Pnevmatikakis and Giovannucci, 2017) (https://github.com/flatironinstitute/NoRMCorre). For most sessions, the rigid motion correction module was sufficient to yield good results; in sessions with non-even shifting of the field of view, the non-rigid motion correction module was used. After motion correction, the field of view was cropped and spatially down sampled 4x to reduce the file size for subsequent neural signal extraction. Neural signals were extracted from the images using the MATLAB-based CNMF-E package (Zhou et al., 2018) (https://github.com/zhoupc/CNMF_E). The results were manually curated to discard non-neuronal ROIs. The resulting C-raw matrix, which was a scaled dF x ROIs, was used for further analysis. For individual ROIs, the time series dF of the whole session was further organized as a 2D matrix dF per trial x trials.

Neural classification. To identify VNS responsive neurons, each trial epoch (± 10s around VNS) was mean z-scored to the 3 seconds prior to VNS. Noise response was estimated by calculating average Z-scored dF for individual neurons using a randomly shuffled VNS onset times in the same session (excluding the 3 s window after each VNS onset in the whole session), and bootstrapping across 1000 repeats. For an individual neuron, if the real maximum averaged Z-scored dF in the 3 s window after VNS is higher than the 95% value of the bootstrapped histogram, the neuron was defined as activated by VNS; if the real minimum averaged Z-scored dF in the 3 s window after VNS is lower than the 95% value of randomized z-scored dF, the neuron was defined as suppressed by VNS.

To measure the onset or peak timing for the VNS response, VNS responsive neurons' dF were Z-scaled with the whole session baseline mean calculated from time points lacking Ca2+ activity (Jimenez et al., 2018) (defined as time points with fluorescence values less than the 0.50 quantile of all fluorescence values). This general-based Z-score process allows dF level above or below 0 before VNS onset each trial and keeps the average dynamics of VNS response more accurately. For individual VNS-activated neurons, the onset of VNS activation was defined as the first time point when the Z-scored dF value reached above 2 s.d. of the mean baseline (the 3 seconds before VNS onset) in the 5 s after VNS onset. For individual VNS-suppressed neurons, the onset of VNS suppression was the first time point when the Z-scored dF value reached below 2 s.d. of the mean baseline (the 3 seconds before VNS onset) in the 5 s after VNS onset.

To identify reach-task responsive neurons, a similar trial-based Z-score processes where employed. Trial dFs were aligned by reach max. The baseline was taken as -6 to -3 s before the time of reach max. The response of individual neurons to the task was measured as the maximum and minimum values of the average Z-scored dF in the -800 to -300 ms (reach preparation), -300 to 200 ms (reach), 200 to 1700 ms (outcome), in reference to reach max as time 0. The cut off value for maximum or minimum dF for these time windows were estimated through a similar randomization procedure as above, in which that the same number of reach trials were randomized across the whole session 1000 times. Success trials and failure trials were analyzed separately unless noted otherwise. Several sub-groups of neurons were categorized as: preparation-activated, preparation-suppressed, reach-activated, reach-suppressed, success-activated, success-suppressed, failure-activated and failure-suppressed. Preparation and reach modulated neurons were grouped together as reach modulated neurons in Figure 7. After neural classification, Z-score procedures were used to obtain the average success modulated neurons response to VNS and no-stimulation sessions.

Cross-registration of multiple sessions and cross session VNS modulated neurons definition

Due to computational power limits, we chose to process neural activity data from each session and register neurons across sessions. The MATLAB-based CellReg package (Sheintuch et al., 2017) (https://github.com/zivlab/CellReg) was used to identify the same

neurons from multiple sessions based on spatial footprints of cellular activity (ROIs). Pairs of neurons with correlation coefficient > 0.65 were regarded as the same neurons. Not all neurons could be tracked from one session to the next due to technical limitations. Only neurons that were cross-registered across the two recording sessions were analyzed in the subsequent VNS modulation analysis.

For individual neurons, if a neuron was categorized as success-activated in one of the two training sessions, the neuron was regarded as a success-activated neuron. To look for significant modulation after VNS onset in VNS sessions of these success-activated neurons, the success outcome response of each neuron was aligned to VNS onset and measured in no-stimulation session and VNS session; the difference in response was obtained by subtracting the no-stimulation response from the VNS session response. A difference in response during the 0∼3s after VNS onset that was higher or lower than 2.5 s.d. of the mean of baseline (-3 to 0 s before VNS onset) for at least 0.15 s was regarded as significant enhancement or attenuation in the VNS session. To look for significant modulation before VNS onset, the neural response was aligned to reach end. The baseline window was set from -6 to -3 s before reach end. This reach end alignment allows us to evaluate differences in neural representation of reach preparation, execution, and outcome. Differences between the reach representation were compared between the Success VNS and no-stimulation sessions. A difference in response during the -3 to 3 s around reach end that was higher or lower than 2.5 s.d. of the mean of baseline (-6 to -3 s in reference to reach end) for at least 0.15 s was regarded as significant enhancement or attenuation. The onset time of the modulation was defined as the first time point of this enhancement or attenuation.

The control, AChR antagonists, and recovery sessions were processed similarly as VNS in home cage sessions, as described above. In addition, these sessions were temporally down sampled to a 15 Hz frame rate to reduce the file size so that each mouse's three sessions imaging data could be motion corrected and concatenated together to save the *post-hoc* cross registration step. For VNS-modulated neurons, the VNS activation window was empirically measured and defined as rise onset to peak timing in Figures 6G and 6H (0.8 to 2.8 s after VNS onset; suppression window as 0.2 to 1.6 s after VNS onset).

QUANTIFICATION AND STATISTICAL ANALYSIS

Statistical analyses were conducted using Graphpad, JMP (SAS), or MATLAB (MathWorks). No normality tests were performed but individual data points are plotted to visualize distribution. We used parametric statistics including paired and unpaired Student's T-tests, and one-way ANOVA with Tukey's HSD *post-hoc* tests. Two-tailed tests and an alpha cutoff of <0.05were employed unless otherwise stated. We employed a mixed model (Restricted Maximum Likelihood model (REML)) for all learning experiments. REML enables us to test how fixed effects (dependent variables) and known random effects (individual mouse, sex, age) correlate to an outcome variable.

$$Outcome = fixed\ effect + known\ random\ effect + error$$

Models were constructed with one or two fixed effects. In cases where there were two fixed effects, we ran full factorial models. To determine early and late phases of learning, a Weibull growth curve was applied to Sham VNS learning data. The formula was:

$$a * \left(1 - Exp\left(-\left(\frac{Day}{b}\right)^{c}\right)\right)$$

a = asymptote, b = inflection point, c = growth rate. The AICc = 1295.90 and the R^2 = 0.21. We used the asymptote of the control cohort (55.50% ± 6.8%) to represent the plateau in success rate. The late learning phase was selected based on the first training day that exceeded the lower 95th percentile of the asymptote (42.15%), which was day 4. We thus called late learning days 5-14 and early learning days 1-4.

Vagus somatosensory-evoked potentials are prolonged in patients with multiple sclerosis with brainstem involvement

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ABSTRACT

Vagus somatosensory-evoked potentials (VSEP) were proposed as a neurophysiological indicator of brainstem dysfunction based on prolonged latencies found in Alzheimer's dementia and Parkinson's disease. We now aimed at a further confirmation of this view independent from neurodegenerative diseases and hypothesized that VSEP in multiple sclerosis with brainstem affection show prolonged latencies, too. In 15 patients with multiple sclerosis according to McDonald and 15 healthy controls after stimulation of the auricular branch of the vagus nerve at the tragus (electrical square impulses, impulse width 0.1 ms, interstimulus interval 2 s, intensity 8 mA), evoked potentials were recorded from electrode positions C3–F3, C4–F4, Fz–F3 and Fz–F4. Analysis of variance showed a significant main effect of the factor diagnosis on latency P1 ($F_{1,24}=7.067$, $P=0.001$), no significant effect for latencies N1 and P2 nor for the amplitudes. A subgroup of patients with signs of brainstem affection showed a trend for longer P1 latencies ($F_{1,11}=5916$, $P=0.033$) as compared with the group without. We take this result as further hint for VSEP to be generated at brainstem level which needs confirmation in larger-scale studies and other brainstem-affecting diseases. The method could be suitable for the demonstration of the involvement of differential brainstem nuclei in various neurodegenerative diseases.

https://journals.lww.com/neuroreport/Abstract/2013/03270/Vagus_somatosensory_evoked_potentials_are.9.aspx