Somatosensation

Mechanoreceptors that respond to touch/pressure on the surface of the body.

Sensory nerve responds propotional to pressure

4 types of mechanoreceptors:

Meissner corpuscles & **Merkel** discs - cutaneous light touch with high resolution.

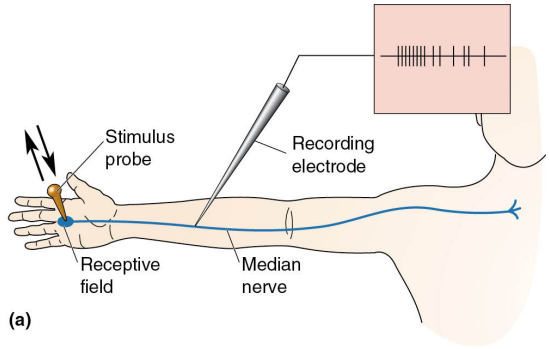
Pacinian corpuscles & **Ruffini** endings - deep receptors responding to stronger force with less acuity.

Meissner and Pacinian are **rapidly adapting** (phasic response) Merkel and Ruffini are **slowly adapting** (tonic response).

(also free nerve endings that respond to temperature, painful stimuli)

Receptive fields map to specific area on the body. **Density** of receptive fields varies across the body (lips, fingers have highest density so most sensitive).
Two-touch discrimination maps out receptive field density.

Recording somatosensory responses

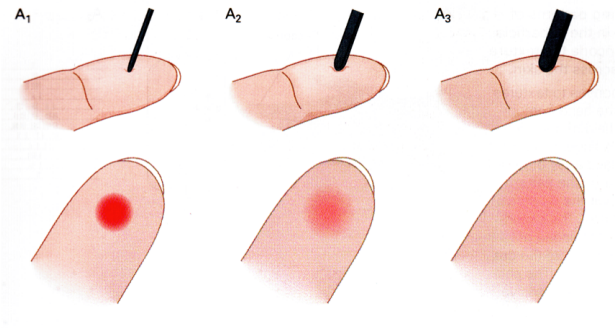


(a)

Me

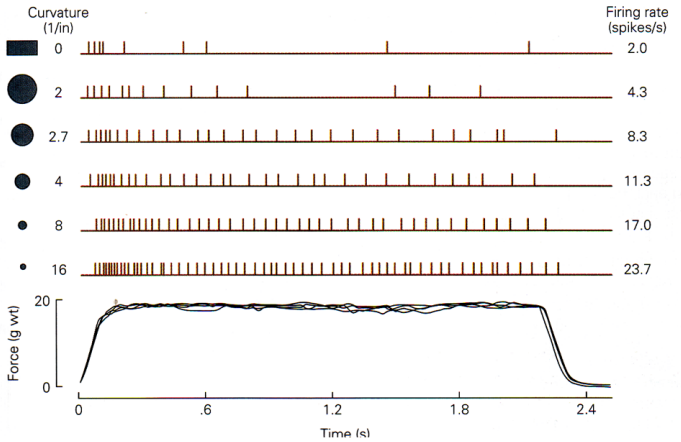
(b)

Receptive field response to pressure



Small point causes intense pressure over small area
Large point spreads pressure over wider area

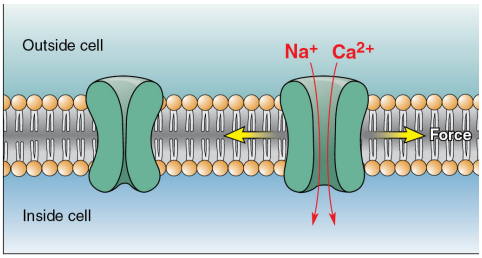
Firing Rate: response to pressure



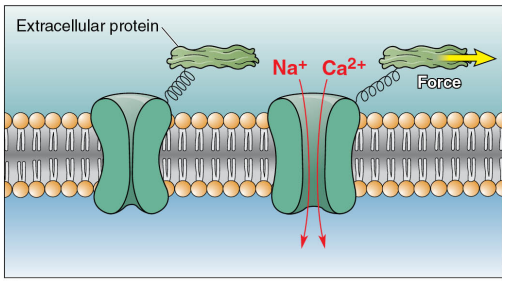
Mechanosensitive Ion Channels

- Mechanoreceptors have unmyelinated axon terminals.
- Mechanosensitive ion channels convert mechanical force into change of ionic current.
- Mechanical stimuli may trigger release of second messengers.
- Specific types of channels in most somatic sensory receptors still unidentified

Some Ion Channels Sensitive to Stretching of Lipid Membrane



Some Ion Channels Open with Force Applied to Extracellular Structures



Some Ion Channels Open with Deformation and Stress on Cell's Cytoskeleton

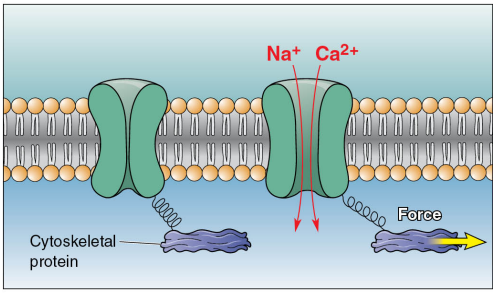
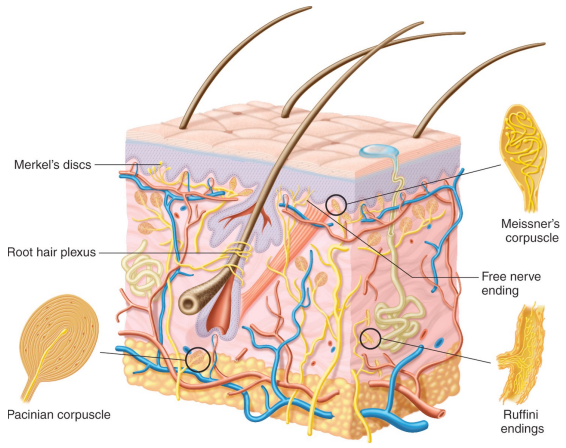


Table 10.2

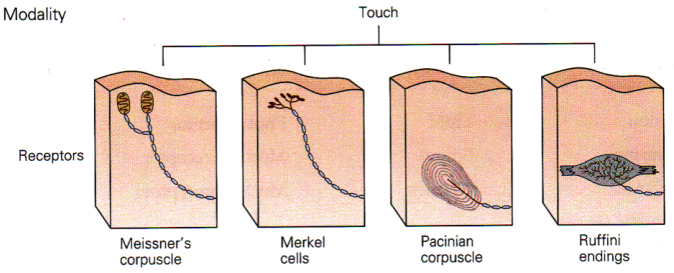
Table 10.2 | Cutaneous Receptors

Receptor	Structure	Sensation
Free nerve endings	Unmyelinated dendrites of sensory neurons	Light touch; hot; cold; nociception (pain)
Merkel's discs	Expanded dendritic endings	Sustained touch and pressure
Ruffini corpuscles (endings)	Enlarged dendritic endings with open, elongated capsule	Sustained pressure
Meissner's corpuscles	Dendrites encapsulated in connective tissue	Changes in texture; slow vibrations
Pacinian corpuscles	Dendrites encapsulated by concentric lamellae of connective tissue structures	Deep pressure; fast vibrations

Figure 10.4



4 Types of Mechanoreceptors

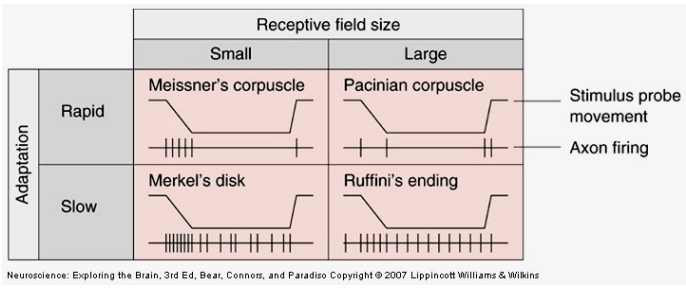


All respond to touch, but have different:
anatomy
receptive fields
intensity/time response characteristics
which make each receptor respond best to particular stimuli

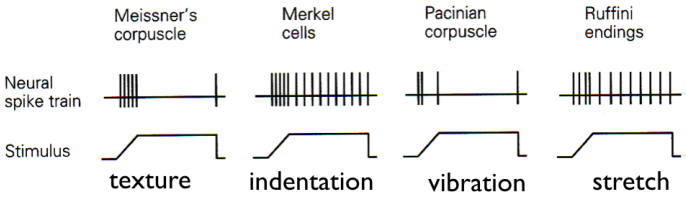
4 Mechanoreceptors

Meissner & Merkel - cutaneous light touch with high resolution.

Pacinian & Ruffini corpuscles - deep receptors responding to stronger force with less acuity.



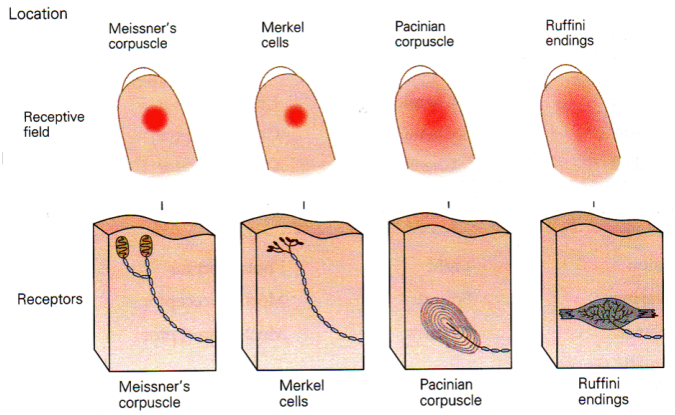
Intensity & timing of response characteristics: slowly-adapting and rapidly-adapting receptors



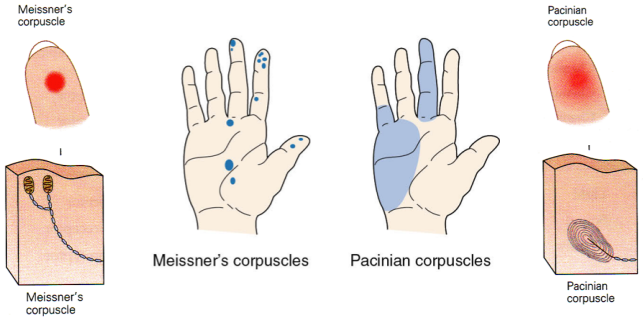
Rapidly adapting -- respond best to onset & offset of stimulus
(or rapidly changing stimulus -- edge or slope detector)

Slowly adapting -- continue to respond to continuous stimulus

Size of receptive field varies among mechanoreceptors



Small and Large Receptive Fields



Receptive Field of a Somatosensory Neuron

Two-point Touch determines density of receptive fields

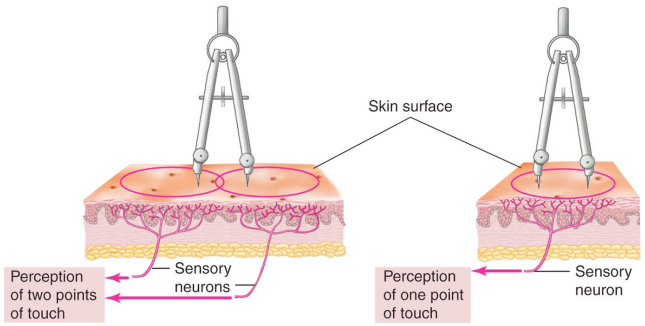


Figure 10.5

Density of receptors determines somatosensory acuity

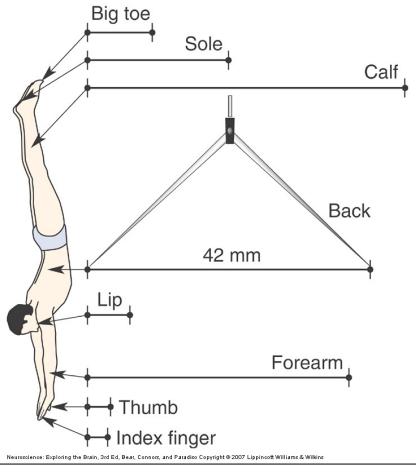


Table 10.3

Table 10.3 | The Two-Point Touch Threshold for Different Regions of the Body

Body Region	Two-Point Touch Threshold (mm)
Big toe	10
Sole of foot	22
Calf	48
Thigh	46
Back	42
Abdomen	36
Upper arm	47
Forehead	18
Palm of hand	13
Thumb	3
First finger	2

FSU!

Source: From S. Weinstein and D.R. Kenshalo, editors, *The Skin Senses,* © 1968. Courtesy of Charles C. Thomas, Publisher, Ltd., Springfield, Illinois.

Somatosensory Nerves

Each somatosensory neuron has a single small **receptive field** (the area of the skin where it innervates mechanoreceptors).

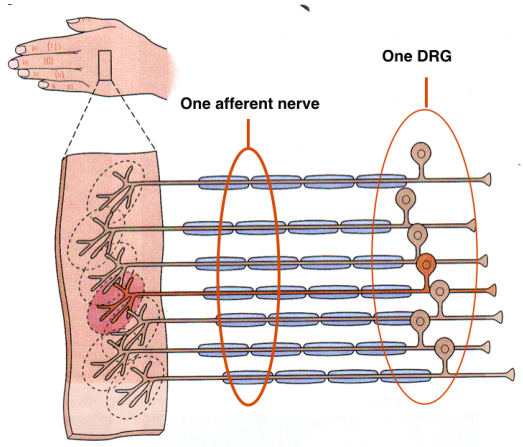
Multiple somatosensory neurons are gathered into a single **spinal nerve**. Cell bodies of the sensory neurons are gathered in **dorsal root ganglia**. Sensory afferents enter the **dorsal horn** of the spinal cord.

Each spinal nerve innervates a single segment of the body (***dermatome*** - *skin section*). Damage to a single spinal segment will affect the corresponding dermatome.

Infections of the peripheral nerves will affect specific dermatomes (e.g. herpes zoster = shingles = chicken pox)

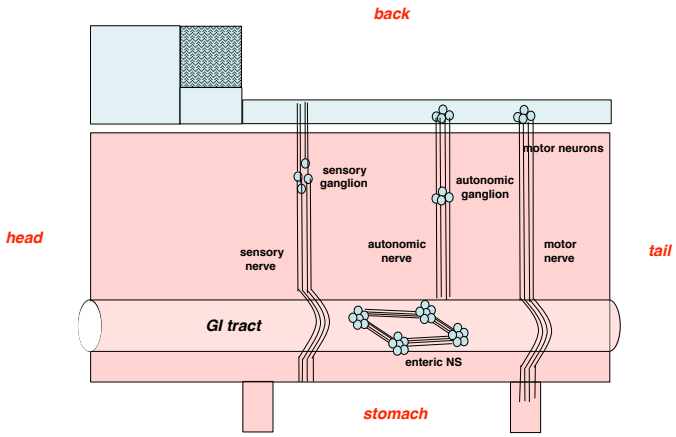
Somatosensory nerves project to **contralateral** side of the cerebral cortex.

Many afferents with overlapping receptive fields in each DRG

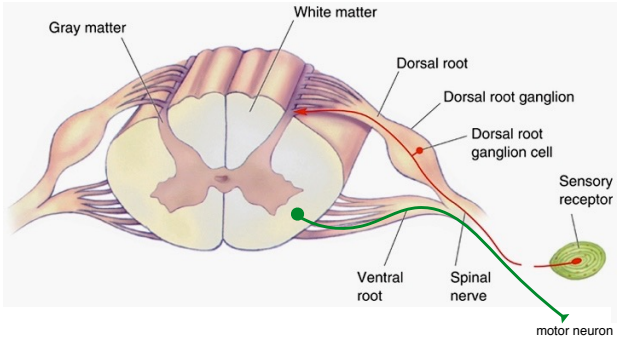


Peripheral Nervous System:

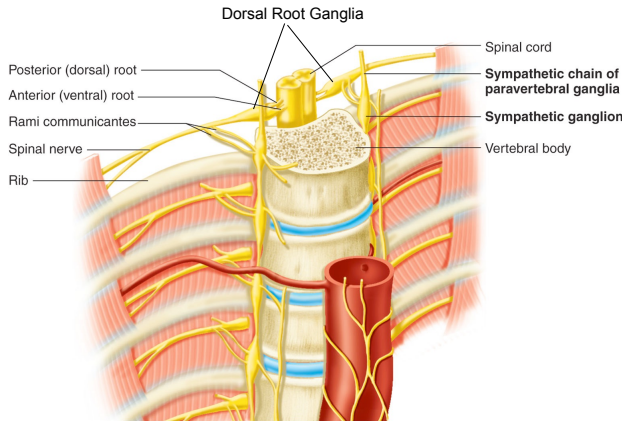
Neurons and nerve fibers outside the brain and spinal cord



Sensory afferent mechanoreceptor neuron: cell body in DRG projects from skin to spinal cord

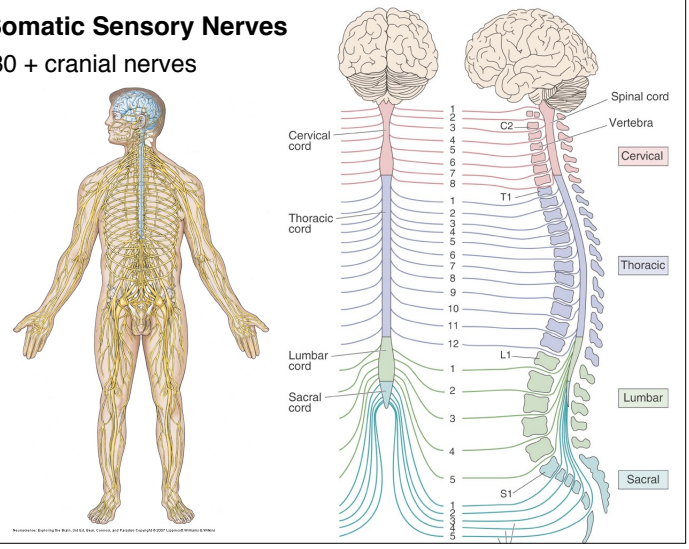


Fox Figure 9.2

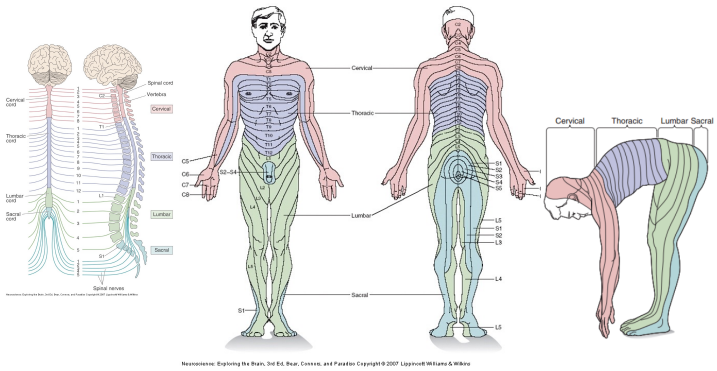


Somatic Sensory Nerves

30 + cranial nerves



One DRG approx. for each vertebra: receptive fields of one DRG = dermatome



Infection by neural virus that lives in DRG cells: herpes zoster (shingles or chicken pox)

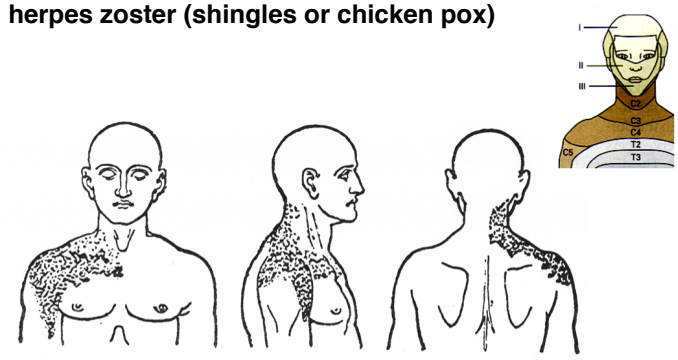
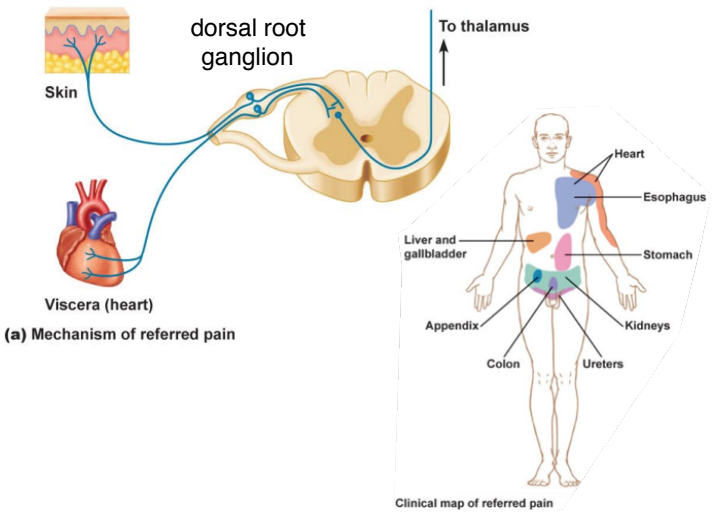


Figure 10.9. Head and Campbell (1900) compared the rashes in individual cases of herpes zoster, like the one shown above, to map the dermatomes in humans.



Somatosensory Cortex

Cortical neurons also have receptive fields that correspond to receptive fields of somatosensory nerves that provide input. Cortex uses simple receptive fields of somatosensory nerves to derive and extract more complex features.

Somatotopy: Cortical neurons are arranged in same topology as peripheral receptive fields on the skin, to make up homunculus. Areas with denser receptive fields have bigger cortical representation (more neurons dedicated to processing).

Feature extraction: Cortical somatosensory neurons have more complex receptive fields than just location. Neurons may also respond to features:

- orientation of pressures across multiple receptive fields
- direction of movement of touch across multiple receptive fields
- (input of multiple peripheral neurons converge on 1 cortical neuron)

Higher cortical levels extract even more complex features (e.g. shapes, object identification). **Stereopsis** is ability to identify the 3D shape of an object.

Ascending Somatosensory Pathways

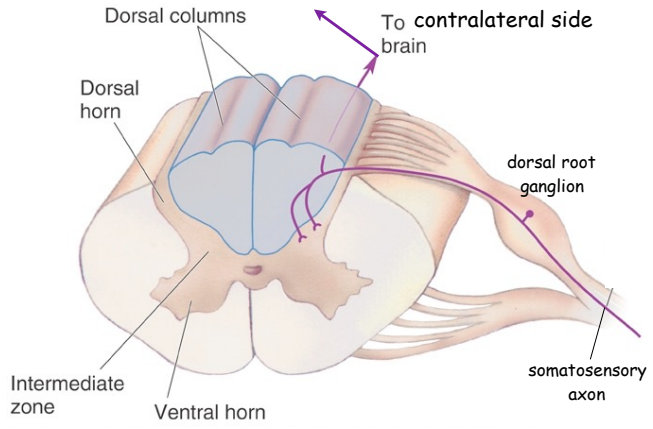
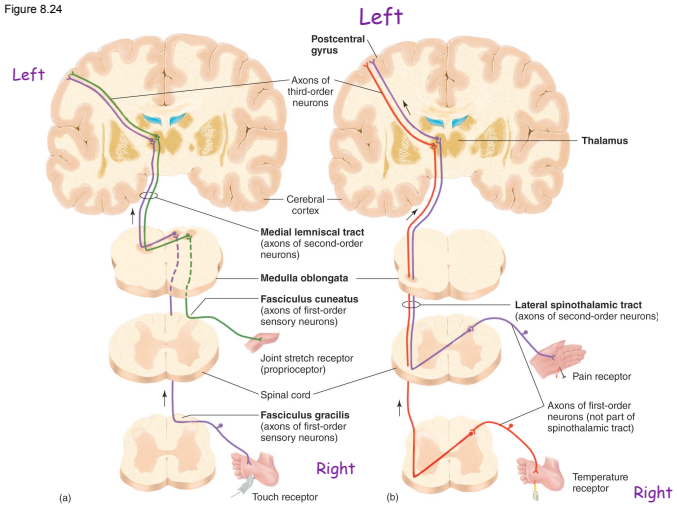
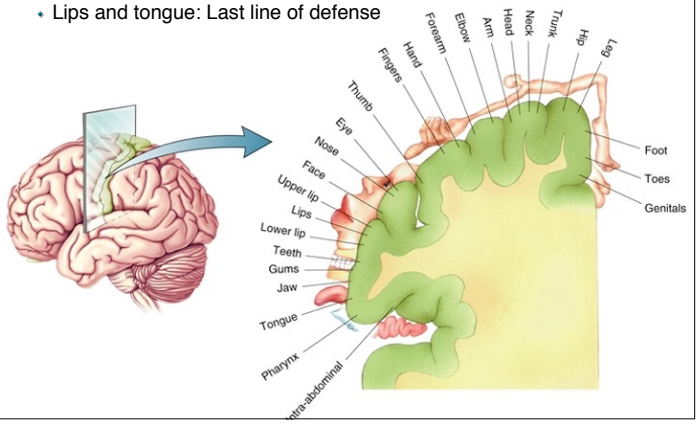


Figure 8.24



- Cortical Somatotopy
  - Homunculus
  - Importance of mouth
    - Tactile sensations: Important for speech
    - Lips and tongue: Last line of defense



How to make cortical map

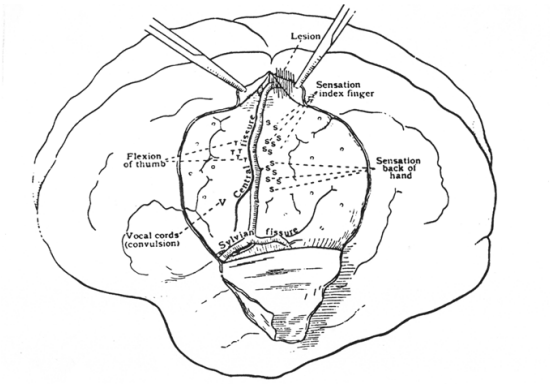


Figure 10.15. Diagram from Harvey Cushing (1909) showing distribution of sensory responses from the postcentral gyrus and motor responses from the precentral gyrus in a conscious human patient who underwent electrical stimulation of the brain.

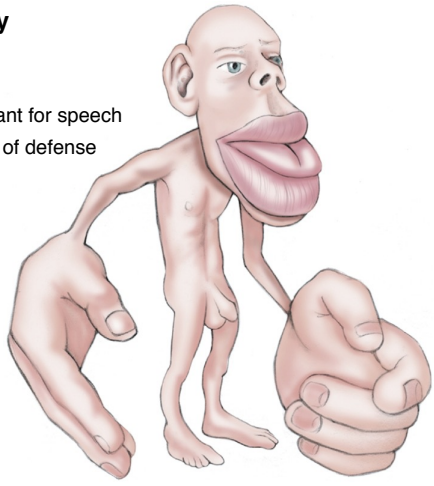
Cortical Somatotopy

Homunculus

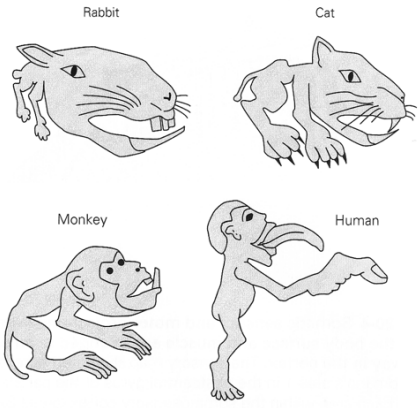
Importance of mouth

Tactile sensations: Important for speech

Lips and tongue: Last line of defense

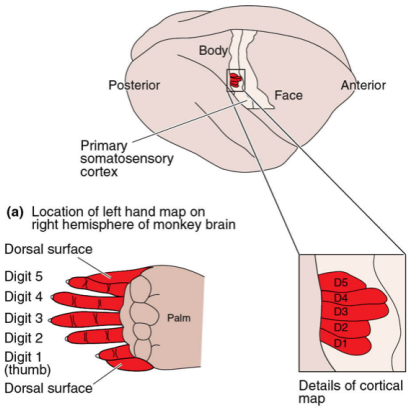


Maps differ between species



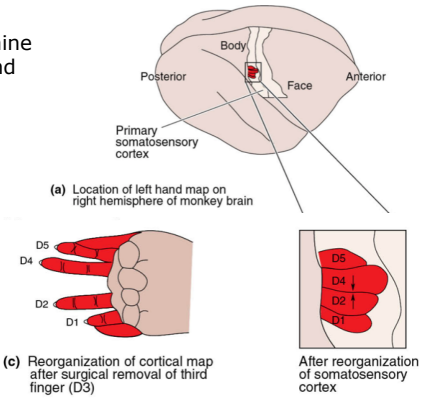
Somatotopic Map Plasticity

- Remove digits or overstimulate— examir somatotopy before and after
- Maps are dynamic.



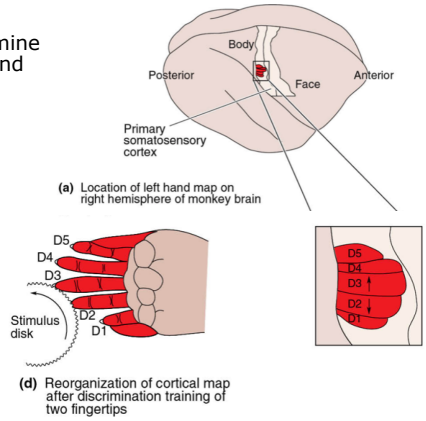
Somatotopic Map Plasticity

- Remove digits or overstimulate— examine somatotopy before and after
- Maps are dynamic.



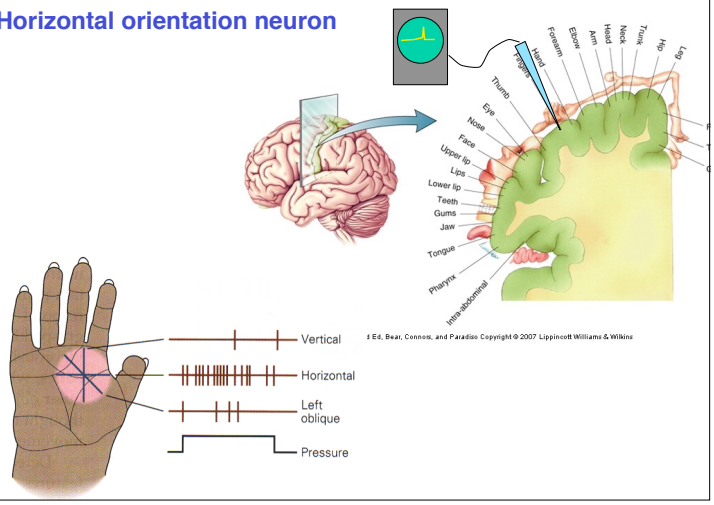
Somatotopic Map Plasticity

- Remove digits or overstimulate— examine somatotopy before and after
- Maps are dynamic.



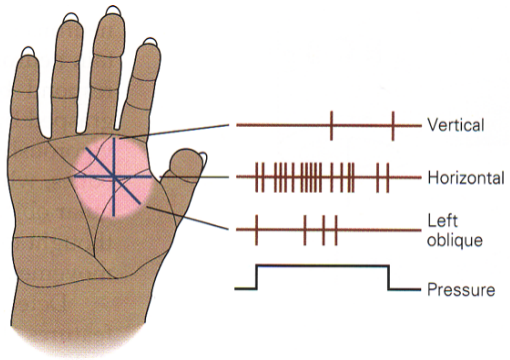
Feature extraction by cortical neurons

Horizontal orientation neuron



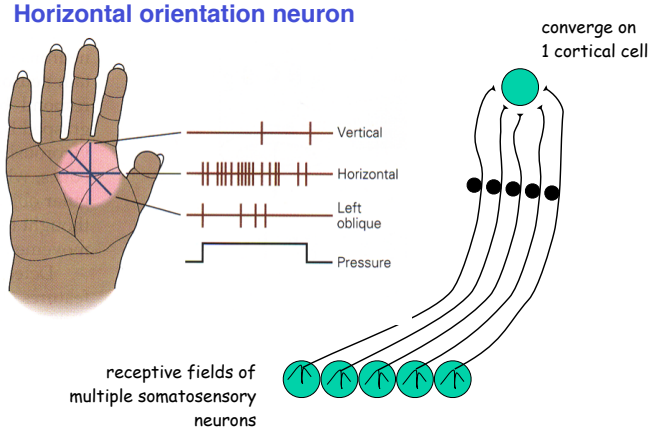
Feature extraction by cortical neurons

Horizontal orientation neuron



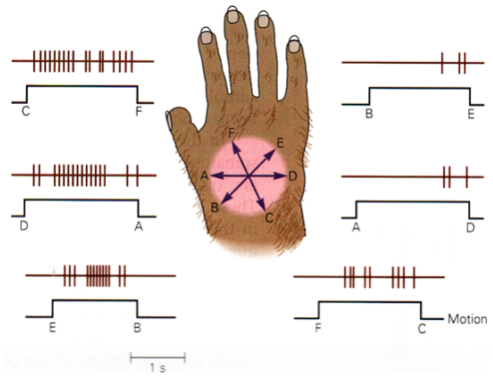
Feature extraction by cortical neurons

Horizontal orientation neuron



Feature extraction by cortical neurons

Directional movement neuron



Stereopsis -- detecting 3D shape of an object

An excellent description of astereognosis appeared in 1898.

B.C. was 24 years old when he presented himself to Dr. Burr for treatment. When he was about 10 years old he was accidently struck on the side of the head by an axe handle with such force that he was thrown into a river, on the bank of which he had been standing. Examination of the head showed that he had a simple depressed fracture of the right parietal bone over the motor area. He remained in a state of alternating coma and delirium for about three weeks. On recovering he found himself partially paralyzed on the left side of the body and face, and completely anesthetic on the same side. The palsy and anesthesia entirely passed away in a few months, sensation returning before motion. He was supposed to have recovered completely, until, on putting his left hand into his coat pocket for the first time after his illness, he discovered that he could not tell what he had in his grasp, though he had preserved the sense of touch. (Burr, 1898, 37)