Regulation of Colonic Mucosal Blood Flow by Exogenous Ecosanoids in the Rat

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We measured colonic mucosal blood flow using a reflectance spectrophotometry in Wistar rats during and after continuous injection of prostaglandins (PGs: PGE1, PGE2, and PGI2), as vasodilators, and thromboxane A2 (TXA2) as a vasoconstrictor. Administration of PGs increased colonic mucosal blood volume and oxyhemoglobin saturation of the colonic mucosal tissue, representing a parameter of mucosal oxygenation. The dose used did not change arterial blood pressure. These results suggest that PGs regulate colonic mucosal hemodynamics and oxygenation, and may thus act as cytoprotective substances. On the other hand, TXA2 injection diminished colonic mucosal blood flow compared with the same dose of PGI2 injection and acted against PGI2. Our results suggest that TXA2 and PGI2 regulate colonic mucosal hemodynamics.

Key words: Prostaglandins, inflammatory bowel disease, colonic vascularization, thromboxane A2, cyclic adenosine monophosphate.

INTRODUCTION

Prostaglandins (PGs) are important substances influencing vascular reactivity, and may provide cytoprotection to the microcirculation. The cytoprotective role of PGs was initially reported in the gastric mucosa (1). Subsequent studies indicated that PGE2, PGI2 and dmPGE1 increase gastric mucosal blood flow when administered at non-secretory doses (2-4). Furthermore, the cytoprotective activity of PGs has also been demonstrated in an animal model of inflammatory bowel diseases (IBD) (5, 6). It has been recognized that the vasodilatory action of PGs enhances colonic blood flow in rabbit colitis (7), and that the administration of PGE2 in the dog increases mesenteric blood flow (8). These studies suggest that PGs play a significant cytoprotective role in both gastric and colonic mucosa. However, the relationship between colonic mucosal microcirculation and exogenous PGs is still unclear.

On the other hand, the combination of thromboxane A2 (TXA2) and PGI2 has been demonstrated to regulate the cardiovascular system (9), while a reduction of 6-keto-PGF1α (PGI2 metabolite) thromboxane B2 (TXA2 metabolite) ratio may alter the cytoprotective capacity of the mucosa of active inflammatory bowel disease (10, 11). We examined the effect of several PGs (PGE1, PGE2, PGI2) and TXA2 on the pattern of colonic mucosal blood flow in normal rats.

METHODS

Ecosanoids (PGE combined cyclodextrin: PGE-α-cyclodextrin and PGE-β-cyclodextrin), PGE metabolites (15-keto-PGE1 and 15-keto-PGE2), PGI2 sodium salt and TXA2 (ONO-3708, STA2) were supplied by ONO Pharmaceutical Co., (Osaka, Japan). Male Wistar rats of approximately 300 g body weight were anesthetized with i.p. injection of pentobarbital (50 mg/kg). SHR (Spontaneous hypertensive rat) and WKY (Wistar Kyoto rat) rats were also used as control groups to examine sympathetic nerve activity. PGs or TXA2 were administered, in normal saline, at an infusion rate of 0.1 ml/min, through a cannula inserted into the femoral vein. Control rats received the vehicle only (normal saline). We also monitored arterial blood pressure through a cannula inserted into the common cervical artery. Infusion of the drug continued for 30 min, and the experiment was followed by another period of 60 min of observation.

The tip of an optic fiber was attached to the caecal mucosa before the injection of ecosanoids. The colonic mucosal hemoglobin concentration index (IHb), a parameter of microcirculatory blood volume, and mucosal oxyhemoglobin saturation index (ISO2), a parameter of mucosal oxygenation, were measured by a tissue spectrum analyzer TS-200 (Sumitomo Electric Industries, Ltd., Osaka, Japan). IHb and ISO2 were calculated according to the equation provided by Sato et al. (12). These experiment were kinetically performed for 90 min commencing with the start of ecosanoids injection. IHb and ISO2 were expressed as a percent change to the basal value before the administration of ecosanoids. The changes of IHb and ISO2 caused the ecosanoids injection were compared with the changes of those caused the saline injection as the
control. Furthermore, the serum PGE2 and cAMP (cyclic adenosine monophosphate) were measured using radio immune assay.

Data were expressed as mean ± SEM. Statistical analysis was performed using Student’s t-test, and a p value of < 0.05 was considered to indicate the presence of a significant difference.

RESULTS

Effect of PG administration on colonic blood flow. Injection of 0.1 μg/kg/min of PGE1 caused a progressive increase in IHb and ISO2. IHb increased maximally to 14.7±8.6 % at 80 min after the start of injection while ISO2 was 15.8±8.0 % at 75 min. On the other hand, a dose of 1.0 μg/kg/min or 10 μg/kg/min of the same substance caused a decrease in systemic blood pressure and the level of IHb and ISO2. However, under these conditions, IHb increased slowly to the higher level than the control level and ISO2 returned to the control level following the recovery of blood pressure (Fig. 1).

Infusion of 0.1 μg/kg/min of PGE2 caused a gradual increase in IHb and ISO2. The maximal increase of IHb was 10.7±4.5 % at 70 min after the start of infusion, while ISO2 was 12.5±8.1 % at 85 min after the start of PGE2 injection. When infused at 1.0 μg/kg/min or 10 μg/kg/min, PGE2 reduced systemic blood pressure and the level of IHb and ISO2, but IHb and ISO2 returned slowly to the control level following the recovery of blood pressure (Fig. 2). We also examined the effect of PGE metabolites, 15-keto-PGE1 and 15-keto-PGE2, at a dose of 5 μg/kg/min. Such dose failed to influence IHb. The injection of 1.0 μg/kg/min of PGI2 had an effect similar to that of 0.1 μg/kg/min of PGE, and did not change systemic blood pressure. The maximal increase of IHb was 11.5±8.2 % at 30 min while that of ISO2 was 10.9±7.6 % at 85 min after the start of PGI2 injection in a dose of 1.0 μg/kg/min. The level of IHb and ISO2 did not change significantly during and after the administration of 0.1 μg/kg/min of PGI2. However, a severe hypotension and reduction in IHb and ISO2 levels were observed during injection of 10 μg/kg/min of PGI2, but both IHb and ISO2 increased slowly to the higher level than the control level following the recovery of blood pressure (Fig. 3).

Figure 1. The effect of exogenous PGE1 on colonic mucosal blood volume, mucosal oxygenation and blood pressure. PGE1 was continuously injected for 30 min at a concentration of 0.1 μg/kg/min (closed circles), 1.0 μg/kg/min (closed squares) and -10 μg/kg/min (open squares). Open circles: saline injection to control rats. Solutions were administered using the same flow rate in the femoral vein of anesthetized rats. Index of colonic mucosal hemoglobin concentration (upper panel) and colonic mucosal oxyhemoglobin saturation (middle panel) were measured by a tissue spectrum analyzer during monitoring of blood pressure (lower panel) during 90 min.

Figure 2. The effect of exogenous PGE2 on colonic mucosal blood volume, mucosal oxygenation and blood pressure. The conditions were similar to those in Fig. 1.
Effect of TXA₂ administration on colonic blood flow.
Whereas the injection of 0.1 µg/kg/min of TXA₂ failed to influence systemic blood pressure, the drug reduced IHb significantly during injection to -12.2±4.7% at 30 min. The level of IHb returned, however, to the control level at 60 min after the commencement of TXA₂ injection. In contrast, injection of a larger dose of TXA₂ (1.0 µg/kg/min) caused a significant fall in systemic blood pressure and further reduced the level of IHb and ISO₂ (IHb, -28.4 ±11.8%; ISO₂, -46.5±24.6%, at 30 min after the start of TXA₂ injection). However, as the blood pressure started to gradually recover, IHb and ISO₂ also progressively increased (Fig. 4). Injection of 0.01 µg/kg/min of TXA₂ failed to have an effect on colonic blood flow. Injection of 10 µg/kg/min of TXA₂ caused a severe and rapid fall in systemic blood pressure and death. Furthermore, the simultaneous injection of 1.0 µg/kg/min of PGI₂ and TXA₂ was also examined. A combination of PGI₂ and TXA₂ showed compromised values with little or on change in blood pressure, IHb and ISO₂ (Fig. 5).

Kinetics of residual PGE₂ following the administration of PGE₂. Administration of PGE₂ (10 µg/kg/min) caused an initial decrease in IHb and ISO₂, but the level of both compounds increased slowly after the cessation of injection. The serum concentration of PGE₂ reached a peak level
The concentration of serum PGE₂ following the administration of exogenous PGE₂ and the effect of such level on colonic mucosal blood volume, mucosal oxygenation and blood pressure. The concentration of serum PGE₂ was measured after the injection of 10 μg/kg/min of PGE₂ to confirm whether the residual PGE₂ (upper panel) influences recovery of colonic mucosal hemoglobin concentration, colonic mucosal oxyhemoglobin saturation and blood pressure (lower panel).

At 30 min after the start of injection, then diminished to the initial value (Fig. 6).

Kinetics of serum cAMP following the administration of PGE₂ or PGI₂. Injection of PGE₂ (0.1 μg/kg/min) or PGI₂ (1.0 μg/kg/min) caused a gradual increase of IHb until 60 min after injection, but failed to influence the level of serum cAMP. However, a higher dose of PGE₂ (10 μg/kg/min) further reduced IHb during injection but the level returned slowly following cessation of PGE₂ injection. Injection of such a high dose of PGE₂ markedly elevated serum cAMP during infusion of PGE₂, but the level rapidly decreased after the end of injection, although it did not return to baseline value (Fig. 7).

Effect of PGE₂ administration on colonic blood flow in SHR and WKY rats. IHb was measured in hypertensive (SHR) and nonhypertensive rats (WKY) in order to examine the correlation between IHb and sympathetic nerve activity. As shown in Fig. 8, under control condi-
DISCUSSION

The major finding of our study is a gradual increase in colonic mucosal blood volume caused by the administration of exogenous PGs (PG\textsubscript{E}, PG\textsubscript{E} and PG\textsubscript{I}). The increase was not due to changes in blood pressure. Furthermore, we also observed an increase in colonic mucosal blood volume with the administration of a high dose of PGs, without affecting the systemic blood pressure. Our results suggest that PGs may play an important role in regulating local tissue oxygen saturation.

Reflectance spectrophotometry can determine not only tissue blood volume but also the average oxy-and deoxyhemoglobin equilibrium in tissue by measuring the absorbance of hemoglobin and tissue oxygen saturation, respectively (13). The present study also demonstrated that exogenous PGs also increased ISO, representing increased tissue oxygen saturation, without influencing blood pressure. Several investigators have described a vasodilatory effect for PGs by demonstrating an increase in gastric mucosal blood flow (1, 2). In this regard, Doua (14) reported that PG stimulates cAMP formation, which, in turn, accelerates the production of glycoprotein and glycosaminoglycan. It was also suggested that PG could provide mucosal cytoprotection by providing a sufficient level of tissue oxygen in mucosa. Thus, our results suggest a possible colonic mucosal cytoprotective role for exogenous PGs in addition to that already described in the gastric mucosa. Our conclusion is based on the finding that several PGs increased colonic mucosal blood flow and local tissue oxygen saturation.

TXA\textsubscript{A} induces platelet aggregation and constriction of vascular smooth muscles, while PGI\textsubscript{I} markedly suppresses platelet aggregation and dilates vascular smooth muscles. Thus, TXA\textsubscript{A} and PGI\textsubscript{I} play an important role in regulating mucosal circulation by maintaining homeostasis in the cardiovascular system (15). Our results demonstrated that PGI\textsubscript{I} increased colonic mucosal blood volume while maintaining a normal blood pressure, while TXA\textsubscript{A} reduced it. These results suggest that the colonic microcirculation is regulated by a balance between PGI\textsubscript{I} and TXA\textsubscript{A}.

Several studies have examined the effect of exogenous PGs on vascular smooth muscles (16-18). By using SHR and WKY rats in the present study, we were able to rule out any action of exogenous PG on the sympathetic nervous system, since no difference in colonic hemo-

dynamics was observed between the two groups of rats even when a high dose of PGE\textsubscript{E} was administered. Furthermore, our findings suggest that PG metabolites (15-keto-PGE) have no effect on colonic blood flow. Residual PGE\textsubscript{E} did not influence the recovery of colonic mucosal blood flow in our study, because the serum concentration of PGE\textsubscript{E} diminished to the initial value following injection of a high dose of PGE\textsubscript{E}. Such recovery may be due to autoregulatory mechanisms acting after a reduction of blood pressure (19), and a change in the distribution of colonic blood flow. We failed to demonstrate increased levels of serum cAMP by PGE\textsubscript{E} or PGI\textsubscript{I} injection under normal level of systemic blood pressure, whereas serum cAMP increased during the administration of a high dose of PGE\textsubscript{E}. Although serum cAMP was too low to detect at normal blood pressure, it is possible that exogenous PGs may have increased cAMP, which may have caused dilated colonic mucosal capillaries.

IBD are characterized by ulceration or inflammation of the colonic mucosa and their etiology is still unknown. Patients with active ulcerative colitis have higher production of PG and TXA\textsubscript{A} metabolites (6-keto-PGF\textsubscript{A} and TXB\textsubscript{A}) in colonic mucosa than normal subjects (10). Furthermore, abundant TXB\textsubscript{A}, and a low 6-keto-PGF\textsubscript{A}/TXB\textsubscript{A} ratio are also described in Crohn's disease (11). These results suggest that deceleration of PGI\textsubscript{I} metabolism and acceleration of TXA\textsubscript{A} metabolism reduce colonic mucosal flow and diminish the cytoprotective capacity in patients with active IBD. Several investigators have described the protective effect of PGE in gastric mucosa (1, 20), and, in fact, PGE is used as a treatment for gastric ulceration. It is of interest that PGE was initially regarded as an inflammatory factor in the mucosa of IBD, but only recently was re-considered as an anti-inflammatory substance inducing suppressor T cells (21). Sharon et al. (22) reported that the level of PGE in rectal mucosa of patients with ulcerative colitis was higher than that found in a normal mucosa. In addition, Hulten et al. (23) reported that colonic mucosal blood flow increased during the active phase, whereas a little or no change in blood flow occurred during the remission phase in patients with ulcerative colitis and Crohn's disease. These results suggest that mucosal restoration in active IBD may possibly be due to the accumulation of endogenous PGE in colonic mucosa, increase in colonic blood flow and oxygenation, stimulation of cellular metabolism, and/or the transport of anti-inflammatory chemical mediators to tissues. The recent demonstration of an effective therapeutic role of PG in an experimental model of colitis (5, 6), suggest that exogenous PGs may prove useful in the therapy of inflammatory bowel diseases.
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REFERENCE