Corticotropin-releasing factor type 1 receptors mediate the visceral hyperalgesia induced by repeated psychological stress in rats

Muriel Larauche, Sylvie Bradesi, Mulgeta Million, Peter McLean, Yvette Taché, Emeran A. Mayer, and James A. McRoberts

1Department of Medicine, 2Center for Neurovisceral Sciences and Women’s Health, 3Center for Ulcer Research and Education: Digestive Disease Research Center, 4Departments of Physiology, Psychiatry, and Behavioral Sciences, and 5Brain Research Institute, David Geffen School of Medicine at University of California, Los Angeles; 6Veterans Affairs, Greater Los Angeles Healthcare System, Los Angeles, California; and 7GlaxoSmithKline (Neurology and Gastrointestinal Centre for Excellence for Drug Discovery), Harlow, United Kingdom

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Larauche M, Bradesi S, Million M, McLean P, Taché Y, Mayer EA, McRoberts JA. Corticotropin-releasing factor type 1 receptors mediate the visceral hyperalgesia induced by repeated psychological stress in rats. Am J Physiol Gastrointest Liver Physiol 294: G1033–G1040, 2008. First published February 28, 2008; doi:10.1152/ajpgi.00507.2007.—Visceral hyperalgesia has been implicated as an important pathophysiological mechanism in functional gastrointestinal disorders. In this study, we investigated whether the sustained visceral hyperalgesia induced by repeated psychological stress in rats involves the activation of CRF1 signaling system using two different antagonists. Male Wistar rats were exposed to 10 consecutive days of water avoidance stress (WAS) or sham stress for 1 h/day, and the visceromotor response to phasic colorectal distension (CRD) was assessed before and after the stress period. Animals were injected subcutaneously with the brain penetrant CRF2 antagonist, CP-154,526, acutely (30 min before the final CRD) or chronically (via osmotic minipump implanted subcutaneously, during stress) or with the peripherally restricted, nonselective CRF1 and CRF2 antagonist, astressin, chronically (15 min before each stress session). Repeated WAS induced visceral hyperalgesia to CRD at 40 and 60 mmHg. CP-154,526 injected acutely significantly reduced stress-induced visceral hyperalgesia at 40 mmHg but not at 60 mmHg. Chronic subcutaneous delivery of astressin reduced the stress-induced visceral hyperalgesia to baseline at all distension pressures. Interestingly, chronically administered CP-154,526 eliminated hyperalgesia and produced responses below baseline at 40 mmHg and 60 mmHg, indicating a hypoalgesic effect of the compound. These data support a major role for CRF1 in both the development and maintenance of visceral hyperalgesia induced by repeated stress and indicate a possible role of peripheral CRF receptors in such mechanisms.

IRRITABLE BOWEL SYNDROME (IBS) is a common functional bowel disorder in which recurrent abdominal pain or discomfort occurs in the absence of any detectable organic abnormalities (48). Symptom-related anxiety and comorbidity with anxiety disorders or depression are common in patients with IBS (29, 56). In addition, many studies have highlighted the importance of psychological stress in the onset (13), maintenance, and exacerbation of IBS symptoms (13, 33).

Corticotropin-releasing factor (CRF) is a key mediator in the body’s stress response (58). CRF and the endogenous related peptides, urocortin 1 (Ucn1 or Urocortin), urocortin 2 (Ucn2), and urocortin 3 (Ucn3), exert their biological actions by binding to two CRF receptors, subtype 1 (CRF1) and subtype 2 (CRF2), which have distinct affinity for CRF ligands (21). In rodents, CRF1 is distributed in brain areas involved in affective, stress, and nociceptive circuitries, including the paraventricular nucleus of the hypothalamus (PVN), the locus coeruleus (LC), and the amygdala (9, 46, 47). At the spinal level, in rats, lumbar CRF1 receptors are present in highest concentrations in laminae I and II (3), where visceral primary afferents terminate (1). In the rat and guinea pig colon, CRF1 is essentially found in the colonic mucosa and in the myenteric and submucosal nervous plexi, whereas CRF2 expression is mainly localized in the submucosal/myenteric layers (11, 28, 66).

It is now well established that the brain CRF/CRF1 signaling system modulates pain responses although the exact sites mediating this modulation remain unidentified (25, 38). The first evidence that brain CRF system plays a role in the modulation of visceral pain in rats was shown by the elimination of visceral hyperalgesia to colorectal distention (CRD) induced by acute partial restraint stress by intracerebroventricular (ICV) injection of the nonselective CRF receptor antagonist, α-hCRF9-41 (19). Conversely, CRF-injected ICV mimicked partial restraint stress-induced visceral hyperalgesia to CRD (19). Later on, the specific participation of CRF1 was established using the non-peptide CRF1-selective antagonist, NBI-35965, which, when given peripherally, prevented visceral hypersensitivity occurring immediately after an acute session of water avoidance stress (WAS) in maternally separated Long-Evans rats (34). Subsequently, with the use of peripheral injection of a different non-peptide CRF1-selective antagonist, CP-154,526, it was shown that CRF1 played a role in the development of delayed visceral hyperalgesia induced by WAS in Wistar rats and maternally separated Long-Evans rats (52, 53). Likewise, antalarmin, another selective nonpeptide CRF1 antagonist, injected intraperitoneally, prevented the visceral hypersensitivity induced by repeated tonic CRD in Fisher rats (35) or the ICV injection of CRF, as well as the one occurring spontaneously in a high anxiety strain of rats (18). Since all of these non-peptide CRF1-selective antagonists injected peripherally cross the blood-brain barrier (BBB), they could act at both peripheral and central sites.

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Studies in humans have corroborated a role for CRF in visceral hypersensitivity and suggested a potential role of peripheral CRF/CRF₁ signaling in the process. Specifically, peripheral injection of ovine CRF, a preferential CRF₁ agonist (42), was shown in healthy controls to lower pain thresholds to colonic distension, reproducing the effect of stress (17). Conversely, systemic administration of the nonselective and peripherally restricted CRF receptor antagonist, α-hCRF₉₋₄₁, was shown to significantly reduce visceral hyperalgesia in IBS diarrhea-predominant patients subjected to colonic electrical stimulation (50).

To date, the evidence for a role of brain CRF/CRF₁ signaling system in the modulation of visceral sensitivity in rodents has been based on the study of visceral hypersensitivity in acute models of stress (32). Given that chronic stress is more relevant in stress-related visceral hypersensitivity in humans (4), we aimed to determine the role of CRF₁ in a chronic intermittent WAS-related visceral hyperalgesia model that we recently developed and characterized to have high face and construct validity to IBS (7). In addition, in view of the growing evidence of peripheral CRF₁ signaling mechanisms in the colon (66) and the recent clinical evidence of a peripheral role for CRF₁ in patients with IBS (50), we determined the central vs. peripheral site of action of CRF₁ in chronic intermittent (1-h/day) WAS-related visceral hyperalgesia by using two CRF₁ antagonists with different properties: 1) a selective nonpeptide antagonist CP-154,526, which crosses the BBB (22), and 2) since there are no peripherally restricted CRF₁ selective antagonists available yet, we used a peripherally acting nonselective peptide antagonist, astressin (20, 49).

MATERIALS AND METHODS

Animals. Adult male Wistar rats (200–250 g) were purchased from Harlan (Indianapolis, IN). Animals were kept on a 12-h:12-h light-dark cycle (lights on at 0600). They were housed in pairs and maintained on a standard rodent food diet (Purina rat chow) with water ad libitum. The animals were allowed to acclimate to the animal facility for 1 wk before surgery. All protocols were approved by the Institutional Animal Care and Use Committee at the Veterans Affairs Greater Los Angeles Healthcare System, Los Angeles, CA (03025-04) and the University of California at Los Angeles (2003-060-02).

Drugs and chemicals. The CRF₁ antagonist CP-154,526 was a gift from Pfizer (Groton, CT). For acute treatment, the CP-154,526 was dissolved in vehicle (5% DMSO, 5% cremaphor, and saline adjusted to pH 2.5 using 5N HCl) and administered subcutaneously at a dose of 32 mg/kg in 0.2 ml. For chronic treatment, the CP-154,526 (20 mg/kg per day) was dissolved in 80% PEG 400 (pH 7.0) and administered subcutaneously (5 µl/h for 14 days) via an osmotic minipump (Alzet minipumps, model 2ML2; Alza, Palo Alto, CA) implanted into the suprascapular area as previously described (2). No signs of inflammation were seen around the wound at the end of the 14-day period of administration or after euthanasia of the animals. The use of different solvents for the acute vs. chronic administration of CP-154,526 was based on the possibility of local tissue injury at site of delivery resulting from the chronic delivery of an acidic solution. Astressin, a nonselective CRF₁ and CRF₂ antagonist, obtained from tocotronics (Ellisville, MO), was dissolved in sterile deionized water and administered subcutaneously as a daily single injection (20 µg/kg per day) in 0.2 ml. The doses of CRF receptor antagonists were based on previous studies showing the blockade of exogenous CRF on colonic motor function (30).

Electromyographic recordings—surgery. Adult male rats were anesthetized with pentobarbital sodium (45 mg/kg, Nembutil; Abbott Laboratories, North Chicago, IL) administered intraperitoneally. Electrodes (Teflon-coated stainless steel wire; AstraZeneca, Mölndal, Sweden) were stitched into the external oblique musculature, just superior to the inguinal ligament, for electromyographic (EMG) recordings as previously described (12). The cannula housing the electrode leads was then externalized laterally through a 4-mm incision on the left side of the abdomen for future access. Wounds were closed in layers with appropriate sutures. Following surgery, rats were housed in pairs and allowed to recover for at least 7 days. Wounds were tested for tenderness to ensure complete recovery from surgery before testing.

CRD procedure. The visceral stimulus employed was distention of the descending colon and rectum with the use of a well-established and validated method for the evaluation and quantification of visceral nociceptive responses (39). Briefly, rats were lightly anesthetized with Halothane, and a lubricated flexible latex balloon (6 cm) was inserted intra-anally (after the distal part of the rectum was gently cleared by massage) into the descending colon at 1 cm proximal to the anus and secured by tapping the catheter of the balloon to the base of the tail. After recovery from anesthesia, animals equipped with the balloon were placed in a Plexiglas cylinder for 30 min. Then the CRD procedure consisting of two series of phasic CRD to constant pressures of 10, 20, 40, and 60 mmHg immediately preceded by 2 CRD at 60 mmHg (each distension being of 20 s duration; with a 4-min interstimulus interval) was performed. The balloon pressure was continuously monitored online with a customized pressure control device (AstraZeneca R&D). The visceromotor response (VMR) to CRD was quantified by measuring EMG activity in the external oblique musculature 20 s before baseline (baseline), 20 s during, and 20 s after termination of CRD. The EMG activity was rectified, and the increase in the area under the curve (AUC) of EMG amplitude (during CRD) over baseline (before CRD) was recorded as the response.

WAS protocol. Each rat was placed on a pedestal (10 × 8 × 8 cm) affixed to the center of a Plexiglas tank floor (45 cm length × 25 cm width × 25 cm height) for a period of 1 h daily for 10 consecutive days. The tank was filled with room temperature water (25°C) up to 1 cm from the top of the pedestal. This well-characterized psychological stressor induces the transcription of CRF gene in the PVN of the hypothalamus and activates the pituitary-adrenal axis along with brain CRF receptor-mediated stimulation of colonic motor function (36). Sham WAS consisted of placing rats for an hour on the pedestal in a waterless container.

Experimental design. Rats were handled and habituated for 30 min to the Plexiglas cylinders used for CRD experiments for 3 days before the start of the experiments including the day of baseline testing. Baseline VMR to graded intensities of phasic CRD (2 × 60 mmHg and two ascending series of 10, 20, 40, and 60 mmHg) were obtained on day 0 (CRD1). From day 1 to day 10, rats were subjected to either WAS or sham WAS (controls). The VMR (CRD2) was recorded 24 h after the last stress or sham stress session. Different groups of animals were used for the three pharmacological studies.

Effect of acute subcutaneous injection of CP-154,526 after daily WAS on visceral response to CRD. Two groups of rats were subjected to the first baseline CRD (CRD1) and 24 h later exposed to WAS (1 h/day) for 10 days. On day 11, rats were submitted to a CRD (CRD2) to assess the effect of chronic intermittent WAS on the VMR response. After 1 h of rest, rats were injected subcutaneously with vehicle (5% DMSO-5% cremaphor-90% saline, 0.2 ml, n = 11) or CRF₁ antagonist, CP-154,526 (32 mg/kg, n = 12) 30 min before CRD3. All experiments were repeated in a sham WAS group to exclude a possible effect of CP-154,526 per se.

Effect of chronic CP-154,526 treatment during the daily WAS on visceral response to CRD. After baseline VMR recording (CRD1), each rat was equipped in the afternoon with one osmotic minipump filled with vehicle (80% PEG 400) or CP-154,526 at a concentration sufficient to deliver a daily dose of 20 mg/kg sc. Two days later, groups were subjected to daily WAS or sham WAS for 10 days, and,
on the following day, the VMR (CRD2) was recorded. All experiments were repeated in a sham WAS group to exclude a possible effect of CP-154,526 per se.

**Effect of repeated subcutaneous injections of astressin before daily WAS on visceral response to CRD.** A baseline VMR recording (CRD1) was performed, and, 24 h later, rats were injected subcutaneously daily with astressin (20 μg/kg per day, n = 12) or vehicle (sterile deionized water, 0.2 ml, n = 11) 15 min before each daily session of WAS for 10 days. The VMR (CRD2) was recorded 24 h after the last WAS procedure on day 11. All experiments were repeated in a sham WAS group to exclude a possible effect of astressin per se.

**Statistical analysis.** Visceral pain data are presented as mean difference ± SED (standard error of the difference), and the statistical significance was analyzed by using two different methods as described below. In all cases, rats with an EMG signal-noise ratio of <0.5 were excluded from the data and statistical analysis. To examine the pressure-response relationship, EMG amplitudes were normalized as percents of the baseline response at the highest pressure (60 mmHg) for each rat and averaged for each group of rats. Such a normalization has generally been used to adjust for interindividual variations of the EMG signal (39). The effects of WAS and/or pharmacological treatments on EMG response to CRD were within one group of animals were analyzed by comparing the poststress or posttreatment measurements to the baseline or pretreatment values at each distention pressure by using a repeated measure two-way ANOVA followed by Bonferroni posttest comparisons. We have presented the data showing the EMG response at day 11 for rats treated with CRF receptor antagonists or vehicle as the mean change from baseline for different pressures of distention as validated in our previous studies (7). These data were analyzed with an ANOVA followed by a post hoc t-test with Bonferroni correction for multiple comparisons. The second method of analysis determined the overall effect of stress by calculating the AUC of the raw EMG amplitude response as a function of pressure for each animal at different times of testing. The change in overall response after stress with and without different treatments was determined by dividing the AUC values by the baseline value for each rat. The resulting ratios were then averaged for each group of rats. Significance was determined using one-way ANOVA followed by Tukey’s posttest comparisons or as unpaired t-tests as appropriate.

**RESULTS**

Seventy-two percent of the rats subjected to chronic WAS developed hyperalgesia, i.e., increased VMR over baseline response to graded CRD. The degree of hyperalgesia was evaluated by calculating the AUC of the EMG response to CRD as a function of pressure after WAS and dividing it by the baseline value for each rat. Thirty-three percent exhibited an increase in AUC between 1 and 50% over baseline, 22% showed increased AUC in the range of 51–100%, and 17% had an increase in AUC ≥101%. These changes are similar to those described previously (7).

**Acute subcutaneous injection of CRF₁ antagonist CP-154,526.** As shown in Fig. 1, A and C, daily 1-h exposure to WAS induced a significant increase in VMR to CRD on day 11 (CRD2) compared with baseline (CRD1) at pressures of 40 and 60 mmHg (P < 0.05, n = 9). CP-154,526 (32 mg/kg) injected subcutaneously 24 h after the last stress session abolished the WAS-induced increase in the VMR response at 40 mmHg (ΔEMG response after CP-154,526 vs. baseline: 4.8 ± 13.9 vs. 54.2 ± 23.6 at 40 mmHg for vehicle; P < 0.05) while not significantly decreasing the VMR at 60 mmHg (ΔEMG response from baseline: 34.6 ± 22.6 vs. 59.7 ± 29.8 at 60 mmHg for CP-154,526 vs. vehicle-treated) (Fig. 2A). Injection of vehicle per se had no significant effect on the VMR compared with baseline (Fig. 2A).

To determine the effect of the CRF₁ antagonist in control conditions, we tested the response to CP-154,526 or vehicle injection in animals previously subjected to repeated sham.
Compared with baseline VMR responses, repeated exposure to sham WAS had no significant effect on the VMR to CRD (Fig. 1, B and C), and injection of vehicle or CP-154,526 did not change the response to CRD under these conditions (see Fig. 2B). In addition, there was no difference in the EMG response to chronic treatment with vehicle or CP-154,526 (32 mg/kg sc) in rats submitted to chronic sham WAS. CP-154,526 did not affect the EMG response after chronic sham WAS compared with vehicle. Data are presented as mean change ± SE of difference, n = 9 in each group.

Chronic subcutaneous administration of CP-154,526. Chronic CP-154,526 (calibrated to give 20 mg/kg per day through an osmotic minipump) abolished the WAS-induced increase of the VMR to CRD (P < 0.05, n = 9–10; Fig. 3A). Chronic subcutaneous administration of CP-154,526 reduced the EMG response to a level similar to baseline (ΔEMG response after CP-154,526 vs. vehicle at 40 mmHg: −9.42 ± 17.11 vs. 50.26 ± 15.20 and 15.72 ± 22.25 vs. 66.35 ± 14.90 at 60 mmHg for vehicle). Daily injections with vehicle or vehicle had no effect on the VMR of rats subjected to sham WAS (Fig. 3B).

Chronic subcutaneous injection of astressin, a CRF1 and CRF2 peptide antagonist. Repeated subcutaneous injections of astressin (20 μg/kg per day) before each WAS session for 10 days abolished the stress-induced increase of the VMR compared with vehicle (P < 0.05, n = 7–10; Fig. 4A). Chronic subcutaneous astressin reduced the EMG response to a level similar to baseline (ΔEMG response after astressin over baseline vs. vehicle: 9.42 ± 17.11 vs. 50.26 ± 15.20 and 15.72 ± 22.25 vs. 66.35 ± 14.90 at 60 mmHg for vehicle). Daily injections with astressin or vehicle had no effect on the VMR of rats subjected to sham WAS (Fig. 4B).
abolished by acute and chronic peripheral administration of a model of visceral pain (7). The enhanced VMR to CRD was investigated in a previously validated rodent development and maintenance of chronic WAS-induced hyperalgesia (8). However, the blockade of visceral hypersensitivity by astressin is likely to be mediated by antagonism of peripheral CRF1. In addition, chronic blockade of CRF1 with CP-154,526 unmasks the analgesic influence of CRF2 on visceral nociceptive pathways (35, 37, 40) leading to the development of analgesia, an effect that was not seen with astressin, which blocks both types of receptors.

The involvement of CRF1 in the maintenance of chronic stress-induced visceral hyperalgesia is supported by our observation that acute treatment with CP-154,526 normalized the VMR to CRD at a pressure of 40 mmHg (but not 60 mmHg), both these pressures being over the pain threshold level in healthy human subjects and rats (10, 55). In previous studies with the use of a single stress session, we found that the same dose of CP-154,526 normalized stress-induced visceral hyperalgesia at distention pressures of both 40 and 60 mmHg (2, 40, 52, 53). The present study demonstrates that the activation of the CRF1 signaling system plays a major role in both the development and maintenance of chronic WAS-induced hyperalgesia to CRD as investigated in a previously validated rodent model of visceral pain (7). The enhanced VMR to CRD was abolished by acute and chronic peripheral administration of a selective CRF1 antagonist with CNS access, as well as by daily subcutaneous injection, before stress exposure, of a peripherally acting nonselective CRF1 and CRF2 antagonist. The data show that chronic intermittent psychological stress-induced visceral hyperalgesia involves CRF1 receptor activation in the brain but also in the peripheral tissue.

Chronic administration of either the nonselective CRF1 and CRF2 antagonist, astressin, or the selective CRF1 antagonist, CP-154,526 (22), during the entire stress exposure completely eliminated the enhanced VMR to CRD induced by chronic intermittent WAS. These data extend further the previous findings on the role of CRF1 receptor signaling in acute stress-related visceral hyperalgesia in rats (19, 34, 52) and provide further evidence for the role of CRF1 in the onset, development and maintenance of stress-induced visceral hypersensitivity following repeated psychological stress in rats. Interestingly, the chronic administration of CP-154,526, but not astressin, induced a small degree of analgesia at the two highest volumes of distention, which was significant at 40 mmHg. One explanation to these different results may be that both central and peripheral CRF1 participate to the visceral hypersensitivity induced by chronic WAS. As CRF2 in the periphery participate to the induction of analgesia (35, 37, 40), the blockade of visceral hypersensitivity by astressin is likely to be mediated by antagonism of peripheral CRF1. In addition, being able to access the central nervous system, it may be speculated that CP-154,526 abolishes both the central and the peripheral components of the pronociceptive CRF1 pathway, whereas astressin, being restricted to the periphery due to its chemical properties (20, 49), only partially blocks the CRF1 pathway. Alternatively, our results may also indicate that chronic blockade of CRF1 with CP-154,526 un masks the analgesic influence of CRF2 on visceral nociceptive pathways (35, 37, 40) leading to the development of analgesia, an effect that was not seen with astressin, which blocks both types of receptors.

**DISCUSSION**

The present study demonstrates that the activation of the CRF1 signaling system plays a major role in both the development and maintenance of chronic WAS-induced hyperalgesia to CRD as investigated in a previously validated rodent model of visceral pain (7). The enhanced VMR to CRD was abolished by acute and chronic peripheral administration of a selective CRF1 antagonist with CNS access, as well as by daily subcutaneous injection, before stress exposure, of a peripherally acting nonselective CRF1 and CRF2 antagonist. The data show that chronic intermittent psychological stress-induced visceral hyperalgesia involves CRF1 receptor activation in the brain but also in the peripheral tissue.

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**Fig. 4.** Chronic treatment with astressin. A: EMG amplitude expressed as mean change from baseline after chronic treatment with vehicle or astressin (20 μg/kg per day sc) in rats exposed to repeated WAS. Astressin administered daily 15 min before each stress session abolished the stress-induced enhancement of VMR to CRD at both 40 and 60 mmHg. *P < 0.05 significantly different compared with vehicle, 2-way ANOVA and Bonferroni’s post hoc t-test. B: EMG amplitude expressed as mean change from baseline after chronic treatment with vehicle or astressin (20 μg/kg per day sc) in rats submitted to chronic sham WAS. Daily injection of astressin before the sham WAS session did not affect the EMG response compared with vehicle, both of which were unchanged from the VMR recorded on day 0. Data are expressed as mean change ± SE of difference, n = 7–10 in each group.
the LC (14, 59), which receives strong CRF innervation from the pontine Barrington’s nucleus (BN) (61). CRF receptors are present in the LC (45), and activation of LC neurons by low levels of colonic distension are mediated by CRF release from the BN within the LC, whereas activation elicited by higher magnitudes of distension involve other mediators, such as glutamate (26). A recent report revealed the involvement of CRF1 in the increased spontaneous discharge rate of LC neurons induced by intracisternal injection of CRF or phasic CRD of 45 mmHg in anesthetized rats (24). These data are in agreement with our results and support the involvement of the CRF1 system only for low volumes of distensions (40 mmHg in our study). On the other hand, there is growing literature suggesting that the normal synaptic glutamatergic transmission in different brain regions such as the lateral septum, central amygdala, LC, BN, and dorsal raphe nucleus are tightly controlled by endogenous levels of CRF and related peptides, urocortin 1 and urocortin 2, which establish a “tone” or homeostasis for normal excitatory glutamatergic transmission (27, 41, 62, 65). It is well known that glutamate and N-methyl-D-aspartate (NMDA) receptors are major players in central sensitization and visceral hyperalgesia (60), particularly at high colonic distension pressures (26). Under stressful conditions, release of large amounts of CRF or related peptides could perturb this synaptic homeostasis by exacerbating the glutamatergic transmission, thereby leading to enhanced visceral sensitivity. Interestingly, CRF mRNA expression was shown to be decreased in the PVN and BN after chronic but not acute administration of CP-154,526 (2). This would be expected to dampen glutamatergic transmission and restore synaptic homeostasis, leading to a decrease in visceral pain at high distension pressures (60 mmHg). This effect, combined with the more direct effect of CRF1 receptor antagonism at lower pressure (40 mmHg) in chronically stressed animals, could explain the disparity in the efficacy of the acute and chronic treatment regimens.

Last, a role for CRF1 at the spinal level is also not excluded. Recent preliminary data from our group (8) show activation of spinal microglia in the chronic WAS model and its possible contribution to the sustained visceral hyperalgesia. Analogous findings have been reported recently in another chronic visceral pain model (63). There is evidence for CRF1 and CRF2 expression on glial cells (64) and the participation of both receptors, as well as CRF ligands in the immune activation of spinal microglia (57).

Taken together, our results show for the first time the involvement of CRF1 in the chronic intermittent stress-induced visceral hyperalgesia in rats. Although the exact site(s) of CRF1 modulation of visceral nociception could not be identified in our experimental setting, the data suggest that both central and peripheral CRF1 are involved in the observed effect. This is supported by the fact that CP-154,526 is characterized as a highly selective antagonist of the rat CRF1 (51, 54) with penetration into the central nervous system under basal conditions (22), whereas astressin is a peptide antagonist with similar affinity for both CRF1 and CRF2 with poor ability to penetrate into the central nervous system under basal conditions (20, 49). These data, coupled with the fact that the brain-penetrating antagonist exerted higher effect than the peripherally acting peptide CRF1/2 antagonist, point to the role of CRF1 signaling both centrally and peripherally in mediating the chronic intermittent stress-related visceral hyperalgesia in rats. However, given that stress increases BBB permeability (15, 16), we cannot exclude the possibility that astressin injected peripherally may have also acted at spinal and/or supraspinal sites. In conclusion, our results support the use of CRF1 antagonists in human conditions, such as IBS, where visceral hyperalgesia is associated with anxiety and symptoms are commonly exacerbated by chronic stress (5).

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