Phloracetophenone-induced choleretic in rats is mediated through Mrp2

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Submitted 20 December 2006; accepted in final form 14 March 2007

Phloracetophenone-induced choleretic in rats is mediated through Mrp2. Am J Physiol Gastrointest Liver Physiol 293: G66–G74, 2007. First published March 15, 2007; doi:10.1152/ajpgi.00578.2006.—Phloracetophenone (2,4,6-trihydroxyacetophenone, THA) is a potent choleretic in the bile fistula rat, although the mechanism is unknown. In the present study, we examined how THA enhances bile secretion. Stepwise infusions of THA (1–4 μmol/min) in the isolated perfused rat liver resulted in an immediate and dose-dependent increase in bile flow (BF), which reached saturation. The increase in BF was not associated with a change in the excretion of bile acids, suggesting that THA stimulated bile acid-independent bile flow. To further define the mechanism, the effect of THA on the excretion of sulfobromophthalein (BSP) and disulfobromophthalein (DBSP), typical multidrug resistance protein-2 (Mrp2) substrates was examined. THA inhibited the biliary excretion of both substrates. Because DBSP is excreted without conjugation to glutathione, in contrast to BSP, the findings suggest that THA might compete with DBSP and BSP metabolites at a common canalicular transport site, presumably Mrp2. THA infusions had no effect on the subcellular localization and distribution of either Mrp2 or the bile salt export pump (Bsep), nor the integrity of the tight junction. In contrast, the choleretic activity of THA was completely absent in the TR rat, an animal model that lacks Mrp2, directly implicating this canalicular export pump as the mechanisms by which THA is excreted in bile. THA also partially reversed the cholestatic effects of estradiol-17β-d-glucuronide, a process also dependent on Mrp2. In conclusion, the choleretic activity of THA and its possible metabolites is dependent on Mrp2. THA appears to stimulate BF by its osmotic effects and may attenuate the cholestatic effects of hepatotoxins undergoing biotransformation and excretion via similar pathways.

The therapeutic potential of a number of these compounds is dependent on this metabolic pathway. For example, genipin, an intestinal bacterial metabolite of geniposide which is the major active compound in Inchingko-to, is an herbal medicine used in China and Japan for treatment of jaundice. Genipin has been shown to have potent choleretic activity (32) and is conjugated with glucuronide in the liver before excretion. Genipin stimulates the insertion of the multidrug-resistance-associated protein 2 (Mrp2) into the bile canalicular membrane and thereby increases the biliary excretion of GSH and BAIF (31).

Ursodeoxycholic acid, an anticholestatic drug, prevents the cholestatic effects of ethinylestradiol by inhibiting both the activity and expression of the hepatic microsomal enzyme involved in ethinylestradiol glucuronidation (29). This in vivo effect appears to be mediated by the major metabolite of ursodeoxycholic acid, tauroursodeoxycholate, which inhibits ethinylestradiol glucuronidation noncompetitively in vitro (29).

Phloracetophenone, or 2,4,6-trihydroxyacetophenone (THA), the aglycone component of phloracetophenone glucoside, is a naturally occurring compound obtained from the rhizome of Curcuma comosa (Family Zingiberaceae) (24). When administered via the duodenum to rats, THA stimulates bile flow and enhances the biliary excretion of bile acids, leading to a lowering in the plasma levels of cholesterol (25, 26). Thus THA may have potential as a therapeutic drug for the treatment of cholestasis and prevention of gallstones (3, 22). However, the underlying mechanism by which THA enhances bile flow remains unknown. In the present study, we utilized the isolated perfused rat liver (IPRL) to examine the effects of THA on bile flow and defined the possible pathways that may account for its choleretic effects. The IPRL model was employed because it facilitates study of the direct action of compounds on the liver without the confounding effects of blood flow or extrahepatic tissue involvement (21). Our findings indicate that the choleretic effect of THA is primarily dependent on Mrp2 and that THA may have therapeutic potential to attenuate E2-17G-induced cholestasis.

MATERIALS AND METHODS

Chemicals. THA was purchased from Fluka Chemie (Buchs, Switzerland). Taurocholate (TC), estradiol-17β-d-glucuronide (E2-17G), glutathione reductase, the reduced form of glutathione (GSH), the reduced form of β-nicotinamide adenine dinucleotide phosphate, tetrasodium (β-NADPH), DTNB, and sulfobromophthalein (BSP)

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were purchased from Sigma Chemical (St. Louis, MO), Phenol-3,6-dibromophthalein disulfonate (DBSP) was from Société d’Etudes et de Recherches Biologiques (Paris, France). Bile acid reagents A and B for bile acid determination were from Trinity Biotech (Wicklow, Ireland). All other chemicals were of analytical grade.

**IPRL studies.** Male Sprague-Dawley rats (190–200 g) were obtained from Charles River Laboratories (Wilmington, MA), and all experimental protocols were conducted under the National Institutes of Health guidelines and were approved by The Yale Animal Care and Use Committee.

Rat livers were isolated and perfused in the Cellular and Molecular Physiology Core of the Yale Liver Center as described previously (6). Following pentobarbital sodium anesthesia (50 mg/kg body wt ip) the bile duct and portal vein were cannulated with PE-10 tubing (Becton Dickinson Primary Care Diagnostics, Sparks, MD) and a 14-gauge Teflon intravenous catheter (Mckesson General Medical, Cheshire, CT), respectively. The liver was perfused immediately at a rate of 30 ml/min with oxygenated (95% O₂–5% CO₂) Krebs-Ringer bicarbonate (KRB) buffer (pH 7.4) containing 0.1% glucose and maintained at 37 ± 0.5°C. After cannulation of the inferior vena cava, the liver was transferred into a temperature-controlled chamber and then perfused at a constant flow rate of 40 ml/min with oxygenated KRB buffer (4.4–5.7 ml·min⁻¹·g liver⁻¹). KRB buffer was gassed continuously with a humidified mixture of 95% O₂–5% CO₂ and maintained at 37 ± 0.5°C by monitoring the temperature with a thermistor probe (Yellow Springs Instrument, Yellow Springs, OH) inserted between the lobes of the liver. The viability of the liver was determined by continuously monitoring perfusion pressure and O₂ consumption throughout the course of experiment. At the end of the experiment, Trypan blue was injected into the liver to evaluate the uniformity of perfusion from the distribution of the staining dye.

All IPRL studies utilized a single-pass system with oxygenated (95% O₂–5% CO₂) KRB (pH 7.4). Following a 15-min period of equilibration, THA was infused and bile flow and biliary excretion of bile acid and total glutathione were assessed. THA was dissolved in solvent (DMSO-absolute ethanol-KRB, 25:15:60) and was infused into the perfusate at a rate of 1.2 ml/h as previously described (23). Body temperature was maintained at 37 ± 0.5°C with a heating lamp. After collection of the control samples for 15 min, THA dissolved in the solvent mixture was injected into the proximal part of duodenum at the dose of 125 or 250 µmol/kg body wt (volume of injection 0.5 ml). Bile samples were collected at 15-min intervals for a total of 90 min. Sample tubes were reweighed and BFR was calculated.

**Immunohistochemistry and confocal analysis.** A separate set of experiments were conducted to examine the effect of THA on the intracellular distribution of the bile salt export pump (Bsep), the multidrug resistance-associated protein 2 (Mrp2), and the tight junction-associated protein, zonula occludens (ZO-1). THA was infused into the IPRL for 25 min, and the liver was removed and cut into a small cubic pieces, immediately frozen in Freon-cooled liquid nitrogen, and then kept at −80°C until use. For tissue preparation, small cubic pieces of liver tissue were cut into 4- to 6-µm-thick sections and mounted on slides. Liver slices were fixed in cold acetone (−20°C) for 20 min. Tissues were then rehydrated by incubation in blocking buffer (PBS, 1% BSA, 0.05% Triton X-100) for 20 min. For Bsep and Mrp2 labeling, tissues were incubated with Bsep antibody (1:200) (Kamiya Biomedical, Seattle, WA) and Mrp2 antibody (1:100) (Axoxra LLC San Diego, CA) diluted in blocking buffer for 2 h at room temperature. After being washed in PBS-0.05% Triton X-100, secondary antibody for Bsep (Alexa594-conjugated goat anti-rabbit IgG) (1:500) and for Mrp2 (Alexa488-conjugated goat-anti-mouse IgG) (1:500) diluted in blocking buffer were applied for 60 min. For ZO-1 labeling, liver slices were incubated with primary antibody to ZO-1 (1:400) (Zymed, San Francisco, CA) for 2 h, washed, and incubated with secondary antibody (1:500) for 60 min. Fluorescent localization was viewed via a Zeiss LSM 510 confocal microscope (Carl Zeiss).

**Analytical methods.** Total bile acid excretion was determined by using a diagnostic bile acid reagent kit (Triotechnology Biotech) that is based on 3α-hydroxysteroid dehydrogenase enzymatic method (17). Total glutathione in bile was measured immediately from bile samples collected in perfused tubes containing 6% sulfosalicylic acid to minimize oxidation of GSH and was determined spectrophotometrically by the enzymatic recycling procedure of Tietze (33) as modified by Griffith (8). Concentration of BSP and DBSP in bile were measured spectrophotometrically at the absorption maximum (580 nm) after appropriate dilution with 0.1 N NaOH.

**Statistical analysis.** All data are expressed as means ± SE. The differences in pairs of samples between control and THA-treated group in IPRL were compared by Student’s paired t-test. For comparing more than two groups, the significance of the difference among groups was analyzed by ANOVA, followed by Student-Newman-Keuls test. Values of *P* < 0.05 were considered to be significantly different.

**RESULTS**

**Effect of THA on BFR.** The choleretic effect of THA infusion into the IPRL was characterized by utilizing a stepwise infusion of THA (1, 2, and 4 µmol/min). This caused a dose-dependent increase in BFR that attained a steady state at 10–15 min after start of the infusion (Fig. 1). THA at a dose of 1 µmol/min caused an immediate increase in bile flow and maintained BFR at 1.8 ± 0.1 µl·min⁻¹·g liver⁻¹ (*n* = 4) compared with 1.0 ± 0.1 µl·min⁻¹·g liver⁻¹ under basal conditions. THA at 2 µmol/min further increased BFR to a maximum level of 2 ± 0.2 µl·min⁻¹·g liver⁻¹, whereas THA at 4 µmol/min did not induce any further increase in BFR. In control animals, BFR slightly declined with time. Thus THA directly stimulated bile flow in a dose-dependent manner but reached a maximum effect.
Effect of THA on biliary secretion of bile acids and total glutathione (GSH + GSSG).

To examine the determinants of bile secretion, the effect of THA on the two major endogenous osmotically active solutes, bile acids and glutathione, was determined. In the isolated perfused liver, the concentration of biliary bile acids in control animals rapidly declined with time and reached a minimal level of 0.9 ± 0.2 mM after 30–35 min of perfusion, as shown in Fig. 2A. The THA-infused livers showed a similar decline in the concentration of bile acids to that of the control. Fifteen minutes after THA infusion, bile acid concentration significantly decreased to 0.4 ± 0.04 mM (*P < 0.05 and **P < 0.01, significant difference from control at the corresponding time).

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Effect of THA on BSP excretion. The multidrug resistance-associated protein 2 (Mrp2) is responsible for the biliary excretion of many glucuronide, sulfate, and glutathione S-conjugates, as well as GSH itself (7). Because THA infusions inhibited the excretion of GSH, Mrp2 was presumed to be a candidate for THA excretion. Therefore we examined the effect of THA on the excretion of BSP and DBSP, two typical substrates of the Mrp2 canalicular membrane transporter. As shown in Fig. 3A, infusion of BSP, at a rate of 0.04 µmol/min, did not alter BFR, which was steadily maintained at 1 µl/min • g liver⁻¹. In contrast, simultaneous infusions of THA (40 µmol/min) caused an immediate and marked approximately twofold increase in BFR within the first 5 min of infusion that subsequently slightly declined with time (Fig. 3A). Concurrent with the increase in BFR, both the concentration and excretion rate of BSP in bile were markedly decreased...
infusion was stopped is likely due to the effect of the increase and decrease in bile flow, respectively, on previously secreted BSP residing within the bile canaliculi and biliary tree, i.e., a washout phenomenon (Fig. 3C).

(Fig. 3, B and C). Biliary BSP concentration was significantly decreased from 4.8 ± 0.2 mM in control to 2.6 ± 0.6 mM 10 min after THA infusions. These findings suggest that THA may compete with BSP for excretion into bile. The small increase in BSP excretion in the first 10 min and the decrease in biliary BSP excretion that persisted for ~10 min after THA infusion was stopped is likely due to the effect of the increase and decrease in bile flow, respectively, on previously secreted BSP residing within the bile canaliculi and biliary tree, i.e., a washout phenomenon (Fig. 3C).

Fig. 3. Effect of THA on bile flow rate (A), biliary sulfobromophthalein (BSP) concentration (B), and BSP excretion rate (C) in the isolated perfused rat liver. BSP at a dose of 0.04 μmol/min was continuously infused into the liver throughout the course of the experiment. THA was added into the perfusion medium for coprofusion at a constant rate of 40 μmol/min at the indicated time point. Values are means ± SE from 4 animals. *P < 0.05 and **P < 0.01, significant difference from control at the corresponding time.

Fig. 4. Effect of THA on bile flow rate (A), biliary dibromosulfobromophthalein (DBSP) concentration (B), and DBSP excretion rate (C) in the isolated perfused rat liver. DBSP at a dose of 0.04 μmol/min was continuously infused into the liver throughout the course of the experiment. THA was added into the perfusion medium for coprofusion at a constant rate of 40 μmol/min at indicated time point. Values are means ± SE from 4 animals. *P < 0.05 and **P < 0.01, significant difference from control at the corresponding time.
Effect of THA on biliary DBSP excretion. Because BSP is conjugated with glutathione, we studied the effect of THA on the excretion of DBSP, a nonmetabolizable analog of BSP that is readily excreted into bile but does not require conjugation as does BSP (5, 9, 14). As seen in Fig. 4A, DBSP infusion did not alter basal BFR at the dose used. Simultaneous infusion of THA with DBSP also caused a rapid increase in BFR from 0.9 ± 0.1 to 1.4 ± 0.2 μl·min⁻¹·g liver⁻¹. However, the increase was not statistically different from the control and it declined with time. THA caused an immediate decrease in both biliary concentration and excretion of DBSP (Fig. 4, B and C). Note that the onset of inhibition of THA on biliary DBSP excretion was more rapid and the effect greater than observed on BSP excretion. Together these findings suggest that THA inhibits the bile excretory phase rather than the preceding intracellular step of phase II conjugation of BSP.

Effect of THA on immunofluorescent localizations of Mrp2, Bsep, and ZO-1 in the liver. Since THA infusions acutely induced a transient increase in BFR, this short-term action of THA might result from the canalicular insertion of submembranous vesicles containing canalicular transport proteins. To examine this possibility, Bsep and Mrp2 proteins in control and THA-treated livers were examined by fluorescent confocal microscopy. As shown in Fig. 5, Bsep and Mrp2 are mainly localized on the canalicular membrane in control livers and no significant changes in the expression or localization of these two transporters were observed after THA was infused at 1, 2, 4, or 8 μmol/min. The possibility that THA increased the permeability of tight junctions was also evaluated. However, the structure and localization of the tight junction protein ZO-1 was unaltered by THA at either a low or high dose (1 and 8 μmol/min) compared with control livers (Fig. 6).

Effect of THA on BFR in TR⁻/⁻ mutant rat. To directly determine whether Mrp2 is the putative canalicular transporter for THA and responsible for its choleretic activity, the choleretic effect of THA was examined in TR⁻/⁻ mutant rats, genetically deficient in Mrp2 transporter (13), by using a bile fistula. As shown in Fig. 7, choleretic activity of THA at doses of 125 and 250 μmol/kg body wt is not observed in the TR⁻/⁻ mutant rat, whereas in normal rats THA at a dose of 250 μmol/kg body wt markedly increased BFR to 197.3 ± 13.4% of control. These studies unequivocally establish that Mrp2 is required for the choleretic activity of THA.

Effect of THA on estradiol-17β-glucuronide (E2-17G) induced cholestasis. Finally we examined the therapeutic potential of THA by determining whether THA could reduce the cholestatic effects of the steroid E2-17G. TC at a dose of 0.5 μmol/min was infused into the IPRL to supplement endogenous bile acid throughout the experiment. As shown in Fig. 8, TC significantly increased BFR by ~190% of the initial BFR (P < 0.05). A single injection of E2-17G rapidly decreased BFR from 191.2 ± 22.7 to 52.6 ± 15.5% of the initial BFR, reaching a minimum value at 10 min after the E2-17G injection. Thereafter, BFR gradually returned toward the TC-stimulated level. In contrast, THA infusions partially prevented the E2-17G induced cholestasis. In addition, the decrease in BFR induced by E2-17G was delayed in time. Moreover, recovery of BFR in THA-infused liver occurred faster, returning to control values 20 min after E2-17G administration (Fig. 8). E2-17G administration rapidly decreased biliary bile acid concentration and excretion in control animals (Fig. 9, A and B). However, after reaching minimum values at 10–15 min, they returned toward normal levels. With THA infusions, the concentration of bile acids continued to be maintained at low levels compared
with E2-17G administration alone (P < 0.05) (15.5 ± 1.4 mM with and 24.8 ± 2.0 mM without THA infusion) (Fig. 9A). However, the transient decrease in bile acid excretion in the THA-infused livers was comparable to controls without THA infusion (Fig. 9B). E2-17G had no effect on the total concentration of glutathione in bile of control animals (Fig. 9C). However, when THA was infused with E2-17G, a marked decrease in biliary total glutathione concentration was observed from 103.0 ± 6.3% in the control group to 27.5 ± 7.0% of the pretreatment value (before E2-17G administration), resulting in a transient decrease in excretion of total glutathione in bile to 9.4 ± 3.1% of the pretreatment value. This was significantly different from the TC-control value, which was 39.3 ± 5.8% of pretreatment value at 15 min after THA infusion (P < 0.05) (Fig. 9D).

**DISCUSSION**

The present study confirms the potent choleretic effect of THA using the IPRL and provides new findings concerning the mechanism by which this choleresis occurs. First, THA infusions resulted in an immediate dose-dependent increase in bile secretion that reached saturation at the higher infusion rate. The latter effect is characteristic of a carrier-mediated transport maximum (Fig. 1). Second, there was no effect on bile acid excretion in these experiments so that the bile salt-independent fraction was stimulated. Prior unpublished studies in the IPRL during bile acid infusions also failed to demonstrate any effect of THA on bile acid excretion. Third, THA selectively inhibited the biliary excretion of BSP and DBSP, both substrates for Mrp2. Together these findings suggest that the choleretic effect of THA was determined by the excretion of osmotically active solutes via Mrp2. Moreover, the choleretic effect of THA did not influence the subcellular localization of the transporter nor its targeting from its submembranous intracellular compartment into the apical membrane, suggesting that this posttranscriptional modification of Mrp2 expression was probably not involved.

In earlier studies in the bile fistula rat, THA increased both BAIF and BADF (23, 26). However, its mechanism of action was unclear, particularly whether THA had direct effects on the liver or acted indirectly via signaling molecules derived from the intestine. The present study, using the IPRL, clearly demonstrates that THA mediates its choleretic effect by a direct effect on the liver. It is also evident that THA increases BFR without stimulating biliary bile acid or glutathione secre-

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**Fig. 6.** Effect of THA on immunofluorescent localization of zonula occludens 1 protein (ZO-1). Confocal microscopy analysis of ZO-1 was performed in livers that were infused with vehicle or THA (1 and 8 μmol/min). A and B: images visualized at different areas of the liver with the same magnification. C: image acquired at high magnification. Bar = 10 μM.

**Fig. 7.** Effect of THA on bile flow rate in TR− and normal rat. A single intraduodenal injection of THA at the doses of 125 and 250 μmol/kg body wt was administered at 45 min. Values are means ± SE from 4 animals. **P < 0.01, significant difference from control at the corresponding time.

**Fig. 8.** Effect of THA on estradiol-17β-D-glucuronide (E2-17G)-induced cholestasis. Taurocholate (TC) at a dose of 0.5 μmol/min was continuously infused to supplement the endogenous bile acid in the liver starting from 15 min to the end of the experiment. THA was added into the perfusion medium for coperfusion at a constant rate of 40 μmol/min from 45 to 90 min of perfusion. E2-17G at a dose of 1 μmol/100 g body wt was administered as a bolus injection into the liver immediately before the start of THA infusion. Values are means ± SE from 4 animals. **P < 0.05 and ***P < 0.01, significant difference from control at the corresponding time. BFR, bile flow rate.
tion. The lack of an effect of THA on bile acid excretion in the present study does not agree with the earlier finding in the bile fistula rat where THA enhanced bile acid excretion and subsequently lowered plasma cholesterol (23, 26). These earlier findings in the bile fistula rat might be due to the washout of bile acids excreted into the biliary tree before the administration of THA.

Since THA did not directly stimulate the biliary excretion of bile acids and glutathione, the two major determinants of bile flow, the mechanism by which THA increases BFR in the isolated liver is most likely due to the excretion of osmotically active solutes of the biotransformed THA. Indeed, two glucuronide metabolites of THA have been identified (S. Khambang, A. Suksamrarn, and P. Piyachaturawat, unpublished observation). This finding is consistent with an earlier report that the glucuronide conjugation of phloracetophenone is the major biliary metabolite (11, 16). Mrp2, the multispecific resistance-associated protein 2, plays an important role in the biliary excretion of a number of endogenous and exogenous compounds including glucuronide, glutathione, and sulfates conjugates (7). In our earlier study on the choleretic effect of 4-monohydroxyacetophenone (a THA analog), there was a clear parallel increase in bile flow and metabolites in bile. Moreover, 4-monohydroxyacetophenone failed to exert a choleretic effect in TR/H11002 rats where the excretion of metabolites was absent (16). By analogy, the metabolites of THA should also be excreted in bile and provide the osmotic force for stimulating bile flow.

Because THA infusions markedly reduced the excretion of free glutathione, it was not clear whether THA was conjugated with GSH before being excreted and/or competed with GSH transport via the canalicular transporter, Mrp2. The rate-limited effects of THA on BFR also could be explained by such a competitive effect or by a direct inhibitory effect on the transport mechanism. Since the biliary excretion of BSP, which largely is dependent on prior conjugation with GSH (5, 9), was also abruptly inhibited by THA coinfusion, this concern was heightened. To clarify whether THA was interfering with GSH conjugation or excretion, we examined the excretion of DBSP, a dibrominated analog of BSP that does not require conjugation with GSH or other biotransformation before excretion in bile (14). The finding that THA also abruptly inhibited biliary DBSP excretion indicates that THA’s inhibitory effects are at the level of the canalicular transporter. This conclusion is also consistent with the findings that preinfusions of DBSP, but not BSP, markedly suppressed the stimulating effect of THA on BFR and that THA inhibited DBSP excretion earlier than BSP. Together these findings suggest that THA competed with these other Mrp2 substrates at the transporter’s substrate binding site or the transport sites.

Although the biliary excretion of osmotically active metabolites is the most likely explanation for THA’s choleretic effects, we cannot exclude the possibility that the compound(s) might directly stimulate the activity of Mrp2 and or the insertion of the transporter from intracellular compartments to the canalicular membrane (15). However, confocal immunofluorescence microscopy indicated that THA had no detectable effect on the subcellular localization of either the canalicular bile salt export pump (Bsep) or Mrp2 even when infused with the highest dose (Fig. 7). Thus it seems unlikely that THA stimulated insertion of vesicles containing new transporters to the canalicular membrane. This conclusion is also supported by our earlier study showing that THA does not increase the hepatobiliary excretion of horseradish peroxidase, a marker of exocytosis (35).
Tight junction permeability can be regulated by changes in osmotic and hydrostatic pressure (28) created by osmotic gradients across the tight junction (30, 34). However, neither low or high choleretic doses of THA altered the structure and localization of the tight junction protein ZO-1 (Fig. 5). This finding is also consistent with our prior studies that indicated that THA does not stimulate the paracellular pathway in rat liver when marked by horseradish peroxidase (35). Thus the choleretic effects of THA are unlikely to be mediated by increasing the permeability of the paracellular pathway.

Finally, we examined the therapeutic potential of THA in a model of cholestasis induced by E2-17G. E2-17G is an endogenous estrogen metabolite that induces an acute, dose-dependent, and completely reversible cholestasis in the rat (18, 19). Although the mechanism by which E2-17G induces cholestasis is incompletely understood, Mrp2 mediated E2-17G excretion into bile is required for its cholestatic effect (12). Since THA has a high choleretic activity and also interacts with Mrp2, we anticipated that THA might attenuate E2-17G-induced cholestasis, presumably by competing with E2-17G for excretion via Mrp2 as shown for BSP and DBSP. As illustrated in Figs. 8 and 9, the findings support this hypothesis. THA infusions in IPRLs receiving a constant infusion of TC, attenuated the cholestasis, presumably by competing with E2-17G for excretion of Mrp2 substrates accounted for attenuation of TC-induced cholestasis in the rat. Since THA does not stimulate the paracellular pathway in rat liver when marked by horseradish peroxidase (35). Thus the finding is also consistent with our prior studies that indicated that THA might attenuate E2-17G-induced cholestasis in rats. 

In summary, we have described a potent choleretic effect of the herbal compound THA in an isolated rat liver perfusion system. THA stimulates bile flow by the saturable excretion of osmotically active solutes into bile via the canalicular transporters. Mrp2. THA’s choleretic effect occurs without alteration of the distribution and localization of canalicular transporters Mrp2 and Bsep or the tight junction protein ZO-1. Its anticholestatic effect appears to be mediated by competing with the excretion of Mrp2 substrates. THA might be an effective and safe candidate for further development as an anticholestatic therapeutic agent.

GRANTS

This study was supported by grants from the Royal Golden Jubilee, Ph.D. Program (Grant no. PHD0177/2543 to L. Tradtrantip and P. Piychaturawat); the Thailand Research Fund (BRG 4680009 to P. Piychaturawat); and National Institutes of Health Grants DK-25636 and P30 DK-34989 (to J. L. Boyer) and DK-48823 and P30 ES-01247 (to N. Ballatori).

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