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AN INVESTIGATION INTO MECHANISMS UNDERLYING ABERRANT PAIN RESPONSES, AND POTENTIAL THERAPEUTIC INTERVENTIONS, IN THE HFD/STZ MODEL OF DIABETIC NEUROPATHY

Frederika Maria Byrne, BSc. (Hons)

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Abstract

It is estimated that 366 million people were living with diabetes in 2011, and this is predicted to rise to 522 million by 2030. One of the most common complications of diabetes is diabetic neuropathy, where patients experience various symptoms of neuropathic pain including mechanical allodynia. Using a high fat diet (HFD) in combination with streptozotocin (STZ) produces a model of diabetes which mimics aspects of type 2 diabetes. The aim of this thesis was to characterise pain responses in the HFD/STZ model and to explore some of the peripheral and spinal mechanisms associated with the changes in somatosensory processing. The effectiveness of a variety of drugs in alleviating/preventing neuropathic pain was also investigated in this model.

The effects of the HFD/STZ model on mechanical sensitivity, and changes in metabolic parameters were investigated, and it was found to cause a robust development of mechanical hypersensitivity and a large increase in plasma glucose and a contrasting decrease in plasma insulin. The impacts of the HFD/STZ model on peripheral nerve function and pathology, and spinal mechanisms of central sensitisation, were explored to help identify the mechanisms underpinning the behavioural pain phenotype in these rats. No neuronal degeneration was detected in DRGs or the spinal cord at the timepoints investigated, and a decrease in microglial activation and GFAP immunoreactivity was observed at later timepoints (day 50). Changes in neuronal responses in the dorsal horn of the spinal cord were then investigated, and there was a trend towards a decrease in mechanically evoked responses of spinal neurones in the HFD/STZ group, but no changes in the threshold for electrical activation of C-fibres, nor any significant changes to electrically evoked responses, were observed. There was no change in spontaneous firing, possibly due to the search criteria used.
The effects of different types of interventions on aberrant pain responses were also investigated. As neuropathic pain often proves intractable, one of the key objectives is to develop new drugs, or to find alternative uses of current drugs, that are able to provide symptomatic relief of pain. The gold standard treatment for pain in diabetic neuropathy, pregabalin (10mgkg⁻¹, p.o.), was effective at alleviating established mechanical hypersensitivity at day 37 in the HFD/STZ model. A novel MAGL inhibitor, MJN110 (5mgkg⁻¹, i.p.), was found to be as effective as pregabalin in this model, highlighting a possible role for endocannabinoid modulators in providing pain relief in diabetes. The antidiabetic pioglitazone (10mgkg⁻¹, p.o.), however, was unable to alleviate mechanical hypersensitivity when administered at day 21 for 28 days. Two other antidiabetic drugs, linagliptin (3mgkg⁻¹, p.o.) and metformin (200mgkg⁻¹, p.o.), did show promise in preventing the development of mechanical hypersensitivity in this model when administered from day 4, independent of glycemic control. It is worth investigating these findings further since both of these drugs are already licensed and have undergone all necessary safety testing, and so could rapidly be put to use if effective.

In conclusion, this thesis has highlighted the role that the HFD/STZ model can play in investigating underlying mechanisms of diabetic peripheral neuropathic pain, and its use in exploring potential new therapeutic options for alleviating this pain.
**Publications**


**Abstracts**


**F.M. Byrne**, S. Cheetham, V. Chapman. Characterisation of the high fat diet/streptozotocin model of diabetes and the effects of the PPARγ ligand pioglitazone. Poster session presented at: 14th World Congress on Pain 7th (IASP); Milan, Italy; August 27-31, 2012.
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Finally, thank you to my family; to my Mum for always being at the end of the phone through four long and tumultuous years, and for Dad for bravely volunteering (!) to proof-read this thesis (although any mistakes are obviously my own). And lastly, to Mike, who needs the biggest thanks for putting up with me during the long and arduous ephys period, for all the 5-star cooking before I proceeded to thank him by falling asleep on the sofa, and for being a wonderfully calming presence in my life.

There's nothing we can't do if we work hard, never sleep, and shirk all other responsibilities in our lives.

- Leslie Knope
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>15d-PGJ2:</td>
<td>15-deoxy-(\Delta^{12},14)-prostaglandin J2</td>
</tr>
<tr>
<td>2-AG:</td>
<td>2-arachidonoyl glycerol</td>
</tr>
<tr>
<td>AEA:</td>
<td>arachidonoyl ethanolamine (anandamide)</td>
</tr>
<tr>
<td>AGE:</td>
<td>advanced glycation end-product</td>
</tr>
<tr>
<td>AMPA:</td>
<td>(\alpha)-amino-3-hydroxy-5-methyl-4-isoxazolepropionic acid</td>
</tr>
<tr>
<td>AMPK:</td>
<td>AMP-activated protein kinase</td>
</tr>
<tr>
<td>ANCOVA:</td>
<td>analysis of covariance</td>
</tr>
<tr>
<td>ANOVA:</td>
<td>analysis of variance</td>
</tr>
<tr>
<td>ATP:</td>
<td>adenosine triphosphate</td>
</tr>
<tr>
<td>AUC:</td>
<td>area under the curve</td>
</tr>
<tr>
<td>BADGE:</td>
<td>bisphenolAdiglycidyl ether</td>
</tr>
<tr>
<td>BB:</td>
<td>biobreeding</td>
</tr>
<tr>
<td>BDNF:</td>
<td>brain-derived neurotrophic factor</td>
</tr>
<tr>
<td>CB1:</td>
<td>cannabinoid receptor 1</td>
</tr>
<tr>
<td>CB2:</td>
<td>cannabinoid receptor 2</td>
</tr>
<tr>
<td>CCI:</td>
<td>chronic constriction injury</td>
</tr>
<tr>
<td>CGRP:</td>
<td>calcitonin-gene related peptide</td>
</tr>
<tr>
<td>CNS:</td>
<td>central nervous system</td>
</tr>
<tr>
<td>DAG:</td>
<td>diacylglycerol</td>
</tr>
<tr>
<td>DCCT:</td>
<td>diabetes control and complications trial</td>
</tr>
<tr>
<td>DPN:</td>
<td>diabetic peripheral polyneuropathy</td>
</tr>
<tr>
<td>DPNP:</td>
<td>diabetic peripheral neuropathic pain</td>
</tr>
<tr>
<td>DPP-4:</td>
<td>dipeptidyl-peptidase-IV</td>
</tr>
<tr>
<td>DRG:</td>
<td>dorsal root ganglion</td>
</tr>
<tr>
<td>EAA:</td>
<td>excitatory amino acid</td>
</tr>
<tr>
<td>EAAT:</td>
<td>excitatory amino acid transporter</td>
</tr>
<tr>
<td>ERK:</td>
<td>extracellular signal-regulated kinase</td>
</tr>
<tr>
<td>FAAH:</td>
<td>fatty acid amidase hydrolase</td>
</tr>
<tr>
<td>FAE:</td>
<td>fatty acid ethanolamide</td>
</tr>
<tr>
<td>GABA:</td>
<td>y-aminobutyric acid</td>
</tr>
<tr>
<td>GDNF:</td>
<td>glial-derived neurotrophic factor</td>
</tr>
<tr>
<td>GFAP:</td>
<td>glial fibrillary acidic protein</td>
</tr>
<tr>
<td>GIP:</td>
<td>glucose-dependent insulinotropic polypeptide</td>
</tr>
<tr>
<td>GLP-1:</td>
<td>glucagon-like peptide-1</td>
</tr>
<tr>
<td>GLT:</td>
<td>glutamate transporter</td>
</tr>
<tr>
<td>GPCR:</td>
<td>G protein-coupled receptor</td>
</tr>
<tr>
<td>GSH:</td>
<td>reduced glutathione</td>
</tr>
<tr>
<td>HbA1c:</td>
<td>glycosylated haemoglobin</td>
</tr>
<tr>
<td>HFD:</td>
<td>high fat diet</td>
</tr>
<tr>
<td>HFD/STZ:</td>
<td>high fat diet (in combination with) streptozotocin</td>
</tr>
<tr>
<td>i.p.:</td>
<td>intraperitoneal</td>
</tr>
<tr>
<td>IASP:</td>
<td>international association for the study of pain</td>
</tr>
<tr>
<td>Iba1:</td>
<td>ionised calcium binding adapter molecule 1</td>
</tr>
<tr>
<td>IENF:</td>
<td>intra-epidermal nerve fibre</td>
</tr>
<tr>
<td>IGF:</td>
<td>insulin-like growth factor</td>
</tr>
<tr>
<td>IRS-1:</td>
<td>insulin receptor substrate 1</td>
</tr>
<tr>
<td>KCC2:</td>
<td>potassium chloride co-transporter 2</td>
</tr>
<tr>
<td>L:</td>
<td>lamina</td>
</tr>
</tbody>
</table>
LC-MS/MS: liquid chromatography/tandem mass spectrometry
MAGL: monoacylglycerol lipase
MAPK: mitogen activated protein kinase
MCP-1: monocyte chemoattractant protein-1
MMP: matrix metallopeptidase
mTOR: mammalian target of rapamycin
mTORC1: mammalian target of rapamycin complex 1
NAA: N-acetylaspartate
NAD: nicotinamide
NCV: nerve conduction velocity
NFκB: nuclear factor κB
NGF: nerve growth factor
NMDA: N-methyl-D-aspartate
NO: nitric oxide
NOD: non-obese diabetic
NRG1: neuregulin 1
NS: nociceptive specific
OEA: oleoylethanolamide
OGTT: oral glucose tolerance test
p.o.: oral
PAG: periaqueductal gray
PARP: poly(ADP-ribose) polymerase
PBS: phosphate buffered saline
PEA: palmitoylethanolamide
PFA: paraformaldehyde
PG: prostaglandin
PKC: protein kinase C
PNL: partial sciatic nerve ligation
PPAR: peroxisome proliferator-activated receptor
PSDC: postsynaptic dorsal column
RAGE: receptor for AGE
ROS: reactive oxygen species
RT: room temperature
RVM: rostral ventromedial medulla
SNI: spared nerve injury
SNL: spinal nerve ligation
SP: substance P
SPBT: spinoparabrachial tract
STT: spinothalamic tract
STZ: streptozotocin
THC: Δ9-tetrahydrocannabinol
TLR: toll-like receptor
TNF-α: tumour necrosis factor-α
TRPV1: transient receptor potential vanilloid 1
TTBS: trizma triton X-100 buffered saline
TZD: thiazolidinedione
URB597: cyclohexylcarbamic acid 3'-carbamoyl-biphenyl-3-yl ester
VLPAG: ventrolateral PAG
WDR: wide dynamic range
ZDF: zucker diabetic fatty
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Chapter 1.

General Introduction
1.1. Diabetes

*Diabetes mellitus* is a metabolic disorder characterised by elevated blood glucose. Globally, it is estimated that 366 million people were living with diabetes in 2011, and this is predicted to rise to 522 million by 2030 (IDF, 2012). Diabetes can be divided into two main categories: type 1 and type 2 diabetes, with type 2 accounting for approximately 90% of diabetic cases (Rydén *et al.*, 2007). Type 1 diabetes is an autoimmune disease in which the pancreatic β-cells in the islets of Langerhans are gradually destroyed by T cells, leading to the pancreas being unable to secrete enough insulin (Atkinson *et al.*, 2001; Bluestone *et al.*, 2010). In type 2 diabetes, the first stage is peripheral insulin resistance, where the sensitivity of tissues to insulin decreases (Rydén *et al.*, 2007). The β-cells initially secrete more insulin to compensate for the insulin resistance, but eventually become less effective (Campbell, 2009). The hallmark of diabetes is hyperglycaemia – where fasting blood glucose is ≥7mM, or glycosylated haemoglobin (HbA1c) is ≥6.5% (American Diabetes Association, 2013). Insulin levels generally have to fall below 0.5ngml⁻¹ for hyperglycaemia to develop (Dobretsov *et al.*, 2007). In healthy individuals, insulin is secreted from β-cells in response to elevated levels of glucose. The roles of insulin include: stimulating amino acid synthesis; suppressing gluconeogenesis; decreasing lipogenesis in fat tissue; and promoting the uptake of glucose in skeletal muscle and the liver, where it is stored as glycogen (Dobretsov *et al.*, 2007). Glucagon, which is released by pancreatic α-cells, performs an opposing role; causing an increase in the release of glucose.

Diabetes leads to a wide variety of complications: microvascular diseases such as retinopathy, nephropathy and neuropathy (including diabetic autonomic neuropathy and focal neuropathy), as well as macrovascular diseases such as cardiovascular disease (Forbes *et al.*, 2013). The focus of this thesis, however, is diabetic peripheral neuropathy (DPN), also known as sensorimotor neuropathy or distal symmetric neuropathy.
1.1.1. Current treatments for diabetes

Exogenous insulin is necessary in the control of type 1 diabetes, but there are a number of drugs available for the treatment of type 2 diabetes (for review see Stumvoll et al., 2005), and these include:

- Thiazolidinediones (TZDs), such as pioglitazone, which help to improve insulin resistance and increase glucose uptake into peripheral tissues.

- Metformin, a biguanide, which reduces hepatic glucose production.

- Glucagon-like peptide 1 (GLP-1) agonists (Gutniak et al., 1992), and dipeptidyl peptidase-IV (DPP-4) inhibitors such as linagliptin, which cause insulin secretion, as well as inhibiting hepatic glucagon secretion and slowing gastric emptying.

- Sulfonylureas, such as glibenclamide, which stimulate insulin secretion from the pancreas.

Those relevant to this thesis are discussed in more detail below.

1.1.1.1. Pioglitazone

TZDs such as pioglitazone act through a peroxisome proliferator-activated receptor (PPAR): PPARγ. PPARs are members of the nuclear hormone receptor superfamily (Dreyer et al., 1992; Issemann et al., 1990), and are activated by fatty acids, eicosanoids and synthetic compounds (Youssef et al., 2004). Once activated, they form heterodimers with retinoid X receptors (Kota et al., 2005). They are able to regulate the transcription of a wide variety of target genes through binding to a specific peroxisome proliferator response element in the promoter region of these genes (Berger et al., 2002), and they then stimulate transcription through recruitment of coactivators (Tan et al., 2005).

There are three different PPAR isoforms – α, β/δ, and γ (Berger et al., 2005). PPARγ is primarily expressed in the adipose tissue, but is also
found at lower levels in kidney, liver, and Schwann cells (Desvergne et al., 1999), as well as microglia and astrocytes in the brain (Bernardo et al., 2008; Moreno et al., 2004). It can also be found in pain pathways where it has been measured in adipocytes in the epineurium of the sciatic nerve, in L5 dorsal root ganglia (DRG), and in neurones in the dorsal horn of the spinal cord (Churi et al., 2008; Maeda et al., 2008).

TZDs have been shown to alter the mRNA levels of a myriad of genes, but primarily those involved in glucose and lipid metabolism (Sears et al., 2007). They normalise expression of the glucose transporter, GLUT4, in adipose tissue and increase expression of GLUT1 in adipose tissue and skeletal muscle (Kramer et al., 2001). They are able to enhance adipocyte insulin signalling, and lipid uptake and metabolism, as well as attenuating lipolysis and free fatty acid release. TZDs are also able to stimulate the redistribution of lipids from insulin-resistant visceral fat depots into subcutaneous fat (Miyazaki et al., 2002) through promoting apoptosis in mature adipocytes in visceral fat, and stimulating adipogenesis in subcutaneous fat, resulting in an increase in smaller, more insulin-responsive adipocytes (Okuno et al., 1998). As more lipolysis takes place in visceral fat (Arner, 1995), the change to more insulin responsive adipocytes in subcutaneous fat leads to a decrease in levels of free fatty acids, therefore enhancing insulin sensitivity (Willson et al., 2000).

TZDs are also able to reduce levels of pro-inflammatory cytokines, such as tumour necrosis factor-α (TNFα) (Dandona et al., 2004), which is increased in obese rodents (Hotamisligil et al., 1993; Xu et al., 2003) and also in patients with type 2 diabetes (Katsuki et al., 1998; Zinman et al., 1999). TNFα has been linked to insulin resistance due to interference with the insulin signalling cascade (Hotamisligil et al., 1996; Hotamisligil et al., 1993).

All of these mechanisms mean TZDs are able to act as potent insulin sensitisers in peripheral tissue, as well as lowering blood glucose,
HbA1c, insulin and triglyceride levels and increasing HDL cholesterol levels (Aronoff et al., 2000; Diamant et al., 2003; Rosenblatt et al., 2001). TZDs may even preserve β-cell function - increasing islet mass, preserving insulin content and improving insulin secretion (Campbell et al., 2007; Kawasaki et al., 2005; Kawashima et al., 2011). This may be through a decrease in lipotoxicity in the β cells, resulting in an inhibition of excessive apoptosis (Berger et al., 2005).

### 1.1.1.2. Metformin

Metformin improves glycemic control and decreases blood sugar levels through multiple mechanisms: a reduction in hepatic glucose output; the inhibition of gluconeogenesis; and by improving the sensitivity of muscle to insulin, leading to increased glucose uptake (Stumvoll et al., 1995).

Metformin causes increased phosphorylation and activation of AMP-activated protein kinase (AMPK), which is termed ‘the energy sensor of the cell’ (Tillu et al., 2012). AMPK responds to the cellular AMP:ATP ratio, and is an important regulator of lipid and glucose metabolism. When it is activated, it downregulates the expression of several genes through phosphorylation of multiple targets, including those involved in gluconeogenesis and lipogenesis in the liver. This leads to a reduction of lipid stores in muscle and liver (Kahn et al., 2005) and inhibition of hepatic glucose production (Zhou et al., 2001a). AMPK also switches on pathways that lead to the uptake and metabolism of glucose in muscle by increasing the translocation of the glucose transporter GLUT4 to the plasma membrane (Hardie, 2007).

### 1.1.1.3. Linagliptin

Linagliptin competitively and reversibly inhibits DPP-4 (Eckhardt et al., 2007), an enzyme that cleaves GLP-1 and glucose-dependent insulino tropic polypeptide (GIP), two incretin hormones which are rapidly secreted from gut endocrine cells after eating (Drucker et al.,
These hormones activate GPCRs and cause glucose-dependent insulin secretion. GLP-1 also inhibits hepatic glucagon secretion, and slows gastric emptying (Drucker, 2006). In humans it has been shown that an oral dose of glucose causes an increased release of insulin compared to an intravenous dose, termed the ‘incretin effect’, but this effect is often much lower in type 2 diabetics (Nauck et al., 1993). At higher concentrations, GLP-1 is still able to exert its insulinotropic activity (Nauck et al., 1993), and therefore augmentation of this incretin through inhibition of DPP-4 can help to control hyperglycaemia.

Linagliptin causes approximately 80% inhibition of DPP-4 (Rauch et al., 2012) and has been shown to increase the levels of circulating GLP-1 by around 2-fold (Rauch et al., 2012; Sarashina et al., 2010), and cause a reduction of approximately 15% in peak glucagon (Rauch et al., 2012). Linagliptin improves HbA1c, has a good safety profile, and is not associated with hypoglycaemia or weight gain (McGill, 2012). It is licensed to treat type 2 diabetes as a monotherapy, but can also be combined with other treatments such as metformin, utilising two complementary modes of action (Gallwitz, 2013).

1.1.2. Animal models of diabetes

Animal models of type 1 diabetes include those induced by chemical ablation of pancreatic β-cells, and rodents who spontaneously develop autoimmune diabetes (Table 1.1). Models of type 2 diabetes include both obese and non-obese rodents, with varying severity of symptoms. Table 1.2 briefly describes the main models of type 2 diabetes, some of which are described in more detail in Chapter 2. Full descriptions and advantages/disadvantages are discussed elsewhere (for review see Chatzigeorgiou et al., 2009; King, 2012; Reed et al., 1999; Rees et al., 2005; Srinivasan et al., 2007), but for brevity only those models mentioned in this thesis are described below.
The most frequently used model is the streptozotocin (STZ) model, as it is cheap and quick to set up, whereas the spontaneous autoimmune models are more expensive, disease onset is less predictable and they are also more time consuming. Non-obese diabetic (NOD) mice and biobreeding (BB) rats, however, can more accurately represent the disease in humans, as they share some of the genes that are linked with susceptibility to type 1 diabetes (for review see Driver et al., 2011; Yang et al., 2006). There are, however, concerns that observations from these highly inbred genetic strains are not representative of the heterogeneity of the human population (Srinivasan et al., 2005). The rodent models summarised in Table 1.1 and 1.2 produce many of the symptoms associated with diabetes, as well as signs of peripheral nerve dysfunction such as nerve conduction velocity (NCV) slowing, and development of mechanical sensitivity, and have been used to investigate pathogenic pathways in early diabetic neuropathy (Forbes et al., 2013). However the majority of these models tend to lack the advanced clinical characteristics of microvascular complications such as segmental demyelination, neurodegeneration, and subsequent axon or fibre loss (Sharma et al., 1974), possibly due to their relatively short lifespan. They are therefore not as useful for studying the long term complications, such as loss of sensory function, unless a long-term study is run. However nerve pathology, such as atrophy of sural axons and loss of large-calibre dermal and small-calibre epidermal axons, can be seen after 4 months of diabetes in ZDF rats (Brussee et al., 2008). This aspect is discussed further in Chapter 3.

It has been postulated that STZ may have a direct neurotoxic effect that is partly responsible for the development of some of the signs of diabetic neuropathy (Bishnoi et al., 2011; Pabbidi et al., 2008b). It has been shown that the timecourse and the degree of thermal and mechanical hypersensitivity were similar in STZ rats that went on to develop hyperglycaemia and those rats that didn't (Bishnoi et al., 2011), and a similar effect was also seen with thermal hyperalgesia in STZ-treated mice (Pabbidi et al., 2008b). They hypothesised that this may be
due to a direct neuronal effect of STZ, which leads to enhanced expression and function of the TRPV1 receptor in DRGs, as well as microglial activation, and increased levels of pro-inflammatory cytokines.

However, other studies have ruled out a direct effect of STZ (Davidson et al., 2009; Romanovsky et al., 2010). Evidence for this comes from studies that show that when STZ rats are treated with insulin they exhibit a decrease in hyperglycaemia and attenuated pain sensation (Courteix et al., 1996; Romanovsky et al., 2006), as well as a reversal of the upregulation of T-current density in small-sized DRG cells (Messinger et al., 2009). This suggests that these aberrant pain sensations must be due to a combination of hyperglycaemia and hypoinsulinaemia, and not just a direct effect of STZ (Romanovsky et al., 2004). Mechanical hyperalgesia has also been shown to correlate with plasma insulin levels in normoglycaemic STZ rats, further substantiating a role of decreased insulin in the development of hypersensitivity (Romanovsky et al., 2006). Finally, pressure pain thresholds were restored to original levels in normoglycaemic STZ rats after four weeks, in parallel with the spontaneous recovery of insulin production in these animals (Romanovsky et al., 2010). Therefore, in this thesis, it was presumed that any development of mechanical hypersensitivity was not a direct neurotoxic effect of STZ.

In this array of animal models of diabetes, the development of diabetic peripheral neuropathic pain (DPNP) can be investigated through a variety of methods. Most commonly, the development of mechanical hypersensitivity is examined using von Frey hairs, and the paw pressure test can be used to assess hyperalgesia. To look at thermal thresholds, both the Hargreaves and the hot plate test can be used. Finally, the formalin test can also be used in the diabetic model itself. Although this is not clinically relevant, it enables the investigation of the effect of hyperglycaemia on prolonged activation of nociceptive pathways in the peripheral and central nervous system (Calcutt, 2002).
<table>
<thead>
<tr>
<th>Method of induction</th>
<th>Model</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemical</td>
<td>High dose STZ (45-90mgkg(^{-1}) in rats)</td>
<td>STZ is used to destroy a high percentage of the pancreatic (\beta)-cells resulting in little endogenous insulin production, which leads to hyperglycaemia and weight loss.</td>
</tr>
<tr>
<td></td>
<td>Multiple low doses of STZ (20-30mgkg(^{-1}) in rats)</td>
<td>This induces insulitis, which causes a decrease in islet number and therefore a decrease in insulin secretion capacity.</td>
</tr>
<tr>
<td>Spontaneous autoimmune</td>
<td>NOD mice</td>
<td>NOD mice develop insulitis at around 3–4 weeks of age, which causes (\beta)-cell destruction. Overt diabetes becomes apparent at around 12-30 weeks, and mice rapidly lose weight and require insulin treatment.</td>
</tr>
<tr>
<td></td>
<td>BB rats</td>
<td>BB rats develop diabetes between 8-16 weeks of age. The level of diabetes is quite severe, and the rats rely on insulin therapy to survive.</td>
</tr>
</tbody>
</table>
Table 1.2 Summary of rodent models of type 2 diabetes

<table>
<thead>
<tr>
<th>Method of induction</th>
<th>Model</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obese models</td>
<td>Lep ob/ob mice</td>
<td>Mutation in the leptin gene. Obesity and mild hyperglycaemia develop by 4 weeks, and increase over time. Hyperinsulinaemia is also present.</td>
</tr>
<tr>
<td></td>
<td>Lepr db/db mice</td>
<td>Autosomal recessive mutation in the leptin receptor. Mice become obese, hyperglycaemic, hyperinsulinaemic and insulin resistant within 4 weeks and develop hypoinsulinaemia later, with a peak in hyperglycaemia between 3-4 months of age.</td>
</tr>
<tr>
<td></td>
<td>Zucker diabetic fatty (ZDF) rats</td>
<td>Mutated leptin receptor. Rats are initially hyperinsulinaemic with severe insulin resistance. When levels of insulin decrease, they become hyperglycaemic at 8-10 weeks of age.</td>
</tr>
<tr>
<td>Induced obesity</td>
<td>High fat diet (HFD) fed C57BL/6J mice</td>
<td>A high fat diet (typically where around 60% of energy is derived from fat) can lead to obesity and the development of hyperinsulinaemia, insulin resistance and glucose intolerance.</td>
</tr>
<tr>
<td>Chemically induced</td>
<td>Nicotinamide (NAD) + STZ</td>
<td>Rats administered NAD 15 minutes before STZ develop moderate, stable hyperglycaemia without any changes in plasma insulin levels as NAD has a protective effect on the cytotoxic action of STZ, resulting in only minor damage to pancreatic β-cell mass.</td>
</tr>
<tr>
<td></td>
<td>Neonatal STZ</td>
<td>STZ administration to neonatal rats can lead to hyperglycaemia at 6 weeks, due to a decrease in normal β-cell mass and β-cell dysfunction.</td>
</tr>
<tr>
<td></td>
<td>HFD/STZ</td>
<td>The HFD causes insulin resistance, followed by a low dose of STZ, which causes hyperglycaemia to develop as a proportion of the β-cells are destroyed.</td>
</tr>
</tbody>
</table>
1.2. Diabetic neuropathy

The prevalence of diabetic neuropathy varies from 10% within one year of diagnosis, to up to 50% 25 years after diagnosis (Pirart, 1978), with an average prevalence of approximately 30% (Said, 2007; Sugimoto et al., 2000), and the likelihood increasing with poor control of plasma glucose levels (Tesar et al., 1996). It has been estimated that approximately 16-21% of diabetic patients experience chronic painful DPN (Abbott et al., 2011; Daousi et al., 2004), and 40-50% of those with diabetic neuropathies experience pain (Veves et al., 2008).

The positive symptoms of DPN can include tingling, burning, spontaneous pain, allodynia and hyperalgesia, whereas the negative symptoms include numbness and loss of sensation (Dobretsov et al., 2007). The longest nerves are affected first, starting at the distal end, and so symptoms tend to follow a ‘stocking and glove’ distribution; starting in the toes, and spreading up the foot and eventually the leg, and can also be seen in the fingers and the hands (Zochodne, 2007). Early on there is a loss of intra-epidermal nerve fibres (IENFs). The loss of protective sensation in the foot can lead to ulceration, which can ultimately result in amputation (Vinik et al., 2000).

1.2.1. Mechanisms associated with diabetic neuropathy

The first changes observed in diabetic neuropathy are a decrease in the NCV in motor and sensory neurones, shunting of excess glucose into the polylol pathway, microangiopathy and impairments of Na⁺/K⁺-ATPase activity (Sima, 2003). Other important factors include inappropriate activation of protein kinase C (PKC) and poly(ADP-ribose) polymerase (PARP), and lack of neurotrophic support due to C-peptide and insulin deficiency (Obrosova, 2009b).
1.2.1.1. Microangiopathy

Microangiopathy leads to abnormalities in blood flow as observed in the sciatic nerve and DRG in the STZ model (Sasaki et al., 1997). This is due to impaired vasodilation with nitric oxide (NO), and increased activity of vasoconstrictors (Zochodne, 2007). There is also an increase in vascular permeability due to a rise in permeability factors such as vascular endothelial growth factor (Brownlee, 2001). As the disease develops there can be loss of microvascular cells, and thickening of the capillary basement membrane of the vasa nervorum, due to overproduction of the extracellular matrix, which is induced by growth factors. All of these changes lead to ischaemic damage to neurones and axons, resulting in axonal degeneration in peripheral nerves, due to severe demyelination.

1.2.1.2. Oxidative stress

In diabetes, metabolic abnormalities lead to increased production of mitochondrial superoxide by the electron transport chain (Brownlee, 2001; Giacco et al., 2010). This in turn results in activation of the intertwined mechanisms described below, resulting in a common fate: further oxidative stress. Excessive reactive oxygen series (ROS), such as superoxide and hydrogen peroxide, and reactive nitrogen series, such as peroxynitrite, are produced, which can lead to damage to lipids, proteins and DNA (Edwards et al., 2008). Peroxidation of lipids leads to formation of products which are toxic to the cell, and if DNA is damaged this can lead to apoptosis. Accumulation of all these products can also cause a loss of neuronal function, and neuronal degeneration (Vincent et al., 2004a). Oxidative stress can also cause mitochondrial dysfunction, and when the mitochondrial permeability transition pore opens, there is a release of cytochrome c and initiation of the apoptotic cascade (Russell et al., 2002). Treatment with antioxidants has been shown to prevent the NCV slowing that occurs as a result of peripheral nerve dysfunction in STZ rats (Cameron et al., 1993; Vincent et al., 2004b), but antioxidants such as α-lipoic acid have demonstrated
limited effects on neuropathic symptoms in randomised double-blind placebo trials (Vincent et al., 2004b).

1.2.1.3. Polyol pathway

Hyperglycaemia results in more glucose being shunted through the polyol pathway. Figure 1.1 summarises this pathway; glucose is converted to sorbitol by aldose reductase with the oxidation of NADPH to NADP+, and then to fructose by sorbitol hydrogenase with NAD+ being reduced to NADH (Duby et al., 2004).

![Figure 1.1](image)

**Figure 1.1** The key features of the polyol pathway, adapted from (Brownlee, 2001).

The polyol pathway uses up NADPH, which is important in the production of reduced glutathione (GSH), another antioxidant, and this depletion of GSH further promotes oxidative stress (Brownlee, 2005). The decrease in NADPH also leads to depletion of osmolytes such as taurine and nerve myo-inositol. Taurine is an antioxidant and vasodilator and its decrease leads to promotion of oxidative stress (Sima, 2003). A 1% taurine diet has been shown to improve the deficits in nerve conduction and blood flow that are seen in STZ mice (Pop-Busui et al., 2001). The loss of myo-inositol causes a decrease in PKC, which leads to impaired Na⁺/K⁺-ATPase activity, resulting in increased levels of sodium which are associated with slowing of NCV (Cherian et
al., 1996). The increased accumulation of fructose also leads to the formation of advanced glycation end-products.

Diabetic transgenic mice overexpressing human aldose reductase had an increased accumulation of sorbitol and fructose, decreased PKC activity, more severe slowing of NCV and more severe neuronal atrophy. These symptoms were ameliorated by the aldose reductase inhibitor, WAY121-409 (Yagihashi et al., 2001). On the other hand, diabetic mice with a knockout for the aldose reductase gene showed no reduction in NCV, and no change in GSH level (Chung et al., 2003). Aldose reductase inhibitors, however, have failed to show promise in diabetic patients.

1.2.1.4. Advanced glycation end-products (AGEs)

AGEs are formed when glucose, fructose or galactose covalently bond with proteins via the Maillard reaction (Ahmed, 2005). These first form a shift base, and then an Amadori product, followed by the irreversible formation of AGEs (Ulrich et al., 2001). AGEs can cause intermolecular cross-linking of proteins such as myelin, which can lead to demyelination (Brownlee, 2001). They can also bind to receptors, such as the Receptor for AGE (RAGE), which is found in DRGs, peripheral nerves, Schwann cells and epidermal fibres (Bierhaus et al., 2004; Toth et al., 2008). RAGE activates nuclear factor kappa B (NFκB), leading to an increased expression of cytokines. RAGE also activates NADPH oxidases, leading to the generation of ROS (Wautier et al., 2001; Yan et al., 1994) and so further increasing oxidative stress in the cell (Vincent et al., 2004a).

1.2.1.5. PKC activation

Hyperglycaemia also leads to increased production of diacylglycerol (DAG), which activates various PKC isoforms including PKC-β and -δ, leading to changes in gene expression (summarised in Brownlee,
eNOS is downregulated, and endothelin-1 and TGF-β are upregulated, which can lead to negative changes in blood flow. NFkB is also upregulated, which causes increased expression of pro-inflammatory genes. PKC-β inhibitors have been shown to improve some of the vascular deficits, such as decreased NCV and reduced blood flow, that are observed in STZ animals (Ahlgren et al., 1994; Ishii et al., 1996; Nakamura et al., 1999). PKC also plays a role in pain pathways and hyperalgesic priming.

### 1.2.1.6. Hexosamine pathway

Hyperglycaemia leads to excess fructose-6-phosphate being diverted from glycolysis to enter the hexosamine pathway, where it is converted to uridine diphosphate-N-acetyl glucosamine. This attaches to the serine and threonine residues of transcription factors, and can lead to altered gene expression, including upregulation of pro-inflammatory genes (Brownlee, 2001).

### 1.2.1.7. Poly(ADP) ribose polymerase

The PARP pathway is stimulated by free radicals and cleaves NAD+ (Edwards et al., 2008). This reduction in NAD+ can lead to a slowing of NCV, small fibre neuropathy, and development of painful symptoms such as thermal and mechanical hyperalgesia and tactile hypersensitivity (Edwards et al., 2008). It also affects glycolysis and mitochondrial respiration, which causes a decrease in energy production and can lead to cell death (Negi et al., 2010).

### 1.2.1.8. Insulin and C-peptide

As well as the importance of hyperglycaemia in diabetic neuropathy, the deficiency of insulin and C-peptide is also important, especially in type 1 diabetes. This is supported by the Diabetes Control and Complications Trial (DCCT), which shows that tight glycaemic control is effective at
reducing the development of diabetic neuropathy by 60%, but not in preventing it entirely, suggesting that other factors must also be important (Sugimoto et al., 2000). C-peptide links the A and B chains of proinsulin together, and is cleaved by proteases. C-peptide has been shown to: improve Na\(^+\)/K\(^+\)-ATPase activity and ameliorate the decrease in NCV, as well as helping to prevent paranodal swelling and axonal degeneration (Zhang et al., 2001b); improve indices of sensory nerve function (by decreasing thermal thresholds) (Johansson et al., 2000); and prevent thermal hyperalgesia in BB/Wor rats (Kamiya et al., 2004). Both insulin and insulin-like growth factors (IGFs) are important neurotrophic factors involved in supporting peripheral neurones, and continuous subcutaneous infusion of IGF-2 was able to attenuate hyperalgesia in ZDF rats (Zhuang et al., 1997). In STZ mice, insulin can decrease mortality and sensory loss, as well as improving neuropathic pain (Francis et al., 2009), and in STZ rats insulin can improve NCV, as well as increasing the number of myelinated fibres in the sural nerve (Singhal et al., 1997). The importance of changes in insulin to the development of DPNP is discussed further in Chapter 2.
1.3. Pain

According to the International Association for the Study of Pain (IASP), pain can be defined as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage”. Nociception, however, is the neural process involving detection of tissue injury, and refers to the physical response to pain, but is not tied to the emotional experience.

1.3.1. Primary afferent nociceptors

Nociception occurs through nociceptors, whose existence was first proposed by Sherrington (1906) over a century ago, and these are defined by IASP as “a high-threshold sensory receptor of the peripheral somatosensory nervous system that is capable of transducing and encoding noxious stimuli”. Nociceptors can detect noxious heat or cold, and intense mechanical stimulation and noxious chemicals, but do not respond to innocuous stimuli (Burgess et al., 1967) such as touch or warming/cooling. Fibres that innervate the body arise from cell bodies in the DRG (Julius et al., 2001). Nociceptors can be divided into three different sub-types depending on their conduction velocity: small diameter unmyelinated C-fibres, slightly larger Aδ-fibres which are thinly myelinated, and myelinated, large diameter (>10µm) Aβ-neurones (for review see Willis et al., 2004).

Aβ-fibres are rapidly conducting and act as low threshold mechanoreceptors - responsible for proprioception and the detection of innocuous stimuli, but some Aβ-fibres do function as nociceptors (Djouhri et al., 2004). This is important as it is Aβ-fibres that are responsible for the development of allodynia (pain elicited by an innocuous stimuli), and after even a small drop in their threshold these nociceptive Aβ-fibres become responsive to innocuous stimuli (Djouhri et al., 2004). It is Aδ- and C-fibres that are mainly responsible for the detection of noxious stimuli. Aδ-fibres are thought to be responsible for
the rapid acute pain sensations of pricking and aching, whereas slowly conducting C-fibres produce a delayed, more diffuse, dull burning pain sensation (Willis et al., 2004).

Two populations of Aδ-fibres exist: Type I and Type II (Treede et al., 1995). Type I respond to high heat (~53°C), mechanical and chemical stimuli. They have a delayed onset to heat stimuli, but they then become sensitised and their discharge rate increases during a prolonged heat stimulus (Treede et al., 1995). They sensitise to burn and chemical injury, and are responsible for development of primary hyperalgesia (Meyer et al., 2005). Type II, on the other hand, are mostly mechanically insensitive, and have a lower thermal threshold (~43°C) and a rapid and fast adapting response to heat and are thought to signal the first pain sensation from heat (Campbell et al., 1983; Treede et al., 1998; Treede et al., 1995).

C-fibre nociceptors can be polymodal, as some respond to noxious mechanical stimuli, intense heat and cold, as well as noxious chemical stimuli such as acid or capsaicin (Meyer et al., 2005). However some C-fibre nociceptors are mechanically sensitive but do not respond to heat, whereas others can be mechanically insensitive but respond to noxious heat (Schmidt et al., 1995). Furthermore, some C-nociceptors may initially be insensitive to both mechanical and thermal stimuli, known as ‘silent’ or ‘sleeping’ nociceptors, but are activated by irritant substances such as mustard oil in experimental conditions (Schmidt et al., 1995), or inflammatory mediators released during inflammation, and can then become sensitised to further mechanical and thermal stimuli.

C-fibres can be divided into two classes based on their neurochemical content: peptidergic and non-peptidergic. Peptidergic neurones release substance P (SP) and calcitonin gene related peptide (CGRP) and express TrkA (a high affinity receptor for nerve growth factor (NGF)), and are reliant on NGF for normal function (Averill et al., 1995; Molliver et al., 1997). Approximately 80% of DRG neurones require NGF for
survival during embryonic development, but in the first three weeks of development approximately half of these neurones stop expressing TrkA, and these are then classified as non-peptidergic neurones (Bennett et al., 1996; Molliver et al., 1997). These neurones express the growth factor receptor, GFRα, as well as the receptor tyrosine kinase, RET, and are reliant on glial-derived neurotrophic factor (GDNF) for survival (Bennett et al., 1998). They also express the P2X3 receptor (an ionotropic ATP receptor), and can be labelled with the plant lectin IB4 (Molliver et al., 1997).

Neurones can be desensitised by repeated stimulation. Repeated activation of the receptors present on the neurones can lead to a downregulation of these receptors, or an exhaustion of mediators. Nociceptors can be desensitised by application of capsaicin, a Transient Receptor Potential Vanilloid 1 (TRPV1) ligand. TRPV1 is expressed exclusively by small-diameter neurones within sensory ganglia (Caterina et al., 2001; Caterina et al., 1997). Capsaicin causes firing of nociceptors and an initial period of enhanced sensitivity, which is followed by a refractory period in which responses to noxious stimuli, including capsaicin, are reduced (Jancso, 1992).

The predominant excitatory neurotransmitter in primary afferent fibres is glutamate, but a wide variety of substances are involved in the central transmission and modulation of nociceptive information. These can include other excitatory amino acids (EAAs), neuropeptides such as SP and CGRP, adenosine triphosphate (ATP) and NO, as well as prostaglandins (PGs) and neurotrophins such as NGF.

Glutamate provides rapid transmission of excitatory pronociceptive inputs in the spinal cord, and can act on a variety of specific receptors. These include the metabotropic glutamate receptors: mGluR1-8, which are GPCRs and the ionotropic glutamate receptors: α-amino-3-hydroxy-5-methyl-isoxazole (AMPA), N-methyl-D-aspartate (NMDA) and kainite,
which are coupled to cation channels (Coggeshall *et al.*, 1997; Mayer *et al.*, 2004).

### 1.3.2. The organisation of the dorsal horn of the spinal cord

Primary afferent nociceptors synapse with neurones in the dorsal horn of the spinal cord, and projection neurones convey the information to higher centres in the brain, where the information is processed.

In 1952, the division of the dorsal horn of the spinal cord of a cat into six laminae was first described (Rexed, 1952). Figure 1.2 shows how the laminae are organised; with I-VI comprising the dorsal horn, VII-IX making up the ventral horn, with lamina X surrounding the central canal. Laminae I and II make up the superficial dorsal horn (with lamina II further subdivided into an outer (IIo) and inner part (IIi)), and these together with V, VI and X are the main targets for primary nociceptive afferents. Lamina I receives nociceptive input from Aδ- and C-fibres, whereas laminae III and IV contain neurones responsive to the innocuous stimulation delivered by Aβ-fibres, and lamina V receives both non-noxious and noxious input from monosynaptic Aδ- and Aβ-inputs and polysynaptic C-fibre inputs (Basbaum *et al.*, 2009).

Three different populations of neurones exist within the dorsal horn of the spinal cord, and these are defined as: non-nociceptive, nociceptive specific (NS) and wide dynamic range (WDR) neurones (Willis *et al.*, 2004). Non-nociceptive neurones are located in III, III and IV, and are activated by innocuous stimuli. NS neurones are typically silent and are specifically activated by noxious stimuli mediated by peripheral nociceptors, and are found in both superficial (lamina I and Ilo) and deep (lamina V, VI and X) layers. WDR neurones are able to encode the intensity of noxious stimuli, and have a graded respond to stimuli that range from low-threshold to those in the noxious range. They respond to thermal, mechanical and chemical stimuli mediated by Aβ-,
Aδ- and C-fibres. These are also found in lamina IV, V, VI and X, as well as laminae I and II. WDR neurones also display a 'wind-up' response (Price et al., 1978), where the response of the neurone to repeated electrical stimulation at a set intensity, with a frequency of >0.5Hz, will increase dramatically, with each stimulus evoking a larger response than the last, and firing continuing even after cessation of stimulation (Mendell, 1966; Schouenborg et al., 1985). NMDA antagonists are able to markedly reduce this wind-up and post stimulus discharge, suggesting that high frequency stimulation of NMDA receptors contributes to wind-up through alleviation of the Mg2+ block (Dickenson et al., 1987).

Dorsal horn neurones can also be classified by their output destination. Propriospinal neurones allow communication between the ipsilateral and contralateral sides, as well as between different segments (Willis et al., 2004), and they are also able to initiate descending inhibition. Projection neurones are responsible for transmitting nociceptive information supraspinally, and are mostly found in laminae I, V and VI, whereas interneurones are responsible for inter- and intra-laminar transfer, integration and modulation of nociceptive information (Millan, 1999).
1.3.3. Ascending pain pathways

There are two types of ascending pathways: monosynaptic and polysynaptic. Monosynaptic pathways project directly from the dorsal horn to the higher brain centres and include the spinothalamic tract (STT), the spinomesencephalic tract, the spinoparabrachial tracts.
(SPBT), and the spinohypothalamic tract. Polysynaptic pathways, on
the other hand, include a relay station of second order neurones on
their journey to higher brain centres, and these include the
spinocervicothalamic pathway, and the postsynaptic dorsal column
(PSDC) pathway.

The STT transmits information to the thalamus, and it has projections
originating from superficial lamina I and deeper laminae IV and V of the
dorsal horn, and also laminae VII and VIII, with half of these originating
in lamina I and the other 50% split evenly between the other laminae
(Dostrovsky et al., 2006). The STT neurones in each of the different
regions of the spinal cord receive afferent input from different primary
afferent fibres. Lamina I STT cells receive input from Aδ- and C-fibres,
and so respond to noxious stimulation including noxious heat and cold,
as well as pinch and itch. STT cells in laminae IV-V receive input from
A-fibres, and also respond to a variety of stimuli encoded by WDR cells.
Finally, STT cells in laminae VII-VIII receive input from skin, and muscle
and joint inputs (Dostrovsky et al., 2005).

The SPBT projects to the medulla and brainstem, which is important for
the integration of nociceptive information with homeostatic, arousal and
autonomic processes, and this information is then conveyed to the
forebrain (Tracey et al., 2007).

The thalamus can be seen as the key relay site for nociceptive
information as it receives nociceptive information from the STT, and is
able to encode information about intensity and topographic localisation
and then transfer it to cortical and subcortical structures (Millan, 2002).
The thalamus has also been hypothesised to be important in chronic
pain, and a decrease in thalamic blood flow contralateral to the site of
pain has been observed in patients with cancer (Di Piero et al., 1991),
and a patient with a left medullary infarct (Garcia-Larrea et al., 2006). In
patients with diabetic neuropathy, a decrease in N-acetylaspartate
(NAA), a marker of neuronal integrity, has been observed in the
thalamus, with a correlation between the reduction in NAA and the severity of the neuropathy (Selvarajah et al., 2008). Another study found lower levels of NAA in the thalamus of diabetic patients, and that these were further decreased in those that experienced pain (Sorensen et al., 2008).

1.3.4. Descending control of pain

The descending pain modulatory system, as seen in Figure 1.3, is an anatomical network that plays an important role in determining the experience of pain, as it can have facilitatory as well as inhibitory effects, and these can be altered depending on emotional or pathological state, and are affected by arousal and expectation (Fields et al., 2005). It is thought that sustained facilitation of pain transmission may be an underlying mechanism of chronic pain (Porreca et al., 2002).

The PAG-RVM (periaqueductal grey-rostral ventromedial medulla) system is important in the descending control of pain (Fields et al., 1991). The PAG receives input from the dorsal horn and is connected to the hypothalamus and frontal cortex, as well as limbic forebrain structures such as the amygdala, and receives input from the spinomesencephalic tract (Millan, 2002). The PAG projects to the RVM, which is responsible for transmitting information to the dorsal horn of the spinal cord. The role of the PAG in descending control was first established in experiments where stimulation of, or microinjections into, the PAG resulted in behavioural analgesia to noxious stimuli (Mayer et al., 1976; Mayer et al., 1971), and similar effects have also been shown in humans (Mayer, 1984).

The RVM includes the nucleus raphe magnus and projects to both the superficial layer and the deep dorsal horn via the dorsolateral funiculus. It mediates bidirectional control as it can exert both facilitatory and inhibitory influences (Porreca et al., 2002). Electrical stimulation of the RVM can be antinociceptive and cause decreased responses of dorsal
horn neurones (Fields et al., 1991), but at a lower intensity it can also prove facilitatory (Zhuo et al., 1990), and these effects can also be seen by microinjection with neurotransmitters (Zhuo et al., 1992). If a lesion is created in the RVM or if it is inactivated with lidocaine, stimulation of the PAG no longer has an analgesic action, highlighting the importance of the RVM as a relay for the PAG to connect with the dorsal horn.

Within the RVM, there are three types of cells: ON, OFF and NEUTRAL (Fields et al., 1991). OFF-cells are tonically active and pause their firing immediately before a withdrawal response as they are inhibited by noxious stimuli (Fields et al., 1983; Porreca et al., 2002). It is thought that it is the OFF-cells that cause descending inhibition of nociception, as decreases in OFF-cell firing have been shown to correlate with increased nociceptive transmission (Fields et al., 1991), and activation of OFF-cells has been correlated with inhibition of nociceptive input (Fields et al., 1999). ON-cells accelerate their firing before a withdrawal reflex occurs, and it has been postulated that ON-cells enable the RVM to have a facilitatory role in pain. Increased activity of ON-cells has been observed in models of hyperalgesia, and administering a drug in the RVM while monitoring neuronal activity, and also the threshold for a reflex to nociceptive stimulation, confirms that ON-cells are responsible for facilitation (for review see Heinricher et al., 2009).
Figure 1.3. Descending control of pain. The modulatory pathway links higher brain centres to the PAG, which projects to the RVM, which exerts inhibitory (−) or facilitatory (+) effects on nociceptive processing. Adapted from (McMahon et al., 2005).

1.3.5. Neuropathic pain

Neuropathic pain is defined by IASP as “pain caused by a lesion or disease of the somatosensory nervous system”, and is chronic and potentially irreversible. Acute pain, and the ability to detect noxious stimuli serves an important evolutionary role by acting as a warning
system to ensure an organism’s survival and well being, through reflex withdrawal responses to a noxious stimuli and protective behaviour of a damaged tissue. Neuropathic pain, however, fulfils no physiological purpose and can be considered pathological (Millan, 1999).

It has been estimated that one in six of the general population are affected by neuropathic pain at some point, and symptoms include spontaneous pain, allodynia, hyperalgesia (heightened sensation of pain) and abnormal sensations such as dysesthesias and paresthesias (Campbell et al., 2006). As well as being present in diabetic neuropathy, it can also be caused by nerve injury, autoimmune disease, infections such as shingles, and neurotoxicity (e.g. by chemotherapy agents) (Zimmermann, 2001).

### 1.3.6. Origins of pain in diabetes

Diabetic neuropathy is a progressive disease with pain experienced due to a wide variety of causes. Painful symptoms usually occur at the onset of diabetic neuropathy, although there tends to be no correlation between the intensity of pain symptoms and the extent of the sensory deficit, and can be influenced by the patient’s psychological and emotional state (Guastella et al., 2009).

Oxidative stress and the other processes described in section 1.2.1, lead to neuronal death. The loss of small Aδ- and C-fibres leads to changes in pain sensation and temperature perception, whereas the loss of larger Aβ-fibres can cause a loss of vibration sensation, and tactile discrimination (Guastella et al., 2009). Along with sensory loss, destruction of C-fibres also causes painful symptoms such as burning, as well as paresthesias and dysesthesias (Guastella et al., 2009). As the disease progresses further and there is greater neuronal loss, chronic pain can still be experienced, even without peripheral stimulation, due to the development of central sensitisation, but eventually the sensory deficits overtake and there is sensory loss.
1.3.6.1. Involvement of primary afferent fibres

When nerves in diabetic patients become injured, this leads to the accumulation of sodium channels along portions of the injured axons. In the STZ model an increase in the expression of the TTX-S sodium channel, \( Na_v^{1.7} \), has been observed, along with a reduction in the expression of the TTX-R sodium channel, \( Na_v^{1.8} \), which is preferentially expressed in small DRG neurones (Hong et al., 2004). An increase in \( Na_v^{1.3} \), and \( Na_v^{1.6} \) has also been observed, which would be expected to lead to a lowered firing threshold (Craner et al., 2002). Despite a decrease in \( Na_v^{1.8} \), there is an increase in its phosphorylation, which results in a modification of the channel properties (Hong et al., 2004), and post-translational modification of \( Na_v^{1.8} \) by methylglyoxal is associated with enhanced sensory neurone excitability (Bierhaus et al., 2012). These changes in sodium channels result in an increase in TTX-S and TTX-R sodium currents in small DRG neurones, which correlates with the development of hyperalgesia and mechanical hypersensitivity, and persists in the long term (Hirade et al., 1999; Hong et al., 2004). In large A-fibre DRG neurones an increase in TTX-S \( Na_v^{1.2} \), \( Na_v^{1.3} \), and \( Na_v^{1.7} \), as well as TTX-R \( Na_v^{1.9} \) has been observed, resulting in an increase in sodium currents, and a shift of the voltage-dependent activation kinetics in the hyperpolarising direction (Craner et al., 2002; Hong et al., 2006). Normalisation of \( Na_v^{1.7} \) levels in STZ rats was able to reduce pain related behaviours (Chattopadhyay et al., 2012). Increased nodal persistent sodium currents have been associated with neuropathic pain in humans with diabetic neuropathy (Misawa et al., 2009).

The changes in these channels facilitate the generation of ectopic electrical impulses and hyperexcitability (Devor, 2005). In the STZ rat model, nociceptive fibres have been shown to fire in an exaggerated spontaneous manner (see Chapter 4 for more detail) (Ahlgren et al., 1992; Chen et al., 2001), and increased excitability of regenerating nerve fibres may also lead to aberrant discharge (Brown et al., 1976).
Ectopic discharges are also seen in models of nerve damage such as the chronic constriction injury (CCI) model, and spinal nerve injury at both the level of peripheral neurones (Tal *et al*., 1996; Wall *et al*., 1983) as well as DRGs (Kajander *et al*., 1992; Liu *et al*., 2000; Study *et al*., 1996; Xie *et al*., 1995). Spontaneous firing has been shown to cause a reduction in thermal, mechanical and chemical thresholds (Howe *et al*., 1977), and nerve injury can also lead to spontaneous discharges in neighbouring uninjured axons, as well as the injured neurones themselves (Ali *et al*., 1999). Ectopic discharges can lead to spontaneous pain and paresthesias (Devor, 2006), as well as contributing to the development and maintenance of central sensitisation (discussed later). Transection of, or anaesthetising the dorsal roots in the spinal nerve ligation (SNL) model, and therefore blocking ectopic discharges, reduced behavioural signs of neuropathic pain (Yoon *et al*., 1996).

As described previously, there is increased activation of PKC in diabetic neuropathy, and PKC also plays a role in nociceptive processing in primary afferents and hyperalgesic priming (for review see Velazquez *et al*., 2007). PKC activation can cause depolarisation of unmyelinated C-fibres by increasing sodium conductance (Dray *et al*., 1988; Rang *et al*., 1988), and enhance currents caused by noxious thermal stimuli (Cesare *et al*., 1996). PKC inhibitors have been shown to block this depolarisation (Burgess *et al*., 1989; McGuirk *et al*., 1992).

In rats, PKC activation is able to increase capsaicin induced TRPV1 currents by increasing depolarisation of TRPV1 (Zhou *et al*., 2001b), which allows the receptor to conduct at lower, non-noxious temperatures, and also at physiologically relevant pHs (Crandall *et al*., 2002), while PKC inhibitors decrease these currents (Zhou *et al*., 2001b). Inflammatory mediators, such as bradykinin, galanin and TNFα enhance the activity of TRPV1 through PKC-dependent pathways, which may play a role in hyperalgesic priming (see references in Velazquez *et al*., 2007). PKC inhibitors can decrease thermal...
hyperalgesia and C-fibre hyperexcitability in STZ rats (Ahlgren et al., 1994). As well as in the periphery, PKC can also modulate neurotransmission at the level of the spinal cord through increasing excitatory neurotransmission and decreasing inhibitory tone.

### 1.3.6.2. Involvement of spinal sensitisation

Sensitisation can occur at both the peripheral and central level, and is important in the development of pain in diabetic neuropathy. Peripheral sensitisation involves a reduced threshold for activation and an amplification in the responsiveness of primary afferent nociceptors, and occurs when these neurones are exposed to inflammatory mediators, which are released by damaged tissues (Dickenson et al., 2002). Central sensitisation, which was first proposed thirty years ago (Woolf, 1983), develops following a primary afferent barrage, which leads to sustained activation of WDR neurones in the spinal cord. These neurones become sensitised, and at this point input from primary afferent neurones is no longer required to elicit responses from these neurones. To demonstrate this, pre-treatment with a local anaesthetic can prevent the cutaneous hyperalgesia that develops following intradermal capsaicin administration, but if the anaesthetic is only given after injection of capsaicin, there is no effect on hyperalgesia (LaMotte et al., 1991), suggesting that peripheral inputs are required for the onset of hyperalgesia, but are not required to maintain it.

Central sensitisation is characterised by an increased responsiveness of nociceptive neurones in the central nervous system (CNS) to both normal and subthreshold afferent input. The recruitment of low-threshold Aβ-fibres means that their input is able to drive nociceptive pathways, resulting in a reduction in the threshold for activation. Central sensitisation also results in an increase in spontaneous activity, as well as an enlargement of peripheral receptive fields (Coderre et al., 1997). These effects are due to increases in membrane excitability, synaptic facilitation, and decreases in inhibitory transmission (for references see...
Latremoliere et al., 2009). The result of central sensitisation is that pain is no longer coupled to the intensity or duration of a peripheral stimulus, and painful sensations can occur in the absence of noxious stimuli. There are a number of mechanisms underlying the development of central sensitisation, and a variety of receptor systems are involved.

GABAergic interneurones are important in both pre- and post-synaptic inhibition of responses of dorsal horn neurones. Blocking these interneurones with γ-Aminobutyric acid (GABA)\textsubscript{A/B} antagonists causes mechanical hypersensitivity and thermal hyperalgesia in naive rats, whereas GABA\textsubscript{A/B} agonists were able to abolish the mechanical hypersensitivity and thermal hyperalgesia seen in SNL rats (Malan et al., 2002). Therefore the loss of inhibitory GABAergic interneurones causes disinhibition of neurones in the dorsal horn, leading to increased neurotransmission, which can contribute to central sensitisation.

When nerves are injured, this causes a phenotypic switch where damaged A-fibres begin to synthesise excitatory neurotransmitters that are normally associated with C-fibres, such as CGRP and SP (Miki et al., 1998; Noguchi et al., 1995). The release of substance P causes activation of post-synaptic NK1 receptors, which leads to downstream activation of intracellular signalling pathways such as mitogen-activated protein kinase (MAPK) and extracellular-signal related kinase (ERK). These pathways lead to activation of NMDA receptors, along with PKC, which potentiates these NMDA-currents through alleviation of the voltage dependent Mg\textsuperscript{2+} block (Chen et al., 1992). Activation of NMDA receptors results in synaptic potentiation (Woolf et al., 1991) where nociceptive stimuli produce larger postsynaptic potentials, resulting in hyperexcitability of dorsal horn neurones. NMDA receptor antagonists are able to reduce the facilitation of these responses (Woolf et al., 1991), and NMDA receptor phosphorylation in the spinal cord coincides with the development of mechanical hypersensitivity in the SNL model (Gao et al., 2005).
Upregulation of AMPA and NMDA receptors in the spinal cord has also been implicated in the development of central sensitisation, and the increase in AMPA receptor expression coincided with the development of mechanical and thermal hyperalgesia in the partial nerve ligation (PNL) model (Harris et al., 1996). mRNA of AMPA and NMDA subunits is upregulated in the STZ model (Tomiyama et al., 2005), and hyperalgesia and mechanical hypersensitivity can be prevented in this model by administration of AMPA- and NMDA-receptor antagonists (Begon et al., 2000; Calcutt et al., 1997; Malcangio et al., 1998), demonstrating the important role these receptors play in central sensitisation.

Neurochemical changes in the spinal cord, such as the release of excitatory amino acids, cytokines and reactive oxygen species cause glial activation, which also plays an important role in the development of neuropathic pain and is discussed further in Chapter 3.

### 1.3.6.3. Involvement of higher centres

As well as the involvement of primary afferent fibres and spinal cord neurones, it has also been hypothesised that higher order pain signalling neurones are involved in the generation and/or amplification of pain signals. Fischer et al. (2009) made recordings from neurones in the thalamic ventral posterolateral nucleus, which relays sensory input from the periphery. Increases in spontaneous activity, evoked activity to both innocuous and noxious stimuli, as well as enlarged receptive fields were reported in the STZ rat model, and this spontaneous activity was generated even in the absence of signals from primary sensory neurones (Fischer et al., 2009). STT neurones also display increased spontaneous activity, enlarged receptive fields and increased responses to mechanical stimuli (brush and pinch), which may be due to the aberrant activity that is observed in the afferent nerves in the STZ model (Chen et al., 2002a).
There is also an increase in serotonergic neurones in the RVM and noradrenergic neurones in the A5 noradrenergic cell group in STZ rats, as well as increased levels of serotonin and noradrenaline at the spinal cord and increased c-Fos expression in the ventrolateral PAG (VLPAG) (Morgado et al., 2011b). As the PAG is responsible for relaying messages from the higher brain centres, such as the amygdala and anterior cingulate cortex, via the RVM (Heinricher et al., 2009), this suggests that in diabetes there may be impairments to descending pain modulation. The high levels of noradrenaline increase the release of GABA, which is increased in the STZ model (Malmberg et al., 2006; Morgado et al., 2008). This increase in GABA, unexpectedly, has an excitatory effect in diabetes, due to a decrease in the expression of the potassium chloride co-transporter 2 (KCC2) (Jolivalt et al., 2008; Morgado et al., 2008). This leads to an increase in intracellular chloride concentrations, and when GABA binds to GABA\(\text{A}\) receptors, there is an efflux of chloride creating a depolarising event (Coull et al., 2003). This, in combination with increased serotonergic activity, results in enhanced activity of spinal neurones, and therefore increased facilitation.

A further study went on to demonstrate that Fos expression (a marker of neuronal activation) increases over time in diabetes, suggesting that spontaneous neuronal activity increases as the disease progresses (Morgado et al., 2011a). The PAG, which has facilitatory as well as inhibitory effects on pain modulation (Heinricher et al., 2009; Vanegas et al., 2004), shows a universal increase in Fos expression at 4 weeks, but at 10 weeks this was limited to only the VLPAG. c-Fos expression is also increased in both superficial and deeper laminae of the dorsal horn in STZ rats (Morgado et al., 2007).

A recent study has shown that in STZ rats there is a decrease in descending pain inhibition as evidenced by a decrease in the spontaneous activity of OFF-cells, as well as the absolute number, and this is coupled with an increase in spontaneous activity of ON–cells.
indicating an increase in descending pain facilitation from the RVM (Silva et al., 2013).

Increased C-fibre evoked wind-up is observed in the STZ mouse model (Kimura et al., 2005), indicating the enhanced excitability of spinal cord neurones. While the conditioning stimulus generates both inhibitory and excitatory influences in normal animals, the decrease in μ-opioid receptors in the dorsal horn of the spinal cord in diabetes (Chen et al., 2002b) means that there is less recruitment of the inhibitory system, leading to enhanced wind-up (Kimura et al., 2005).
1.4. **Aims of the thesis**

The aim of this thesis was to characterise pain responses in the HFD/STZ model and to explore some of the peripheral and spinal mechanisms associated with the changes in somatosensory processing. The effectiveness of a variety of drugs in alleviating/preventing neuropathic pain was also investigated in this model.

The objectives were to:
1. study the development of mechanical hypersensitivity in the HFD/STZ model.
2. investigate underlying mechanisms by examining indices of neurodegeneration in the DRG and spinal cord, and the potential contribution of microglia and astrocytes in the spinal cord.
3. characterise the electrically and mechanically-evoked responses of wide dynamic range neurones in the dorsal horn of the spinal cord.
4. explore the possibility of using currently prescribed antidiabetics versus existing and novel analgesics to alleviate pain responses in this model.
Chapter 2.

Assessment of the HFD/STZ diabetic model
2.1. Introduction

2.1.1. The STZ model of diabetes

As discussed in Chapter 1, there is an array of animal models of diabetes. One of the most frequently used models is the STZ model, as it is quick, easy and cheap to set up.

Streptozotocin (2-deoxy-2-(3-(methyl-3-nitrosoureido)-D-glucopyranose) is a toxin which selectively destroys pancreatic β-cells, and is derived from Streptomyces achromogenes. It enters through the glucose transporter, GLUT2, and causes alkylation of DNA (Szkudelski, 2001). Other effects include formation of superoxide radicals, which cause the release of toxic amounts of nitric oxide, which also damages DNA (Szkudelski, 2001). Alkylation of DNA leads to overstimulation of PARP, which causes a decrease in NAD+, and subsequently ATP, leading to the necrosis of β-cells (Lenzen, 2008). It is this activation of PARP that is considered one of the main reasons for the diabetogenicity of STZ (Szkudelski, 2001). Depletion of NAD+ also results in the inhibition of insulin synthesis and secretion (Lenzen, 2008).

A wide range of doses of STZ are used in the induction of diabetes in rats, and these vary from multiple low doses (20mgkg⁻¹) (Skalska et al., 2010; Taliyan et al., 2012; Zhang et al., 2008), to high doses of up to 75-90mgkg⁻¹ (Aubel et al., 2004; Lindner et al., 2006; Nadig et al., 2012), with the majority ranging somewhere between 45-70mgkg⁻¹.

Administration of STZ leads to hyperglycaemia and hypoinsulinaemia, which is evident in the first few days after injection, and is maintained at a similar level as the model develops. Other symptoms that are typically associated with STZ administration are stunted growth, polydipsia, polyuria and polyphagia (Chatzigeorgiou et al., 2009).
2.1.2. Neuropathy in the STZ model

The development of changes in mechanical and thermal thresholds in response to nociceptive and non-nociceptive stimuli has been extensively studied in the STZ model. A decrease in mechanical withdrawal thresholds is first seen 1-2 weeks after injection with STZ, and reduces further as the model progresses (Ahlgren et al., 1993; Calcutt et al., 1996; Courteix et al., 1993; Dobretsov et al., 2003; Fuchs et al., 2010; Xu et al., 2011). There are conflicting reports about whether thermal hyperalgesia (Courteix et al., 1993; Fuchs et al., 2010; Ulugol et al., 2004) or hypoalgesia (Bianchi et al., 2012; Fox et al., 1999; Malcangio et al., 1998; Piriz et al., 2009) is seen in the STZ model. Recent reports have suggested that STZ causes thermal hyperalgesia in the early stages, which is followed by thermal hypoalgesia after approximately six weeks (Bishnoi et al., 2011; Pabbidi et al., 2008a; Pabbidi et al., 2008b), similar to what is seen clinically (Obrosova, 2009a).

A variety of drugs are effective at reversing the manifestation of pain behaviours in the STZ model. Four weeks after STZ administration, high single doses of morphine (20mgkg⁻¹) and baclofen (16mgkg⁻¹) were able to reverse mechanical hyperalgesia in the paw pressure test, and chronic treatment (for 6 days) with MK-801 (0.1mgkg⁻¹) completely reversed mechanical hyperalgesia (Malcangio et al., 1998). Another study looked at the acute effect of five drugs on mechanical withdrawal thresholds at 3 and 7 weeks after STZ injection (Yamamoto et al., 2009). Pregabalin (30mgkg⁻¹) was the most effective and reversed the decrease in withdrawal thresholds at both timepoints. Mexiletine (100mgkg⁻¹) and morphine (10mgkg⁻¹), however, were only able to partially reverse the decrease in withdrawal thresholds at 3 weeks, and were ineffective by 7 weeks. Other studies have also shown hyporesponsiveness to morphine, with its antinociceptive abilities abolished 12 weeks after STZ administration (Nielsen et al., 2007). Amitriptyline (3mgkg⁻¹) was only able to partially alleviate mechanical
hypersensitivity at 7 weeks, and diclofenac (10mg kg$^{-1}$) was ineffective at all timepoints.

### 2.1.3. Criticisms of the STZ model

The STZ model has been criticised as it can leave animals in poor condition. Fox et al. (1999) expressed doubts as to its validity as a model of diabetic neuropathy, as the animals suffered from diarrhoea, polyuria, enlarged and distended bladders, and reduced growth. These rats were assessed to be chronically ill, as they appeared very lethargic and displayed no exploratory behaviour, and 24% were removed before the end of the four week study. They hypothesised that the behavioural results obtained might not be valid as they could be caused by general ill-health rather than neuropathy itself. The body condition score of rats has also been correlated with withdrawal thresholds (Hoybergs et al., 2008), emphasising the importance of monitoring rats for weight loss and general body condition, to ensure that any behavioural data obtained cannot be attributed solely to their poor condition.

### 2.1.4. Alternatives to the STZ model

While the STZ model has been widely used, it is a model of type 1 diabetes, but only a small proportion of cases of diabetes are accounted for by type 1 diabetes, with 90-95% of sufferers having type 2 diabetes (Cheng, 2005). There are several alternatives to the single high-dose of STZ that can produce a model which more closely resembles type 2 diabetes:

Nicotinamide, an antioxidant, can be administered 15 minutes before STZ, which leads to moderate hyperglycaemia, glucose intolerance and reduced insulin stores (Masiello et al., 1998). NAD is able to scavenge free radicals, as well as causing inhibition of PARP, and increasing levels of NAD+, and this helps to reduce the amount of damage that is
caused to β-cells (Szkudelski, 2012). This model can therefore be considered more typical of type 2 diabetes, and doses of each compound can be adjusted to alter the severity of diabetes that is produced. This model is also quite stable and so can be used for longer-term studies looking at different diabetic complications (Szkudelski, 2012).

Another alternative is to give an intraperitoneal (i.p.) injection of STZ to neonatal rats, which leads to only partial destruction of the β-cell population. This leads to moderate hyperglycaemia which increases with age, abnormal glucose intolerance and an initial increase in insulin levels as the rat attempts to maintain glucose homeostasis (Takada et al., 2007). However, by 12 weeks of age, the rats show a decrease in pancreatic insulin content, indicating that the β-cells have become exhausted, resulting in overt hyperglycaemia. These features are similar to the natural course of type 2 diabetes in humans. While those two models are both valid alternatives to the STZ model, they do not take into account the risk factors which often contribute to the development of type 2 diabetes such as a poor diet, and a sedentary lifestyle, which both contribute to obesity, and can lead to diabetes (Cheng, 2005).

### 2.1.5. The HFD/STZ model

In 1998, Luo et al. reported an alternative to the high dose STZ model. A low dose of STZ in combination with either a high fat or high sugar diet was shown to induce diabetes in mice, with a disease progression more similar to that of type 2 diabetes in humans. The diet caused the mice to become insulin resistant, resulting in a compensatory increase in the production of insulin. This is similar to that of the prediabetes state which involves impaired fasting glucose and impaired glucose tolerance, which is associated with insulin resistance (Bock et al., 2006). It was only following injection of STZ, when a proportion of the β-cells were destroyed, leading to a decrease in the production of insulin,
that the mice developed hyperglycaemia. Importantly, the same dose of STZ did not cause any changes in the mice that were fed a normal diet (Luo et al., 1998).

In 2005, this model was replicated in rats (Srinivasan et al. (2005), which were fed a high fat diet (58% calories as fat) for two weeks, which led to increased body weight, blood plasma glucose, insulin, triglycerides and total cholesterol, and a decrease in the glucose disappearance rate during an insulin-glucose tolerance test, indicating that the rats were becoming insulin resistant. STZ injection (35mgkg⁻¹) in the HFD rats resulted in frank hyperglycaemia, but only decreased insulin to what would be considered a normal level. They proposed that this model was more clinically relevant, and also had the benefit of being much cheaper than genetic models of type 2 diabetes. Further studies investigated the influence of the dose of STZ, in combination with a high fat diet, on this model of diabetes (Zhang et al., 2008). STZ at 45mgkg⁻¹, given as a single dose, was shown to result in diabetes more than 50% of the time, compared to 25-35mgkg⁻¹ STZ. They also found that only the higher dose was able to produce a blood glucose concentration of over 10mM (24.5mM). This finding, and data from my own pilot experiments, prompted me to select 45mgkg⁻¹ STZ for the studies described in this thesis.

2.1.6. HFD/STZ: a model of diabetic neuropathy?

While the HFD/STZ model has been shown to produce all the metabolic changes we would expect – polyuria, polydipsia, stunted growth rate, and related changes in glucose and insulin, the development of mechanical hypersensitivity has not yet been widely investigated. Of the handful of groups who have assessed altered nociception in the HFD/STZ model, results have not always been in agreement, and the length of time the high fat diet is fed before injection, the percentage of fat in the diet, and the dose of STZ have varied between groups. Davidson et al. (2011b; 2012) fed a high fat diet for 8 weeks followed by
30mgkg\(^{-1}\) of STZ and in the Hargreaves test they observed a hypoalgesic response, with an increase in withdrawal latency from the thermal stimulus, which was confirmed by Yang et al. (2011) who gave 4 weeks of a high fat and high sucrose diet, followed by 35mgkg\(^{-1}\) of STZ. Conversely, Kumar et al. (2009) fed rats a HFD for 2 weeks and administered 35mgkg\(^{-1}\) of STZ, but saw a hyperalgesic response in the tail-immersion and hot-plate test. Similar discrepancies in the findings of thermal nociception have also been reported in the STZ model, where there are reports of both thermal hypoalgesia and hyperalgesia.

### 2.1.7. Aim of the study

The aim of this study was to investigate the effects of a HFD in combination with STZ on metabolic parameters and mechanical and thermal sensitivity, to determine whether the metabolic changes produced in this model resulted in the development of hypersensitivity.
2.2. Methods

2.2.1. Animals

All experiments were carried out under Personal Home Office Licence 40/9559 and Project Home Office Licence 40/3124, in accordance with the UK Home Office Animals (Scientific Procedures) Act 1986 and IASP guidelines. 18 male Sprague-Dawley rats (200-250g), obtained from Charles River (Kent, U.K.), were individually housed on a normal light cycle (lights on: 07:00 - 19:00) with free access to the high fat diet (60% fat by caloric content; D12492 diet; Research Diets, New Jersey, USA) and tap water at all times. Food and water intake, and body weight were monitored at least twice weekly.

2.2.2. The HFD/STZ model of diabetes

After three weeks consumption of the high fat diet, the rats were divided into two stratified groups on the basis of body weight and mechanical withdrawal thresholds, and they received an i.p. injection of STZ (45mgkg⁻¹; 3mlkg⁻¹; n=12) or citric acid buffer (n=6). STZ (batch/lot number 019K1022) was purchased from Sigma Aldrich (Poole, UK), and dissolved in 0.05M citric acid, pH 4.5.

A blood sample was drawn from the tail vein, and a minimum plasma glucose concentration of 15mM was required to confirm diabetes. Any HFD/STZ rat with a plasma glucose concentration lower than this was excluded from any further analysis.

2.2.3. Development of the HFD/STZ model

In a pilot study, a dose of STZ (55mgkg⁻¹) caused two spontaneous deaths, and several rats that were in poor health throughout the study, leading to a lower dose of 45mgkg⁻¹ being chosen for this study. This dose produced all of the same metabolic symptoms that were seen
previously, but left the rats in better health. An even lower dose has been shown to result in a much smaller percentage of rats going on to develop diabetes (Zhang et al., 2008), whereas in this study all 12 of the rats injected with STZ had plasma glucose levels of >15mM.

As was established in the introduction, it is of upmost importance that rats are regularly monitored to ensure that any behavioural data obtained cannot be explained away as a side effect of their poor condition, and animals seen to be in very ill-health must not be allowed to continue in a study. Therefore in this, and future studies, a set of strict guidelines was followed to decide if/when to remove a rat from a study. It was decided that rats showing a combination of the following symptoms must be humanely killed:

- Lethargy.
- Lack of response to stimuli such as handling.
- Partially closed eyes.
- Significant lack of grooming.
- Huddling in corners, “fluffed up” appearance, sitting hunched over, cold.
- Weight loss of greater than 25% of their initial bodyweight.

Rats were therefore closely monitored at all times, and body weight was measured and general condition was observed at least once a day. Rats that exhibited weight loss of 18% or greater (irrespective of any other symptoms) in the first week after dosing with STZ, were drawn to the attention of the NACWO, and their continuance in the study was carefully considered. Any rats exhibiting weight loss of between 20% and 25% of their initial bodyweight with no other symptoms or loss of condition were allowed to remain on the study, but were checked twice daily.
2.2.4. **Behavioural testing**

von Frey testing was carried out to assess the sensitivity of the hindpaws to mechanical stimulation using calibrated von Frey hairs of bending forces 1, 1.4, 2, 4, 6, 8, 10 and 15 g (Semmes-Weinstein monofilaments, Linton Instrumentation, Norfolk, UK). The day before behavioural testing commenced, the rats were acclimatised to the apparatus by placing them in the testing equipment (transparent Perspex boxes with a wire mesh floor; Medical Engineering Unit, University of Nottingham, UK) and leaving them to settle for half an hour, and then applying a 10 g von Frey hair five times to each hindpaw. On the day of testing, the rats were allowed to habituate for 30 minutes before testing began. A modified form of the up-down method (Dixon, 1980) was utilised to determine the mechanical withdrawal threshold. von Frey filaments were applied to the plantar surface of each hindpaw in turn for five seconds, with an interval of >3 seconds between repetitions. Stimulations were performed three times, or until a withdrawal response was elicited. The 6 g von Frey hair was applied first: if there was a response, the next lowest von Frey hair was applied; and if there was no response, the next highest von Frey hair was applied. This was repeated until there was either no response at the highest weight (15 g) or the lowest force that elicited a withdrawal response was found (Guasti et al., 2009). All behavioural testing was carried out between 08.00-12.00. As diabetic neuropathy produces a bilateral injury, the average withdrawal response of both hindpaws was calculated.

The Hargreaves test was performed to evaluate thermal sensitivity (Hargreaves et al., 1988). Rats were placed in a clear Plexiglass chamber on an elevated platform and allowed to habituate for 30 minutes. A radiant heat source was positioned underneath the hindpaw, and the time from initiation of radiant heat until paw withdrawal was measured automatically. There was a cut off of 20 seconds to avoid tissue damage. Each paw was tested five times, with at least 5 minutes
between each trial to avoid sensitisation, and the mean withdrawal latency was calculated.

All behavioural testing was performed blind to the treatment groups.

2.2.5. Blood sampling

After a four hour fast, 100µl of blood was taken from the lateral tail vein by vein stab and collected into lithium heparinised tubes (Sarstedt Microvette CB300) and plasma was separated by centrifugation (2,400 g for 5 min at 4°C) to produce a single aliquot of plasma (approximately 50µl) which was frozen (-80°C) and subsequently assayed for glucose (Thermoelectron infinity glucose reagent; Microgenics, UK) and insulin (Mercodia rat insulin ELISA; Diagenics, Milton Keynes, UK).

2.2.6. Oral glucose tolerance test (OGTT)

An oral glucose tolerance test was performed at day 120. Rats were deprived of food overnight and the following day the lateral tail vein was cannulated, and a baseline blood sample (120µl) was taken immediately before the glucose load (2g/kg p.o.), along with an aliquot of whole blood (25µl) for HbA1c determination (direct enzymatic HbA1c assay; Diazyme, Germany) into an EDTA vial (Sarstedt Microvette CB300K2E). Further blood samples were taken 15, 30, 45, 60, 120 and 180 minutes post glucose administration and plasma was separated by centrifugation as described above.

2.2.7. Total pancreatic insulin content

The pancreas (n=1 for HFD/Veh, n=3 for HFD/STZ) was removed, weighed and homogenized in acid ethanol (0.18 mol/l in 70%[vol./vol.] ethanol) for subsequent determination of total pancreatic insulin content (Mercodia rat insulin ELISA).
2.2.8. Statistics

Statistical advice was sought from a statistician at RenaSci.

Analysis of body weight, food intake and water intake was by an analysis of covariance (ANCOVA) with Tukey’s post-hoc test, with the average of day -7 to 0 as the covariate. Analysis of plasma glucose, plasma insulin, the OGTT, HbA1c and mechanical withdrawal thresholds was by a Mann Whitney test. Additional analysis of the OGTT was by a Friedman test with Dunn’s multiple comparison post-hoc test. Analysis of the Hargreaves test was by an unpaired t-test.

In all analyses, a p value of less than 0.05 was considered statistically significant.
2.3. **Results**

2.3.1. **Effects of HFD/STZ on body weight, and food and water intake**

Prior to injection with STZ, both groups of HFD rats exhibited a steady weight gain of ~53g per week (Figure 2.1A). The day after injection with STZ there was a dip in the body weight of the HFD/STZ group, and after this they exhibited a significantly stunted growth rate in comparison to the HFD/Veh group (p<0.001), with a difference of ~260g between the two groups at the end of the study (521±30g vs. 782±52g at day 120). The HFD/STZ group exhibited a fourfold increase in daily water consumption (22.0±0.8g vs. 88.3±6.2g at 120 days post STZ), compared to the HFD/Veh controls (p<0.001) and this was evident from the first days after injection with STZ (Figure 2.1B). The HFD/STZ group also exhibited a small increase in food consumption, compared to the HFD/Veh group (Figure 2.1C), although this was only significant at certain points throughout the study (p<0.05).

2.3.2. **Effects of HFD/STZ on metabolic parameters**

The present study also demonstrated that the HFD/STZ model caused changes in metabolic parameters that are indicative of diabetes. At day -5, prior to injection of STZ, the mean plasma glucose concentration was 8.5±0.4mM in the HFD/Veh group and 8.4±0.5mM in the HFD/STZ group. Following injection with STZ this remained stable in the HFD/Veh group at 8.9±0.4mM, whereas it increased threefold to 24.0±0.9mM (p<0.001) in the HFD/STZ group (Figure 2.2A). In the HFD/STZ group, plasma insulin concentration decreased (1.05±0.17ngml⁻¹) whereas there was a slight increase in the HFD/Veh group (3.02±0.49ngml⁻¹) compared to levels prior to STZ injection (2.41±0.63ngml⁻¹ in the HFD/Veh group and 2.01±0.33ngml⁻¹ in the HFD/STZ group at day -5; Figure 2.2B; p<0.001), These values were maintained throughout the rest of the study.
Figure 2.1 Effects of HFD/STZ (n=12) on (A) body weight, (B) water intake and (C) food intake, in comparison with HFD/Veh (n=6). All data represent mean ± SEM, analysis was by an ANCOVA (with the average of day -7 to 0 as a covariate): * p<0.05, ** p<0.01.

In comparison to HFD/Veh controls, body weight and water intake, p<0.001 from day 1.
Figure 2.2 Effects of HFD/STZ (n=12) on (A) fasting plasma glucose and (B) fasting plasma insulin, in comparison with HFD/Veh (n=6). Blood was collected after a four hour fast. All data represent mean ± SEM (day 134 n=2 for HFD/Veh, n=6 for HFD/STZ, no statistical analysis was performed at this time point). The error bar at day 134 for glucose is too small to be visible. Analysis was by a Mann-Whitney: ** p<0.01, *** p<0.001.
A measure of average plasma glucose concentration is HbA1c. HbA1c is formed when haemoglobin reacts with glucose molecules, and is found in red blood cells. These cells have a life cycle of about two months, thus the amount of glycosylated haemoglobin they contain is directly related to the average plasma glucose concentration during this time (Koenig et al., 1976). As shown in Figure 2.3, HbA1c levels were significantly increased (p<0.01) in the HFD/STZ group compared to the HFD/Veh controls.

![Figure 2.3 Effects of HFD/STZ (n=12) on HbA1c levels, in comparison with HFD/Veh (n=6). All data represent mean ± SEM, analysis was by a Mann Whitney: ** p<0.01](image-url)
An OGTT was performed to determine how quickly glucose was cleared from the blood following the delivery of a glucose load. In the HFD/Veh group there was an increased production of insulin, which was significant from 30 minutes until 60 minutes (p<0.01), and had returned to basal levels after 120 minutes (Figure 2.4B). This increase in insulin prevented a large fluctuation in the plasma glucose concentration, resulting in only a small, but significant (p<0.05) increase from 15 to 60 minutes (Figure 2.4A). Significantly less insulin was produced in the HFD/STZ group (p<0.001, compared to HFD/Veh); with only a significant increase from basal levels seen at 15 minutes (p<0.05), and as a result there was a much larger increase in plasma glucose concentration (p<0.001, compared to HFD/Veh, Figure 2.4A). However, as with the HFD/Veh group, plasma glucose concentration had returned close to basal levels at 120 minutes post glucose administration.

Finally, pancreatic insulin content in the HFD/STZ group was also quantified at the end of the study. Levels of pancreatic insulin in the HFD/STZ group were very low (5700±1400μg insulin/g pancreas). Due to time limitations and the resources required for this test, pancreatic insulin concentration was only assessed in one sample from the HFD/Veh group (95200μg insulin/g pancreas), and therefore statistical analysis could not be performed.

All of these results confirm that the HFD/STZ model of diabetes produces robust metabolic changes that can be correlated with the disease in humans.
Figure 2.4 Effects of HFD/STZ (n=12) on (A) plasma glucose and (B) plasma insulin during an OGTT, in comparison with HFD/Veh (n=6). Rats were fasted overnight, and the next morning (day 120) a glucose load was given (2g.kg⁻¹, p.o.) and blood samples were collected at 0, 15, 30, 45, 60, 120 and 180 minutes. All data represent mean ± SEM, analysis was by a Mann Whitney:

** p<0.01, *** p<0.001 (HFD/STZ vs. HFD/Veh)

Additional analysis was by a Friedman test with Dunn’s multiple comparison post-hoc test:

& p<0.05, && p<0.01, &&& p<0.001 (HFD/Veh vs. HFD/Veh at T0)

# p<0.05, ## p<0.01, ### p<0.001 (HFD/STZ vs. HFD/STZ at T0)
2.3.3. Effects of HFD/STZ on mechanical withdrawal thresholds

The mean mechanical withdrawal threshold of the hindpaws of HFD/Veh controls throughout the study (14.1±0.6g) was consistent with responses in naive rats. Following injection of STZ, there was a progressive decrease in the mechanical withdrawal threshold of the hindpaws in the HFD/STZ rats, compared to the HFD/Veh controls. A significant difference in the hindpaw withdrawal thresholds of the two groups was first evident at day 46 (Figure 2.5). By day 120, the mean mechanical withdrawal threshold of the HFD/STZ group was 7.0±0.7g compared to 14.2±0.5g in the HFD/Veh group. This decrease in mechanical withdrawal threshold is indicative of the presence of mechanical hypersensitivity. It is noteworthy that the development of mechanical hypersensitivity is very slow in comparison to the metabolic changes.

Figure 2.5 Effects of HFD/STZ (n=12) on mechanical withdrawal threshold of the hindpaws, in comparison with HFD/Veh (n=6). All data represent mean ± SEM, analysis was by a Mann-Whitney:
* p<0.05, ** p<0.01, *** p<0.001
Finally, the Hargreaves test was carried out on two consecutive days at the end of the study to determine whether the thermal withdrawal latency was altered in the HFD/STZ rats compared to the HFD/Veh controls. There were no significant differences in the thermal withdrawal latency between the two groups at these two timepoints (Figure 2.6).

**Figure 2.6** Effects of HFD/STZ (n=12) on thermal withdrawal latency in the Hargreaves test, in comparison with HFD/Veh (n=6). All data represent mean ± SEM, analysis was by an unpaired t-test.
2.4. Discussion

2.4.1. Metabolic effects in the HFD/STZ model

In the present study, the combination of a HFD and a single dose of STZ were examined for their ability to produce a type 2-like model of diabetes. The HFD/STZ model resulted in all of the metabolic changes that were expected (Srinivasan et al., 2005). There was a decreased growth rate, and a huge increase in water consumption, which resulted in a large increase in urine production. These changes were evident in the first few days after STZ injection, and were significant from the first week onwards. The rats also developed hyperglycaemia, and hypoinsulinaemia, with a large rise in plasma glucose levels, and a corresponding decrease in plasma insulin. Injection of STZ significantly reduced food intake during the first week, but after this the intake fluctuated in both groups but remained relatively stable, with the HFD/STZ group taking in more calories than the HFD/Veh controls in general, which was significant at several timepoints. In the OGTT, administration of glucose in the HFD/Veh rats caused a significant increase in the production of insulin, followed by a rapid decrease in plasma glucose levels. However, in the diabetic HFD/STZ rats, the insulin-secretory response was greatly decreased and the level of plasma insulin was only significantly changed from basal levels at 15 minutes. This increase did not bring it close to the basal level of the HFD/Veh rats, resulting in a much larger increase in plasma glucose levels.

2.4.2. Mechanical withdrawal thresholds in the HFD/STZ model

The mechanical withdrawal threshold of the hindpaws in the HFD/Veh group was stable throughout the duration of the study, but in the HFD/STZ group the mechanical withdrawal threshold was decreased significantly by day 46 and this decrease persisted for a further ten
weeks until the study was terminated. The timecourse of the changes in mechanical withdrawal threshold of the hindpaws in the HFD/STZ rats was slower than the rapid metabolic changes produced in this model. This indicates that the development of mechanical hypersensitivity is not just a direct consequence of hyperglycaemia, but must also be due to other underlying mechanisms, some of which will be investigated in Chapters 3 and 4.

The timecourse of the change in mechanical withdrawal thresholds in the HFD/STZ model reported in this first study is slower than the rapid development of mechanical hypersensitivity reported in the STZ-alone model, where changes are first seen after 1-2 weeks (Ahlgren et al., 1993; Calcutt et al., 1996; Courteix et al., 1993; Dobretsov et al., 2003; Fuchs et al., 2010; Xu et al., 2011). However in the studies in Chapters 3-5 there was a slightly faster progression, with a significant decrease in mechanical withdrawal thresholds first reported between 2-3 weeks after STZ injection.

There has only been one other report looking at the development of mechanical hypersensitivity in the HFD/STZ model so far, in which 2 weeks of high fat diet followed by 35mgkg$^{-1}$ of STZ was reported to not alter mechanical withdrawal thresholds of the hindpaw, mechanical hyperalgesia in the pinprick test or thermal/cold thresholds, compared to a higher dose of STZ alone (Ferhatovic et al., 2013). However this study resulted in a much more moderate model of diabetes, with lower plasma glucose levels and a steady increase in body weight.

Previous studies suggest that it is not just prolonged hyperglycaemia that is responsible for the development of mechanical hypersensitivity, but also insulin deficiency. Insulin implantation has been shown to prevent the development of mechanical hypersensitivity, and established hypersensitivity was reversed by prolonged insulin treatment, but not by a single insulin injection (Calcutt et al., 1996). Similarly, Hoybergs et al. (2007) showed that low-dose insulin
administration, which did not significantly change hyperglycaemia, reversed tactile hypersensitivity and mechanical hyperalgesia. Furthermore, in a long term (24 week) study, insulin implantations at day 7 after STZ restored blood glucose, and also prevented the development of mechanical hypersensitivity (Otto et al., 2011). Thus it seems likely that the development of mechanical hypersensitivity is related, in part, to a prolonged insulin deficiency (Calcutt et al., 1996).

The relationship between plasma insulin and glucose and the development of mechanical hypersensitivity was further investigated by Romanovsky et al. (2004). In this study, mechanical hypersensitivity was compared between STZ treated rats that became hyperglycaemic (20-25mM) and those that maintained normal blood sugar levels, but displayed a decrease in pancreatic β-cell area and plasma insulin levels, similar to early stage type 1 diabetes (Romanovsky et al., 2010). Interestingly, both groups of rats showed a decrease in mechanical withdrawal thresholds as soon as 1 week after STZ injection, which was fully developed at 3 weeks (Romanovsky et al., 2004). They concluded that it could not be solely hyperglycaemia that was responsible for the development of hyperalgesia. In a further study, Romanovsky et al. (2006) found that in STZ treated rats that did not go on to develop hyperglycaemia, plasma insulin levels were correlated with paw pressure withdrawal thresholds. Furthermore, low-dose injections of insulin, which increased plasma insulin without affecting plasma glucose levels, reversed changes in mechanical sensitivity (Romanovsky et al., 2006). More recently, Otto et al. (2011) hypothesised that insulin deficiency and impaired insulin signalling results in a loss of neurotrophic support which contributes to changes in sensory afferent fibre function.

Finally, at the end of this study, the thermal nociceptive thresholds were examined in all of the HFD/STZ and HFD/Veh control rats over two days. No difference was seen on the first day, and the withdrawal latency was slightly longer in the HFD/STZ rats on the second day, but
no significance was seen. As no significant changes in thermal withdrawal thresholds were seen in this first study, and due to the inconsistencies in the literature so far, the remaining work in this thesis focuses on the changes in mechanical withdrawal thresholds in this model of diabetes.
Chapter 3.

Investigating the impact of the HFD/STZ model on peripheral nerve function, and spinal mechanisms of central sensitisation
3.1. **Introduction**

The work in this chapter will investigate the impact of the HFD/STZ model on peripheral nerve function and spinal mechanisms of central sensitisation, to help identify the mechanisms underpinning the behavioural pain phenotype in these rats.

Fluoro-Jade-B and CGRP are used as measures of peripheral nerve function and pathology, as well as for investigating changes in the spinal cord.

### 3.1.1. Fluoro-Jade B

Fluoro-Jade B is a fluorescent ligand which is used to detect and quantify degenerating neurones. It stains cell bodies, dendrites, axons and axon terminals, and although the exact mechanism is unknown, it has been speculated that it may bind to a polyamine (Schmued *et al.*, 2000).

Fluoro-Jade has been used to detect whether neuronal death is induced in the brain in diabetic models when exposed to hypoglycaemia. No neuronal death was detected in the hippocampus or the cortex at 1 or 4 weeks in STZ treated rats, or in the hypothalamus at 8 weeks following STZ treatment (Lechuga-Sancho *et al.*, 2006). However neuronal death has been induced in the cortex by hypoglycaemia at 1 week in STZ treated rats (Bree *et al.*, 2009). Fluoro-Jade has also been used to detect degenerating neurones in the spinal cord (Kudo *et al.*, 2006; Marmiroli *et al.*, 2009; Nguyen *et al.*, 2004; Orendacova *et al.*, 2005; Saganová *et al.*, 2006) and DRGs (Lazaridis *et al.*, 2011; Marmiroli *et al.*, 2009) in a variety of models that induce neuronal death, although there are some reports that it also stains astrocytes in the spinal cord (Anderson *et al.*, 2003).
As no neuronal death has been detected in the brain of STZ rats, I was interested in investigating whether any neuronal death occurs in the DRGs or spinal cord of HFD/STZ rats, and whether this might play a role in the progression of diabetic neuropathy.

### 3.1.2. CGRP

CGRP plays an important role in the transmission and modulation of peripheral and central nociceptive processing (Neugebauer, 2009). CGRP is synthesised and stored in primary afferent axons, especially small DRG cells and unmyelinated axons (van Rossum et al., 1997; Willis et al., 2004). CGRP receptors are mostly found in laminae I and II in the spinal cord, the major terminal site of nociceptive primary afferents, but they can also be found in deeper laminae (Ye et al., 1999).

Levels of CGRP in the spinal cord can be increased by noxious stimuli (Morton et al., 1989; Schaible et al., 1994) and by inflammation (Schaible et al., 1994; Willis et al., 2004), as well as electrical stimulation of unmyelinated afferents (Morton et al., 1989; Schaible et al., 1994) and administration of carrageenan (Garry et al., 1992). The CCI model of neuropathic pain is, however, associated with a decrease in CGRP immunoreactivity (Bennett et al., 1989; Yu et al., 1996). Spinal application of CGRP has pro-nociceptive effects (Li et al., 2001; Oku et al., 1987; Sun et al., 2004a; Sun et al., 2003; Sun et al., 2004b), and a CGRP antagonist (CGRP<sub>8-37</sub>), or anti-CGRP antiserum, prevents or reduces central sensitisation of dorsal horn neurones (Neugebauer et al., 1996; Sun et al., 2004a; Sun et al., 2004b; Yu et al., 2002), as well as attenuating hypersensitivity in animal models of inflammatory and neuropathic pain (Jang et al., 2004; Kawamura et al., 1989; Kuraishi et al., 1988; Sun et al., 2003; Yu et al., 1996). CGRP knock-out mice showed no pain responses in the hot plate test, and no development of secondary hyperalgesia in a model of knee joint inflammation (Zhang et al., 2001a).
The impacts of STZ induced diabetic neuropathy on levels of CGRP in different tissues in the rat have varied, as outlined below in Table 3.1. An increase in CGRP-positive fibres and basal CGRP release has been reported in the skin, whereas a decrease in CGRP content/mRNA levels/CGRP-positive neurones has been reported in nerves and DRGs. Finally, in the spinal cord, there was no change in basal CGRP release at 5 weeks in STZ treated rats, but an increase in capsaicin-stimulated release of CGRP was observed (Bishnoi et al., 2011).
Table 3.1 Summary of the effects of STZ-induced diabetes on CGRP expression/release in different tissues.

<table>
<thead>
<tr>
<th>Tissue</th>
<th>Change</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
<td>Doubling of basal and capsaicin-evoked release of CGRP in 8 week STZ rats</td>
<td>Ellington et al., 2002</td>
</tr>
<tr>
<td></td>
<td>Increase in CGRP-positive fibres in 12 week STZ rats</td>
<td>Karanth et al., 1990</td>
</tr>
<tr>
<td>Vagus nerve</td>
<td>Decrease in CGRP content in 8 week STZ rats</td>
<td>Calcutt et al., 1998</td>
</tr>
<tr>
<td></td>
<td>No change in the levels of CGRP-positive neurones in the nodose ganglion in 8, 16 or 24 week STZ rats</td>
<td>Regalia et al., 2002</td>
</tr>
<tr>
<td>Sciatic nerve</td>
<td>Decrease in CGRP content in 4 week STZ rats</td>
<td>Brewster et al., 1994; Diemel et al., 1994</td>
</tr>
<tr>
<td>DRGs</td>
<td>Decrease in mRNA levels in 4 week STZ rats</td>
<td>Brewster et al., 1994; Diemel et al., 1994</td>
</tr>
<tr>
<td></td>
<td>Decrease in CGRP positive neurones in 4 week and 12 month STZ rats</td>
<td>Adeghate et al., 2006; Zochodne et al., 2001</td>
</tr>
<tr>
<td>Spinal cord</td>
<td>No change in basal CGRP release in 5 week STZ rats, but an increase in capsaicin-stimulated release of CGRP</td>
<td>Bishnoi et al., 2011</td>
</tr>
</tbody>
</table>
3.1.3. Microglia

Glial cells are 10 to 50 times as numerous as neurones in the CNS and belong to one of three groups: microglia, astrocytes or oligodendrocytes (Gao et al., 2010). Glia play an important role in central sensitisation in neuropathic pain, and so it is important to elucidate their role in the spinal cord in the HFD/STZ model.

Microglia represent 5-10% of glia in the CNS (Tsuda et al., 2005). It is currently believed that microglia derive from the yolk sac macrophages that seed the rudimental brain during early foetal development (for review see Ginhoux et al., 2013). When ‘resting’, microglia have a small soma with thin, branching processes which survey the microenvironment for stimuli such as CNS trauma, ischemia and infection (Tsuda et al., 2005).

There are a wide variety of pathways that lead to activation of microglia (Smith, 2010), and these include:

- Matrix metallopeptidase 9 (MMP9), which is thought to contribute to the initiation of neuropathic pain through IL-1β cleavage (Kawasaki et al., 2008).
- Fractalkine, a chemokine which is cleaved by MMPs, and its receptor CX3CR1, which is mainly expressed by microglia. CX3CR1 expression is increased during neuropathic pain, and it is thought that fractalkine can attract CX3CR1-expressing microglia to sites of ongoing pathology (Verge et al., 2004).
- Monocyte chemoattractant protein-1 (MCP-1, OR CCL2), and its receptor CCR2, which is upregulated in microglia following nerve injury (Zhang et al., 2006a)
- Toll-like receptors (TLRs), which cause activation of NFκB, and the subsequent release of IL-1β, IL-6 and TNFα, resulting in a positive feedback loop in the pain-pathway (Kim et al., 2007a). TLR4 activation has been shown to correlate with the onset of
- Behavioural sensitivity in the spared nerve injury (SNI) model (Tanga et al., 2004).
- Neuregulin-1 (NRG1), a growth factor, is released by primary afferents and binds to erbB2, 3 and 4, which are expressed by microglia. Blockade of erbB2 reduces accumulation of microglia and attenuates hypersensitivity in the SNL model (Calvo et al., 2010).
- ATP and its receptors (especially P2X4 and P2X7) (Hide et al., 2000; Inoue et al., 2007; Tsuda et al., 2013).

Microglia can also be activated by ROS, NO, substance P (Zhou et al., 2010), brain-derived neurotrophic factor (BDNF), PGs, glutamate (Tikka et al., 2001) and heat shock proteins which are upregulated by peripheral nerve injury (Costigan et al., 1998).

Once microglia are activated, they show dramatic changes in morphology including: hypertrophy and thickened and retracted processes (Eriksson et al., 1993); increases in the levels of microglial markers such as ionized calcium binding adapter molecule 1 (Iba1) and CD11b (Tsuda et al., 2005); as well as proliferation (Gehrmann et al., 1995; Romero-Sandoval et al., 2008a). Activation of microglia and phosphorylation of p38 MAPK is involved in Ca²⁺ sensitive intracellular signalling cascades and leads to the production of pro-inflammatory cytokines (Hanisch, 2002; Kim et al., 2007a; Kreutzberg, 1996; Ledeboer et al., 2005; Zhuo et al., 2011). They also release cytotoxic molecules such as ROS (Kim et al., 2010), NO (Tikka et al., 2001), and PGs (Candelario-Jalil et al., 2007), as well as BDNF (Coull et al., 2005), substance P, excitatory amino acids, and ATP. These substances can, in turn, activate nearby astrocytes, microglia and neurones (Zhou et al., 2010).

Microglial activation in the spinal cord has been seen in a variety of animal models of pain, including the formalin model (Fu et al., 2000; Fu et al., 1999; Sweitzer et al., 1999), models of peripheral nerve injury.
Minocycline, a second-generation tetracycline with anti-inflammatory properties (for review see Garrido-Mesa et al., 2013), selectively prevents the activation of microglia and blocks the release of pro-inflammatory cytokines IL-1β and TNFα (Ledeboer et al., 2005; Padi et al., 2008). Minocycline is able to attenuate the development of neuropathic pain in sciatic inflammatory neuropathy and acute spinal immune activation with intrathecal HIV-1 gp120 (Ledeboer et al., 2005), CCI (Padi et al., 2008), and L5 spinal nerve transection (Raghavendra et al., 2003). Minocycline is not, however, effective against already established hypersensitivity (Ledeboer et al., 2005; Padi et al., 2008; Raghavendra et al., 2003).

As well as a role in models of nerve injury, microglia have also been shown to play a part in the development of painful symptoms in animal models of diabetes. Microglia are upregulated in the spinal cord of rats as soon as 4 days after injection with STZ (Talbot et al., 2010), as well as at later timepoints; 2-4 weeks (Tsuda et al., 2008); 3 weeks (Kim et al., 2012b); 4 weeks (Morgado et al., 2011a); and 5 weeks (Wodarski et al., 2009). In STZ treated mice, a slower change in the number of microglia was reported, with no change evident at 1 month, but an increase at 3 months, peaking at 5 months, and decreasing slightly by 8 months post model induction (Toth et al., 2010). An increase in the density of Iba1-positive endoneurial macrophages was also seen in the sciatic and tibial nerves of STZ rats (Nukada et al., 2011). However, in the db/db mouse model of type 2 diabetes, no change in spinal microglial activation was observed at postnatal week 6 or 16 (Liao et al., 2011).

An increase in ERK (Tsuda et al., 2008), JNK and p38 phosphorylation (Sweitzer et al., 2004) in both neuronal and microglial cells in the spinal cord and DRG of STZ treated rats has been reported, indicating an increase in their activation, which correlates with the hyperalgesic state (Daulhac et al., 2006). Inhibitors of all three of these signalling
molecules were able to attenuate these painful symptoms (Daulhac et al., 2006; Sweitzer et al., 2004).

Treatment with minocycline in STZ animals also causes a decrease in microglial activation, as well as attenuating the increased levels of IL-1β, B₁R, TNFα and TRPV1, and reversing cold and tactile hypersensitivity (Morgado et al., 2011a; Pabreja et al., 2011; Talbot et al., 2010). Infusion of lidocaine in the early phase, but not the late phase, was also able to attenuate tactile hypersensitivity in STZ mice through inhibition of microglial activation (Suzuki et al., 2011).

3.1.4. Astrocytes

Astrocytes are the most abundant cells in the CNS, and they are able to form networks with themselves and are closely associated with neurones and blood vessels (Saravia et al., 2002). This enables them to play a role in maintaining the balance of the neuronal environment through homeostatic regulation of water, ions and pH (Montgomery, 1994), as well as protecting against toxic insults such as reactive oxygen species (Lamigeon et al., 2001). Astrocytes also play a role in synaptic transmission, where excess amino acids such as glutamate are removed from the synaptic cleft by excitatory amino acid transporters (EAATs; Nakagawa et al., 2010), preventing over-excitation and neurotoxicity. They also play a role in mediating glucose metabolism, as uptake of excess glutamate leads to stimulation of glycolysis, where glucose is converted to lactate. This produces ATP, which is used for the synthesis of glutamine from glutamate (Magistretti et al., 1999).

Nociceptive stimuli, as well as pro-inflammatory cytokines, can lead to activation of astrocytes, as they express receptors for nociceptive neurotransmitters such as glutamate, substance P and CGRP (Marchand et al., 2005). They can also be activated by MMP2 (Kawasaki et al., 2008). When astrocytes are activated, they exhibit a
hypertrophic morphology, with thickened process, and upregulation of glial fibrillary acidic protein (GFAP), an intermediate cytoskeletal filament protein specific for astrocytes. In turn, activation of astrocytes leads to further production and release of pro-inflammatory cytokines, chemokines, prostaglandins, NO, ATP, D-serine and glutamate, which can contribute to enhanced pain sensitivity. As with microglia, activation of astrocytes leads to activation of ERK and JNK signalling pathways, which release pro-inflammatory factors which can lead to further astrocyte activation (Milligan et al., 2009).

An increase in GFAP staining due to hypertrophy of activated astrocytes, known as astrogliosis, has been observed in the spinal cord in a variety of neuropathic and inflammatory pain models, paralleling the development of hypersensitivity (Garrison et al., 1991; Obata et al., 2006; Raghavendra et al., 2004; Sweitzer et al., 1999; Wang et al., 2009). Whereas microglia numbers undergo a more rapid increase, and then a later decrease, astrogliosis has a more delayed initiation, but is then sustained long-term (up to 150 days in one study) (Raghavendra et al., 2004; Tanga et al., 2004; Zhang et al., 2006a). It is therefore hypothesised that upregulation of astrocytes contributes to the maintenance of chronic pain, whereas microglial activation is responsible for the development. However this pattern is not always observed in all animal models of pain (see Colburn et al., 1999; Romero-Sandoval et al., 2008a). Fluorocitrate, which functionally and morphologically suppresses glial cell activation, reduced hypersensitivity for 5 days in a postoperative pain model (Obata et al., 2006), as well as attenuating thermal and mechanical hyperalgesia in the zymosan model (Meller et al., 1994), and attenuating the induction, and reversing the early phase of developed mechanical hypersensitivity, in neonatal capsaicin-treated adult rats (Nakagawa et al., 2007).

In contrast to this upregulation of astrocytes in animal models of chronic pain, there are conflicting reports about the changes in levels of GFAP
staining in various models of diabetes. Some groups have shown a significant decrease in GFAP staining in areas of the brain including the cerebral cortex, hippocampus, cerebellum and corpus callosum in STZ rats (Coleman et al., 2004; de Senna et al., 2011; Lechuga-Sancho et al., 2006; Renno et al., 2012; Zuo et al., 2011). In the retina, the intensity of GFAP staining in astrocytes was decreased as soon as 1 month following STZ injection, and decreased further as the studies progressed (Barber et al., 2000; Rungger-Brandle et al., 2000). Conversely, other groups have shown an increase in GFAP staining in the hippocampus, cerebral cortex, and cerebellum at 6 week in STZ rats (Baydas et al., 2003), and in the hippocampus in NOD and STZ mice (Saravia et al., 2002).

In the spinal cord, a decrease in the number of GFAP-immunoreactive astrocytes was seen in the dorsal and ventral horns, as well as the central region, with the number decreasing further between 6 and 12 weeks after STZ injection (Afsari et al., 2008), and this has also been reported at 5 weeks in the same model (Wodarski et al., 2009). However, there have also been reports of no change in GFAP expression at 4 weeks post-STZ (Tsuda et al., 2008), and in a recent report an increase in GFAP expression was seen at 3 weeks (Kim et al., 2012b). In the db/db mouse model of type 2 diabetes, an increase in the amount of GFAP staining was seen in the dorsal horn of the spinal cord from 8 weeks of age, and was maintained thereafter (Dauch et al., 2012; Liao et al., 2011). L-α-amino adipate (a specific astrocyte inhibitor) was able to attenuate mechanical hypersensitivity and phenyl-alpha-tert-butyl nitrone (an antioxidant) significantly decreased the levels of GFAP, suggesting that oxidative stress may be an underlying cause of the increase in spinal GFAP expression (Liao et al., 2011).

The role(s) of astrocytes and microglia in any of the models of diabetic neuropathy have yet to be fully elucidated, as seen in some of the conflicting results described above. It is therefore of upmost interest to
quantify levels of activated microglia and astrocytes in the spinal cord in the HFD/STZ model.

### 3.1.5. Aim of the Study

The aim of this study was to investigate the effect of the HFD/STZ model on immunohistochemical staining in the DRGs and spinal cord. Fluoro-Jade B staining was used to investigate whether any neuronal death could be detected in the DRGs or spinal cord, and the expression of CGRP positive neurones was also investigated, as well as the activation of microglia and astrocytes in the spinal cord.
3.2. Methods

For detailed methods of induction of diabetes, blood sampling and von Frey testing see Chapter 2.

3.2.1. Animals

All experiments were carried out under Home Office Licence 40/3124, in accordance with the UK Home Office Animals (Scientific Procedures) Act 1986 and IASP guidelines. 47 male Sprague-Dawley rats (200-250g), obtained from Charles River (Kent, UK), were individually housed on a normal light cycle (lights on: 07:00 - 19:00) with free access to either normal chow or a high fat diet (60% fat by caloric content; D12492 diet; Research Diets, New Jersey, USA) and water at all times. The rats were divided into two stratified groups on the basis of body weight, and the lean/Veh group were fed chow, and the HFD group were fed the high fat diet. After three weeks consumption of diet, the HFD group was stratified into two further subgroups on the basis of body weight and mechanical withdrawal thresholds, and the lean/Veh and HFD/Veh groups received an i.p. injection of citric acid buffer, and the HFD/STZ group received an i.p. injection of STZ (45mgkg\(^{-1}\)). Blood samples were taken at days -5, 8, 23 and 44. von Frey testing was carried out twice weekly.

3.2.2. DRG and spinal cord immunohistochemistry

Tissue was removed and prepared for immunohistochemistry at the following stages of the model: day 10 (Lean/Veh: n=6; HFD/Veh: n=6; HFD/STZ: n=3); day 30 (Lean/Veh: n=5; HFD/Veh: n=5; HFD/STZ: n=4); and day 50 (Lean/Veh: n=6; HFD/Veh: n=6; HFD/STZ: n=4).

Rats were overdosed with sodium pentobarbital and transcardially perfused with 0.9% saline followed by 4% paraformaldehyde (PFA; Sigma, U.K.) in 0.1M phosphate buffered saline (PBS). The lumbar
spinal cord, as well as L4, L5 and L6 DRGs were excised and post-fixed in 4% PFA for 48 hours and then stored in 30% sucrose in 0.1M PBS/0.02% sodium azide solution at 4°C. Spinal cord tissues were frozen with dry ice and fixed to a microtome stage (Leica SM2010R) with mounting media and sliced into 40um sections through L4/L5. DRGs were suspended in mounting media, and frozen in a chilled acetone solution, and then sliced on a cryostat (Leica CM3050) into 15μm sections, and mounted onto Superfrost Plus microscope slides (Thermo-Scientific, UK).

**Table 3.2** Primary and secondary antibodies used in immunohistochemistry experiments

<table>
<thead>
<tr>
<th>Primary antibody (source)</th>
<th>Dilution/conditions</th>
<th>Secondary antibody (all Molecular Probes, Oregon)</th>
<th>Dilution/conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rabbit anti-Iba1 (Wako, Japan)</td>
<td>1:1000, 72hrs, 4°C</td>
<td>Alexaflour 488 donkey anti-rabbit</td>
<td>1:500, 2hrs, RT</td>
</tr>
<tr>
<td>Mouse anti-GFAP (Thermo-Fisher, UK)</td>
<td>1:100, 18hrs, RT</td>
<td>Alexaflour 568 donkey anti-mouse</td>
<td>1:500, 2hrs, RT</td>
</tr>
<tr>
<td>Rabbit anti-CGRP (Millipore, UK)</td>
<td>1:1000, 18hrs, RT</td>
<td>Alexaflour 488 goat anti-rabbit</td>
<td>1:500, 2hrs, RT</td>
</tr>
<tr>
<td>Mouse anti-NeuN (Fisher Scientific, UK)</td>
<td>1:100, 1hr, RT</td>
<td>Alexaflour 568 donkey anti-mouse</td>
<td>1:500, 2hrs, RT</td>
</tr>
</tbody>
</table>
3.2.2.1. NeuN and Fluoro-Jade B

A pilot study was run double-labelling spinal cord and DRG sections with Fluoro-Jade B and GFAP as it has previously been reported that Fluoro-Jade B can stain astrocytes in the spinal cord, instead of degenerating neurones (Anderson et al., 2003; Damjanac et al., 2007). In this pilot study, there was no colocalisation between Fluoro-Jade B and GFAP (data not shown), and so double-labelling with NeuN was run in this study instead.

Neuronal cells were stained using NeuN and dying or degenerating neurones were stained using Fluoro-Jade B (Millipore) (Schmued et al., 2000). The same protocol used for Iba1/GFAP was followed for staining with NeuN, but whereas the spinal cord sections were mounted after the secondary antibody had been washed off, the whole process was carried out on DRG sections which were already annealed to microscope slides. The sections were allowed to air-dry on a slide warmer at 50°C for half an hour, and then the following solutions were applied:

- 1% sodium hydroxide in 60% alcohol, 5 minutes
- 70% alcohol, 2 minutes
- distilled water, 2 minutes
- 0.06% potassium permanganate, 3 minutes
- distilled water, 2 minutes
- 0.0004% Fluoro-Jade B solution (freshly made up from stock solution each day)
- distilled water, 3 minutes (x3)

The slides were then dried on a slide warmer at 50°C, immersed in xylene for 1 minute, and then coverslipped with DPX.

3.2.2.2. CGRP

The same protocol was followed as for Iba1/CGAP except only using the CGRP primary and secondary antibodies (Table 3.2).
3.2.2.3. Iba1 and GFAP

Microglial cells were stained using Iba1 and astrocytes were stained using GFAP. Sections were blocked for 1 hour in 0.1M PBS containing 3% goat serum/0.3% Triton X-100 at room temperature (RT). Sections were then incubated with an Iba1 primary antibody (Table 3.2) diluted with Trizma Triton X-100 buffered saline (TTBS). Five 10 minute washes in 0.1M PBS were carried out, and then sections were incubated with secondary antibody (Table 3.2), and another five 10 minute washes were carried out. This process was then repeated on the same sections, this time using GFAP primary and secondary antibodies (Table 3.2). Sections were then mounted on gelatinised microscope slides, air-dried overnight at RT in the dark and coverslipped using Fluoromount (Sigma).

3.2.3. Quantification of antibody staining

7 individual spinal cord sections and 6 DRG sections were analysed per rat. For Iba1 and GFAP, and NeuN and Fluoro-Jade B, images were taken of the dorsal horn, ventral horn and central region, whereas only images of the dorsal horn were taken for CGRP. The mean of the left and right half of the dorsal and ventral horn was calculated for each section.

Lba1 and GFAP, and CGRP stained sections were visualised using a 20× 0.4NA objective lens on a Leica DMIRE2 fluorescence microscope, running Volocity 5.5 (PerkinElmer) equipped with a Hamamatsu Orca ER camera. NeuN and Fluoro-Jade B stained sections were visualised using a 20× 0.4NA objective lens on a Leica DMIRB fluorescence microscope, running Volocity 5.5 equipped with a Hamamatsu Orca ER camera.
Figure 3.1 Schematic diagrams of L4, L5 and L6 of the spinal cord with: orange boxes marking the approximate dorsal horn region utilised for Iba1, GFAP and Fluoro-Jade B quantification; blue boxes marking the eyebrow region of the superficial dorsal horn used for CGRP quantification; and turquoise boxes and purple boxes marking the ventral horn and central region respectively that were utilised for GFAP quantification. Adapted from (Sagar et al., 2011)

3.2.3.1. NeuN and Fluoro-Jade B

Images were acquired using an exposure time of 400ms for Fluoro-Jade B, and 600ms for NeuN. A heat map was applied on each image so that positively stained cells could be more easily identified from background staining. The total number of cells positively-stained with Fluoro-Jade B was counted manually for each DRG and spinal cord section.
3.2.3.2. CGRP

Images were acquired using an exposure time of 35ms. Immunofluorescence was quantified via region of interest analysis as “eyebrow” staining in the superficial dorsal horn, using threshold intensity values on Velocity 5.5 software.

3.2.3.3. Iba1 and GFAP

Images were acquired using an exposure time of 444ms for Iba1. Only activated, and not the total number of microglia, were counted manually in a quadrant of the dorsal horn in individual sections. Microglia were defined as activated if they displayed a clearly swollen cell body with reduced processes, which differ from normal or resting microglia where cell bodies are largely absent and large ramified processes are displayed (as illustrated in Figure 3.2). Assessment was performed by two independent blinded investigators, who quantified total number of activated microglia.

The mean fluorescence grey intensity was also measured. Background fluorescence was measured by taking an image of an area within the sample, using the parameters described above, which contained no labelled structures, that was then subtracted from all images using IMAGE J (NIH open software with Macbiophotonics plugins). Following background subtraction, mean fluorescence grey intensity was determined for each image using IMAGE J.

For quantification of GFAP, single-plane images of the superficial dorsal horn of the spinal cord were acquired using an exposure time of 393ms, and mean fluorescence grey intensity was measured as described above. All image analysis, cell counts and fluorescence measurements were performed “off-line” on captured images taken from stained sections.
Figure 3.2 Scale bar is 100μm. An image at 40x magnification of Iba1 staining in the dorsal horn of the spinal cord. Pink arrows indicate examples of ‘resting’/ramified microglia, and white arrows indicate examples of activated microglia.

3.2.4. Statistics

Analysis of body weight, food intake and water intake was by an ANCOVA with Tukey’s post-hoc test, with the average of day -7 to 0 as the covariate. Analysis of plasma glucose, plasma insulin and mechanical withdrawal thresholds was by a Kruskal-Wallis test with Dunn’s post-hoc test. Analysis of all immunohistochemistry was by a 2-way analysis of variance (ANOVA) with Bonferroni post-hoc test. In all analyses, a p value of less than 0.05 was considered statistically significant.

Rats were excluded from analysis of pain behaviour if in the two weeks before injection with STZ the average hindpaw mechanical withdrawal threshold was <10g. In this study, this represented 6 rats – 3 lean/Veh, 2 HFD/Veh and 1 HFD/STZ.
3.3. Results

3.3.1. Effects of HFD/STZ on body weight, and food and water intake

Consistent with the previous chapter, the HFD/STZ group exhibited a significantly stunted growth rate in comparison to both the lean/Veh and the HFD/Veh controls (p<0.001), with the HFD/Veh group gaining significantly more weight than the lean/Veh controls (p<0.05, Figure 3.3A). Water intake was significantly increased in the HFD/STZ group (p<0.001), and there was no difference between the lean/Veh and the HFD/Veh controls (Figure 3.3B). The HFD/Veh group had a significantly higher caloric intake than the lean/Veh controls (p<0.05, Figure 3.3C), whereas the HFD/STZ group had a significant decrease in caloric intake in the first week after injection with STZ (p<0.001), and the caloric intake was then maintained at around the same level as the HFD/Veh controls, increasing significantly at various timepoints during the study.

3.3.2. Effects of HFD/STZ on metabolic parameters and development of mechanical hypersensitivity

Again, consistent with Chapter 2, there was a threefold increase in the plasma glucose levels in the HFD/STZ rats, and this remained stable for the duration of the study (Figure 3.4A). A small increase in plasma glucose concentration was also seen in the HFD/Veh group in comparison to the lean/Veh controls, although this was only significant at day -5 (p<0.05). The plasma insulin concentration was significantly decreased in the HFD/STZ group at day 8 (p<0.001), and this decreased further as the model developed (Figure 3.4B). There was an increase in the plasma insulin levels in the HFD/Veh group compared to the lean/Veh control group at day -5 (p<0.01), indicating that the HFD leads to the development of hyperinsulinaemia.
Figure 3.3 Effects of HFD/STZ on (A) body weight, (B) water intake and (C) food intake, in comparison with HFD/Veh and lean/Veh controls. Up to day 10: n=17 for lean/Veh and HFD/Veh, and n=11 for HFD/STZ. Up to day 30: n=11 for lean/Veh and HFD/Veh, and n=8 for HFD/STZ. Day 30 onwards: n=6 for lean/Veh and HFD/Veh, and n=4 for HFD/STZ. All data represent mean ± SEM, analysis was by an ANCOVA (with day -7 to 0 as covariate) with Tukey’s post-hoc test:

(* vs. HFD/Veh, # vs. lean/Veh)

* p<0.05, ** p<0.01, *** p<0.001; # p<0.05, ## p<0.01, ### p<0.001

In comparison to HFD/Veh controls, body weight and water intake for HFD/STZ, p<0.001 from day 3.
Figure 3.4 Effects of HFD/STZ on (A) fasting plasma glucose and (B) fasting plasma insulin, in comparison with HFD/Veh and lean/Veh controls. n numbers are displayed on the graphs. All data represent mean ± SEM, analysis was by a Kruskal-Wallis test with Dunn’s post-hoc test: * p<0.05, ** p<0.01, *** p<0.001
Consistent with Chapter 2, the combination of HFD/STZ was associated with a progressive decrease in mechanical withdrawal thresholds of the hindpaws (Figure 3.5). There was no difference in mechanical withdrawal thresholds between the lean/Veh and the HFD/Veh controls, with the mechanical withdrawal thresholds of both groups stable at ~15g. At day 10, the first timepoint at which tissue was collected for immunohistochemistry, there was no significant difference in mechanical withdrawal thresholds. The decrease in mechanical withdrawal thresholds in the HFD/STZ group first became significant at day 15, and continued to decrease as the model progressed until day 50.

**Figure 3.5** Effects of HFD/STZ on mechanical withdrawal thresholds of hindpaws, in comparison with HFD/Veh and lean/Veh controls. Up to day 10: n=14 for lean/Veh, n=15 for HFD/Veh, and n=10 for HFD/STZ. Up to day 30: n=9 for lean/Veh, n=10 for HFD/Veh, and n=8 for HFD/STZ. Day 30 onwards: n=5 for lean/Veh and HFD/Veh, and n=4 for HFD/STZ. All data represent mean ± SEM, analysis was by a Kruskal-Wallis test with Dunn’s post-hoc test: (* vs. HFD/Veh) * p<0.05, ** p<0.01, *** p<0.001
3.3.3. Effects of HFD/STZ on degenerating neurones

The effect of HFD/STZ treatment on the total number of Fluoro-Jade B positive cells per rat in DRGs (Figure 3.6A) and the dorsal horn of the spinal cord (Figure 3.6B) was quantified. Overall, there were very few Fluoro-Jade B positive cells present in either tissue. No significant changes in the number of Fluoro-Jade B positive cells in either the DRGs, or the spinal cord, were observed at any of the timepoints in the HFD/STZ model.

Tissues were also stained with NeuN to assess the colocalisation between NeuN and Fluoro-Jade B, ensuring that any Fluoro-Jade B positive cells were indeed neurones, and not astrocytes as has been previously reported (Damjanac et al., 2007). All of the Fluoro-Jade B positive cells were found to colocalise with NeuN.

Figure 3.7A-C shows representative stitched merged images of DRGs, showing colocalisation between Fluoro-Jade B positive cells (green) and NeuN staining (red) and Figure 3.8A-C shows representative images of Fluoro-Jade B staining in dorsal horn spinal cord sections in a lean/Veh, HFD/Veh and HFD/STZ rat respectively. The intensity of staining of any Fluoro-Jade B positive cells observed in this model was very low when compared to models which produce severe neurodegeneration, as can be seen in Figure 3.8D.
Figure 3.6 Effects of HFD/STZ on total number of Fluoro-Jade B positive cells per rat in (A) DRGs and (B) the dorsal horn of the spinal cord at different timepoints, in comparison with HFD/Veh and lean/Veh controls. n numbers, representing total number of rats, are displayed on the graphs (total number of Fluoro-Jade B positive cells in 7 spinal cord sections and 6 DRGs were quantified for each rat). All data represent mean ± SEM, analysis was by a 2-way ANOVA.
**Figure 3.7 (A-C)** Representative stitched merged images composed of 20x magnification tiles, showing colocalisation of Fluoro-Jade B staining (green) and NeuN staining (red) in DRGs in a Lean/Veh, HFD/Veh and HFD/STZ rat respectively. Scale bar is 100μm. Arrows indicate Fluoro-Jade B positive staining. Images have been altered in Image-J (minimum brightness set to 20, and maximum brightness set to 150 for Fluoro-Jade B, and 15 and 75 respectively for NeuN)
Figure 3.8 Scale bar is 50μm (A-C) Representative images at 20x magnification of Fluoro-Jade B staining in dorsal horn spinal cord sections in a Lean/Veh, HFD/Veh and HFD/STZ rat respectively. Arrows indicate positive staining. Images have been altered in Image-J (minimum brightness set to 20, and maximum brightness set to 150). (D) Image taken from Kudo et al. (2006) showing Fluoro-Jade B staining in the spinal cord after hemorrhagic shock and cardiac arrest, to compare intensity of staining.
3.3.4. Effects of HFD/STZ on expression of CGRP

The impact of the HFD/STZ model on peptidergic afferent fibre innervations into the dorsal horn was assessed by the quantification of CGRP immunofluorescence in the superficial laminae of the dorsal horn of the spinal cord. Overall, there were no differences in CGRP immunofluorescence in the superficial dorsal horn between any of the groups at any of the timepoints (Figure 3.9A), except for a significant decrease in the expression of CGRP in the HFD/Veh controls at day 10, in comparison to the lean/Veh group (p<0.01). Figure 3.9B-D shows representative images of CGRP staining in dorsal horn spinal cord sections in a lean/Veh, HFD/Veh and HFD/STZ rat, respectively.

As seen on page 88:

**Figure 3.9 (A)** Effects of HFD/STZ on expression of CGRP in the superficial laminae of the dorsal horn, in comparison with HFD/Veh and lean/Veh controls. n numbers, representing total number of rats, are displayed on the graph (mean of 7 spinal cord sections per rat). All data represent mean ± SEM, analysis was by a 2-way ANOVA with Bonferroni post-hoc test: ** p<0.01. **(B-D)** Representative images at 20x magnification of CGRP staining in the superficial laminae of the dorsal horn of the spinal cord in a Lean/Veh, HFD/Veh and HFD/STZ rat respectively. Scale bar is 50µm. Images have been altered in Image-J (minimum brightness set to 20, and maximum brightness set to 100).
A

Area of CGRP positive staining in the eye brow region of the dorsal horn (AU)

Day 10 Day 30 Day 50

Lean/Veh HFD/Veh HFD/STZ

**

B

C

D
3.3.5. Effects of HFD/STZ on activation of glia

The number of activated microglia in the dorsal horn of the spinal cord was compared at different timepoints and between the different treatment groups. Although there were some small differences between the absolute numbers of activated microglia at the different timepoints in the lean/Veh and HFD/Veh groups, overall there was no significant change. In the HFD/STZ group there was a tendency for the number of activated microglia in the dorsal horn to be lower at all timepoints, but this was most evident at the later timepoints (Figure 3.10A). However, statistical analysis with a 2-way ANOVA did not reveal any significant differences. It was evident, however, that there was a large amount of variability in the data, in particular at the early timepoints and in the lean/Veh and HFD/Veh groups. To overcome this issue, the number of activated microglia in the HFD/Veh and HFD/STZ group were expressed as a percentage of the lean/Veh controls and a non-parametric Mann-Whitney analysis was performed. This revealed a significant decrease ($p<0.05$) in the number of activated microglia in the HFD/STZ group, in comparison with the HFD/Veh group at both day 30 and day 50 (Figure 3.10B). Analysis of the mean grey intensity of Iba1 staining revealed no differences between any of the groups at any of the different timepoints (Figure 3.10C). Figure 3.11A-C shows representative images of Iba1 staining in dorsal horn spinal cord sections in a lean/Veh, HFD/Veh and HFD/STZ rat respectively, with examples of activated microglia indicated with arrows.

The expression of GFAP in the dorsal horn of the spinal cord was also compared at different timepoints and between the different treatment groups. Again, there was no significant change in the expression of GFAP at the different timepoints in the lean/Veh and HFD/Veh treatment groups. In the HFD/STZ model there was a tendency for the expression of GFAP in the dorsal horn to be lower, and this was most evident at day 50 (Figure 3.12A). As with the microglia, statistical analysis with a 2-way ANOVA did not reveal any significant differences.
as there was a large amount of variability in the data. When the expression of GFAP in the HFD/Veh and HFD/STZ group was expressed as a percentage of the lean/Veh control and a Mann-Whitney analysis was performed, this revealed a significant decrease (p<0.05) in the expression of GFAP in the HFD/STZ group at day 50, in comparison with the HFD/Veh group. The expression of GFAP was also examined in the ventral horn and the central region, and this revealed a similar pattern, with a decrease in GFAP expression in the HFD/STZ group. In the ventral horn, a significant decrease (p<0.05) can be seen in the HFD/STZ group, in comparison to both control groups at day 50, with no change evident until this later timepoint (Figure 3.12B). In the central region, a significant decrease in the HFD/STZ group, in comparison with both control groups is also seen at day 50, but in this region a decrease is also observed as soon as day 10, and this decrease is significant compared to the lean/Veh controls at this timepoint (Figure 3.12C). Figure 3.13A-C shows representative images of GFAP staining in dorsal horn spinal cord sections in a lean/Veh, HFD/Veh and HFD/STZ rat respectively.
Figure 3.10 Effects of HFD/STZ on (A) number of activated microglia per quadrant in the dorsal horn (B) number of activated microglia (expressed as a percentage of lean/Veh controls) and (C) mean grey intensity of Iba1 staining in the dorsal horn at different timepoints, in comparison to HFD/Veh and lean/Veh controls. n numbers, representing total number of rats, are displayed on the graphs (mean of 7 spinal cord sections per rat). All data represent mean ± SEM, analysis was by a 2-way ANOVA for A and C, and a Mann-Whitney test for B:
* p<0.05
Figure 3.11 (A-C) Representative images at 20x magnification of Iba1 staining in the dorsal horn of the spinal cord in a Lean/Veh, HFD/Veh and HFD/STZ rat respectively. Scale bar is 50μm. Arrows indicate examples of activated microglia. Images have been altered in Image-J (minimum brightness set to 20, and maximum brightness set to 120).
Figure 3.12 Effects of HFD/STZ on mean grey intensity of spinal GFAP immunofluorescence in the (A) dorsal horn, (B) ventral horn and (C) central region at different timepoints, in comparison with HFD/Veh and lean/Veh controls. n numbers, representing total number of rats, are displayed on the graphs (mean of 7 spinal cord sections per rat). All data represent mean ± SEM, analysis was by a 2-way ANOVA with Bonferroni post-hoc test: * p<0.05, ** p<0.01
Figure 3.13 (A-C) Representative images at 20x magnification of GFAP staining in the ventral horn of the spinal cord in a Lean/Veh, HFD/Veh and HFD/STZ rat respectively. Scale bar is 50μm. Images have been altered in Image-J (minimum brightness set to 20, and maximum brightness set to 100).
3.4. **Discussion**

The inclusion of a lean/Veh group provided an important additional control to this study which was absent in Chapter 2. Specifically, this allowed me to demonstrate that the HFD produced an increase in glucose and insulin by the time the STZ injection was given, indicating that the rats may already be insulin resistant at this stage, as discussed in the previous chapter (Srinivasan *et al.*, 2005). The development of mechanical hypersensitivity in this study was consistent with the data presented in Chapter 2, although the decrease in mechanical withdrawal thresholds was evident at an earlier timepoint. The points at which tissue was collected represent timepoints: when there is no mechanical hypersensitivity (day 10); when there is an evident, but not maximal, decrease in withdrawal thresholds (day 30); and when mechanical hypersensitivity is well established (day 50). The aim was that using these timepoints would reveal any effects of time on the parameters being investigated.

The present study investigated the impact of the HFD/STZ model on peripheral nerve function. The number of Fluoro-Jade B positive cells in DRGs and spinal cord was assessed to determine the presence of neuronal degeneration. No changes in the total number of Fluoro-Jade B positive cells in the DRG or spinal cord are reported, with numbers of Fluoro-Jade B cells being very low in all groups. Immunohistochemistry was also used to investigate potential changes in the expression of CGRP, and activation of microglia and astrocytes in the spinal cord in the HFD/STZ model. Reports from previous studies of animal models of diabetes have been mixed, and some of the results herein are consistent with the current literature whereas others are at odds with what has been seen previously. The HFD/STZ model elicited no significant changes in CGRP expression in the spinal cord. A decrease in activated microglia in the dorsal horn was observed, and there was a significant decrease in GFAP expression in the dorsal and ventral horn,
as well as the central region, which became more obvious at the latest time point - 50 days after STZ injection.

### 3.4.1. Fluoro-Jade B staining

The number of Fluoro-Jade B positive cells present in the DRGs and dorsal horn of the spinal cord was very low in all three groups, and HFD/STZ had no significant effect on the number of positive cells. As Fluoro-Jade B stains for dying or degenerating neurones, this would suggest that there is very little neurodegeneration taking place in the HFD/STZ model at the timepoints studied. The intensity of the Fluoro-Jade B staining was also very low when compared to previous studies by other groups who used Fluoro-Jade in the spinal cord, where a very obvious staining of neurones was reported. However, these studies used models of ischemia, acute inflammation or neurodegeneration, where any neuronal death is very apparent (Kudo et al., 2006; Nguyen et al., 2004; Orendacova et al., 2005; Saganová et al., 2006). In future, it would be advantageous to also run a control group of rats which underwent an ischemic insult, so that the Fluoro-Jade B positive staining in the HFD/STZ model could easily be compared to the changes seen in a robust model of neuronal degeneration.

All of the Fluoro-Jade B positive cells were colocalised with NeuN, confirming that they were neurones. In a previous study, no colocalisation between Fluoro-Jade positive cells and NeuN was observed in a model using a moderate hypoglycaemic insult (Tkacs et al., 2005). They hypothesised that when neurones undergo cell death, NeuN is broken down, and so this, along with the very low intensity staining of Fluoro-Jade B would suggest that any neurodegeneration taking place is not in the advanced stages.

Consistent with my data, no neuronal death has been detected with Fluoro-Jade in the brain of STZ rats at 2 or 8 weeks (Bree et al., 2009; Lechuga-Sancho et al., 2006; Won et al., 2012), and so it is possible that no neuronal death occurs in diabetic rats until later timepoints.
These results in the spinal cord are in agreement with what has been seen in the literature so far. As reviewed in Mizisin et al. (2007), no changes in the grey matter of the spinal cord have been reported in animal models of diabetic neuropathy, with reductions in perikaryal volume of motor and sensory neurones, but no signs of neuronal degeneration (Sidenius et al., 1980). However there have been conflicting reports about whether there is structural injury and neuronal loss in sensory ganglia. Two studies have revealed a significant increase in apoptosis in the DRG at 1 month (Russell et al., 1999), and also 3 and 12 months following STZ treatment in rats (Schmeichel et al., 2003). Zochodne et al. (2001) examined neuronal numbers in dorsal root ganglion at 2 and 12 months after STZ injection, and reported a significant reduction in neurone diameter and area, and a trend towards a decrease in neuronal number at the later timepoint. These results were confirmed in a similar study, with no neuronal loss observed, but instead an increase in the ratio of small type-B neurones to large type-A neurones (Kishi et al., 2002), with a similar pattern observed at 1 month (Sidenius et al., 1980). No neuronal loss has been reported in the DRG at 3 months in STZ treated rats (Severinsen et al., 2007). In the diabetic BB rat, there is no change in neurone number at 4 months (Kamiya et al., 2005b), but there is severe neuronal loss of SP and CGRP neurones in the DRG at 10 months of age (Kamiya et al., 2006). In the present study, the latest timepoint was 7 weeks, and so in agreement with the aforementioned studies, no neuronal degeneration/loss was observed at this early stage of diabetic neuropathy. It would therefore be interesting to carry out a longer term study, to see if these effects could be observed after a longer duration of diabetes in this model. These data add to the hypothesis that the STZ model should be considered a model of the early stages of diabetic neuropathy, as it does not exhibit the sort of structural changes in nerves that we would expect to see in human diabetic neuropathy (Wattiez et al., 2012).
3.4.2. CGRP expression

Changes in the levels of CGRP in diabetic animal models have not yet been fully elucidated. So far there have been reports of an increase in: the basal release of CGRP in the skin (Ellington et al., 2002), the capsaicin-stimulated release of CGRP in the skin and spinal cord (Bishnoi et al., 2011; Ellington et al., 2002), and the number of CGRP-positive fibres in skin (Karanth et al., 1990), whereas no change has been seen in: the levels of CGRP immunoreactive neurones in the nodose ganglion of the vagus nerve (Regalia et al., 2002) or the spinal cord and DRG (Jiang et al., 2004; Terenghi et al., 1994). Conversely, a decrease has been seen in: CGRP content in the vagus nerve (Calcutt et al., 1998), and the sciatic nerve (Brewster et al., 1994; Diemel et al., 1994), the number of CGRP-positive neurones in the DRG (Adeghate et al., 2006), and finally the expression of CGRP mRNA in the DRG (Zochodne et al., 2001) and sciatic nerve (Diemel et al., 1992). Therefore the results reported here of no significant changes in CGRP expression in the spinal cord add another piece of the puzzle, but the full picture of the role of CGRP in diabetic neuropathy is yet to be elucidated.

3.4.3. Microglial activation

The changes in the number of Iba1 positive cells morphologically identified as activated microglia in the spinal cord in this study are not in agreement with the existing literature. In general, an upregulation of activated microglia in the spinal cord has been reported in STZ treated rats over a similar timescale to that investigated in this study. Changes in the number of activated microglia are seen as soon as 4 days after STZ injection (Talbot et al., 2010), and then at various timepoints over the following five weeks. However the method by which activation of microglia is calculated varies between the different studies. Some use Iba1 as a marker of microglia (Talbot et al., 2010; Tsuda et al., 2008; Wodarski et al., 2009), whereas others used CD11b/OX-42 (Kim et al.,
2012b; Morgado et al., 2011a; Tsuda et al., 2008). Whereas Iba1 stains all microglia, and their activation state can then be assessed by morphological changes, CD11b only stains classically activated microglia, and will not stain for alternatively activated or ‘resting’ microglia. In these studies, activation of microglia is then assessed by calculating mean pixel energy (Talbot et al., 2010), or by densitometric analysis (Morgado et al., 2011a), whereas others count cell bodies stained with Iba1 (Tsuda et al., 2008; Wodarski et al., 2009), and some go further and assess whether the microglia being counted appear activated. In future studies looking at microglia in the diabetic model, it would be sensible to use both antibodies, and a consistent method of detecting activation so that results could be more easily compared between groups. In this study, Iba1 was used, and only activated microglia were counted, assessed as those displaying large cell bodies and thickened retracted processes (Eriksson et al., 1993). As the expected increase in microglial activation was not observed using this method, the mean grey intensity of these sections was also calculated to see whether this method would confirm these findings. Using this method, no change in Iba1 expression was seen between any of the three groups at the three different timepoints. As the greater numbers of activated microglia in the lean/Veh and HFD/Veh controls would be expected to show an increased expression of Iba1 (Tsuda et al., 2005), it is possible that although there were fewer activated microglia in the HFD/STZ group, there was actually an overall increase in the number of microglia, even if they did not show the classic changes in morphology that are indicators of activation.

Tsuda et al. (2008) also investigated whether microglial activation was altered in different segments of the spinal cord, and found that they were most strongly activated in the L4 segment, with weaker Iba1 immunofluorescence in segments L5 and L6. In this study lumbar regions 4-6 of the spinal cord were all cut together, and so the different segments were unable to be identified with certainty, and so any positive results that may have been seen in L4 may have been masked
by the inclusion of L5 and 6. Therefore in a future study, these lumbar regions should be cut separately to see whether there are more regional specific changes.

Another factor that would be interesting to investigate in future immunohistochemistry studies in the HFD/STZ model, would be to double-label cells with markers for phospho-ERK (Morgado et al., 2011a; Sweitzer et al., 2004; Tsuda et al., 2008) and phospho-p38 (Morgado et al., 2011a; Sweitzer et al., 2004), as these MAPK pathways are often activated in microglia. As no increase in the number of activated microglia was observed in this study, double-labelling with these markers would either confirm that there is less activation of microglia, or may be able to show that although no increase in number is seen, there is in fact an increase in the activation of these MAPK pathways in the microglia, despite no change in the phenotypic state. It would also be of interest to see whether treatment with minocycline, which inhibits activation of microglia, would be effective at preventing the development of mechanical hypersensitivity in the HFD/STZ model. All of these further ideas would help to explain, or build upon, the results observed in this study.

### 3.4.4. Astroglial activation

To date previous studies of GFAP expression in the spinal cord in the STZ model have been mixed. A decrease in GFAP immunoreactivity has been reported by some groups (Afsari et al., 2008; Wodarski et al., 2009), no change by others (Tsuda et al., 2008), and finally an increase in GFAP immunoreactivity in one recent report (Kim et al., 2012b). My data report a significant decrease in GFAP-immunoreactive astrocytes in three different regions of the spinal cord in the HFD/STZ model, which is particularly evident at the latest timepoint. This finding is in agreement not only with studies in the spinal cord, but also in other regions of the CNS such as the brain and the retina, where decreases in GFAP expression have also been reported (Barber et al., 2000;
It is important to note that although a decrease in GFAP immunoreactivity in the brain of STZ treated rats has previously been reported, this did not correlate with a decrease in astrocyte number per se (Coleman et al., 2004). The basis for these decreases in GFAP immunoreactivity may be related to the large decrease in insulin exhibited in these models (Afsari et al., 2008). Co-application of insulin and thyroid hormone has been shown to alter the morphology of astrocytes, with cell processes becoming thicker and more distinct, as well as increasing the activity of glutamine synthase (Aizenman et al., 1987), and enhancing the expression of GFAP in astrocytes (Toran-Allerand et al., 1991). These effects of insulin on astrocytes were reversible (Aizenman et al., 1987), suggesting that insulin may play an important role in regulating normal astrocytic function. The decrease in GFAP-immunoreactive astrocytes demonstrated in HFD/STZ rats may be indicative of an altered metabolic and functional role, meaning that the astrocytes are unable to maintain their neuronal support role in the CNS (Afsari et al., 2008). This idea is further consolidated by the demonstration that insulin treatment restores GFAP levels in the diabetic STZ-treated rat (Coleman et al., 2010).

The changes in GFAP immunoreactivity suggest that the contribution of astrocytes to spinal cord homeostasis in this model may be altered. Glutamate-transporter 1 (GLT-1 or EAAT2), and glutamate/aspartate transporter (GLAST) are predominantly expressed in astrocytes, with GLT-1 found predominantly in the superficial dorsal horn (Regan et al., 2007; Rothstein et al., 1994; Xin et al., 2009). In nerve injury models of pain, astrocyte activation has been associated with decreased GLT-1 and GLAST (Sung et al., 2003; Xin et al., 2009), as well as a decrease in other glutamate transporters, such as excitatory amino-acid carrier 1 (Sung et al., 2003; Wang et al., 2006), resulting in a decrease in
glutamate uptake (Binns et al., 2005). Whether the decrease in GFAP staining reported herein in the HFD/STZ model is associated with a decrease in these transporters remains to be determined. It has been hypothesised that decreased GLT-1 expression can lead to pain hypersensitivity, due to enhanced glutamatergic synaptic neurotransmission (Nakagawa et al., 2010), and inhibition of glutamate transporters has been shown to produce spontaneous nociceptive behaviours and thermal and mechanical hypersensitivity (Liaw et al., 2005; Weng et al., 2006).

No changes in GLT-1 or GLAST expression, but an increased uptake of glutamate was observed in the brain of 4 and 8 week STZ treated rats (Coleman et al., 2004; Coleman et al., 2010). An increase in the level of glutamate in the peripheral nerve in 4 week STZ treated rats has also been reported (Li et al., 2004), but the presence of mechanical hypersensitivity was not investigated in any of these studies. GCPII, which reduces glutamate release, attenuated hyperalgesia in the BB rat (Zhang et al., 2006b). It would therefore be interesting to see whether the expression of GLTs, and the levels of glutamate, are altered in the spinal cord of HFD/STZ rats.

In conclusion, I have demonstrated a decrease in GFAP expression in the spinal cord, no change in CGRP expression, and no neuronal degeneration induced in the HFD/STZ model by 7 weeks. However, a decrease in activated microglia was observed in this study, and this warrants further investigation to see whether this result can be repeated in this model. As pain behaviour is evident in the HFD/STZ model, and some of the changes described in this chapter only go part way to explaining its development, the next stage was to investigate whether there is a change in neuronal responses, which was investigated in Chapter 4.
Chapter 4.

Electrophysiological characterisation of spinal neuronal responses in the HFD/STZ model of diabetes, and the effects of pioglitazone intervention
4.1. Introduction

4.1.1. Involvement of primary afferent fibres in the STZ model

Aβ-, Aδ- and C-fibres have all been postulated to be important in the development of painful symptoms in diabetic neuropathy. Sustained mechanical stimulation (Chen et al., 2001) and noxious chemical stimuli (Chen et al., 2003) have been shown to elicit a greater number of action potentials in C-fibres in the STZ model than in controls, with only a subset of C-fibres (1 in 3) being markedly hyper-responsive (Ahlgren et al., 1992; Chen et al., 2003; Chen et al., 2001). In agreement with this, a facilitation of responses to suprathreshold mechanical stimulation in C-fibres (Ahlgren et al., 1994; Ahlgren et al., 1992; Suzuki et al., 2002), as well as an increase in spontaneous firing, and a decrease in response thresholds in response to ramp-pressure stimulation have all been observed in STZ rats (Suzuki et al., 2002). This increase in afferent firing may lead to sensitisation of spinal nociceptive circuits (Kamiya et al., 2005a).

Other groups have hypothesised that Aβ- and Aδ-fibres also play a role in the development of painful symptoms. When resiniferatoxin was used to desensitise unmyelinated C-fibres, the development of mechanical hypersensitivity was unaffected in the STZ model (Khan et al., 2002). Indeed, Aβ- and Aδ-fibres developed abnormal spontaneous discharges, a decrease in their activation threshold, and an increase in evoked responses to von Frey filaments. A decrease in mechanical thresholds in Aδ-fibres has also been seen in STZ treated rats between 3-7 weeks (Ahlgren et al., 1992).
4.1.2. Involvement of WDR neurones in the dorsal horn of the spinal cord in the STZ model

As discussed in Chapter 1, the spinal cord plays a pivotal role in the integration and modulation of noxious inputs, and is a critical site involved in sensitisation mechanisms associated with chronic pain. Previous studies in models of diabetes have shown that dendritic spine remodelling in the spinal cord is seen at 4 weeks after STZ injection when mechanical hypersensitivity and hyperalgesia are apparent, but not before the painful symptoms develop at 1 week, suggesting that this too may play a role in neuropathic pain (Tan et al., 2012). They also examined the activity of WDR neurones at L4-L5 in the spinal cord in the STZ model at 4 weeks, and an increase in spontaneous activity, enlarged receptive fields and increased peripherally evoked responses to brush, press, pinch and von Frey stimuli was observed (Tan et al., 2012). An increase in the response of somatic WDR neurones to a brush stimulus in 4-11 week STZ treated rats was also seen when the thoracic region, T3, of the spinal cord was examined (Ghorbani et al., 2011).

In a previous study of spinal dorsal horn WDR neurone activity (T12-L2) in 6 week STZ treated rats, an increase in spontaneous activity was reported (Pertovaara et al., 2001), but there was no change in noxious heat-evoked responses, after discharges, or receptive field size, and there was a decrease in the responses evoked by mechanical stimulation (2, 4, 12 and 75g von Frey hairs).

Previous studies in STZ rats have therefore consistently demonstrated an increase in the spontaneous activity of WDR neurones, but the impact of these models of diabetic neuropathy on evoked responses of spinal neurones is less consistent. This may reflect the different models and timescales involved, as well as the experimental methods such as the depth of anaesthesia. It will be interesting to explore this aspect in
the HFD/STZ model to see how evoked neuronal responses to mechanical and electrical stimulation are altered.

4.1.3. Pioglitazone and other PPARγ agonists

Pioglitazone is one of a class of drugs called the thiazolidinediones that are used to treat type 2 diabetes. The TZDs act on the nuclear receptor PPARγ and their mechanisms of action are discussed in Chapter 1. Recently it has been demonstrated that they may also play a positive role in diseases such as atherosclerosis, cancer and neurodegenerative disorders such as Alzheimer’s disease (Churi et al., 2008). They have also shown promise in alleviating inflammatory and neuropathic pain through a variety of different mechanisms, as discussed below. I was therefore interested in investigating a potential role of pioglitazone in alleviating the mechanical hypersensitivity that is observed in the HFD/STZ model.

4.1.4. PPARγ agonists in inflammatory pain

Table 4.1 summarises the effects of the PPARγ agonists: 15-Deoxy-Δ-12,14-prostaglandin J2 (15d-PGJ2, a natural agonist of PPARγ (Desvergne et al., 1999)), rosiglitazone, and pioglitazone, in the carrageenan and post-incisional models of inflammatory pain. It can be seen that they are able to reduce inflammation, and that these effects were blocked by bisphenolAdiglycidyl ether (BADGE) or GW9662, two PPARγ antagonists, indicating that their effects are mediated through this receptor (Cuzzocrea et al., 2004; Morgenweck et al., 2010).

It is hypothesised that these PPARγ agonists might work by regulating macrophage polarity to induce an analgesic effect, which is elaborated on in the discussion, and transplanting rosiglitazone-treated peritoneal macrophages to the injured site in the post-incisional model had an analgesic effect (Hasegawa-Moriyama et al., 2012; Takahashi et al., 2011).
Table 4.1 Summary of the effects of acute doses of PPARγ agonists in various models of inflammatory pain.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Model</th>
<th>Behavioural Outcomes</th>
<th>Biochemical outcomes</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rosiglitazone 100mgkg⁻¹, i.p.</td>
<td>Carrageenan in rats</td>
<td>-</td>
<td>Inhibited paw oedema (only when given before carrageenan)</td>
<td>(Taylor et al., 2002)</td>
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<tr>
<td>Rosiglitazone 10mgkg⁻¹, i.p.</td>
<td>Carrageenan in rats</td>
<td>-</td>
<td>Inhibited paw oedema, and attenuated the increase in PARP, iNOS and COX-2 in the lungs. Effects blocked by BADGE</td>
<td>(Cuzzocrea et al., 2004)</td>
</tr>
<tr>
<td>Pioglitazone 25-50mgkg⁻¹, i.p.</td>
<td>Carrageenan in rats</td>
<td>No effect on mechanical hypersensitivity</td>
<td>Inhibited paw oedema</td>
<td>(Oliveira et al., 2007)</td>
</tr>
<tr>
<td>15d-PGJ2 200μg, i.t. Rosiglitazone 50μg, i.t.</td>
<td>Carrageenan in rats</td>
<td>Reduced thermal hyperalgesia</td>
<td>- Inhibited paw oedema</td>
<td>(Morgenweck et al., 2010)</td>
</tr>
<tr>
<td>Rosiglitazone 10μg into the paw</td>
<td>Post-incisional pain in mice (induces paw swelling and infiltration of immune cells)</td>
<td>Attenuated thermal hyperalgesia and mechanical hypersensitivity</td>
<td>- Inhibited paw oedema - Attenuated the infiltration of immune cells - Increased the ratio of M1 (pro-inflammatory): M2 (anti-inflammatory) macrophages</td>
<td>(Hasegawa-Moriyama et al., 2012)</td>
</tr>
</tbody>
</table>
4.1.5. PPARγ agonists in neuropathic pain

Table 4.2 summarises the effects of PPARγ agonists in different models of neuropathic pain. The effects of these drugs are thought to be mediated, at least in part, by actions at the level of the spinal cord; perhaps through decreasing the activation of microglia, leading to a decrease in pro-inflammatory cytokines, and modifying central sensitisation. This could explain their long lasting effects after administration has ceased.

4.1.6. PPARγ agonists in diabetic neuropathy

A limited number of studies have also evaluated the effects of PPARγ agonists in models of diabetic neuropathy. Troglitazone treatment was shown to protect against the slowing of NCV and fibre atrophy in STZ rats, as well as acting as a free radical scavenger and reducing TNFα production (Qiang et al., 1998). Rosiglitazone treatment was able to improve thermal hypoalgesia, as well as reducing oxidative stress in the sciatic nerve in STZ-treated mice, without having any effect on hyperglycaemia (Wiggin et al., 2008). Evidence that rosiglitazone activated genes responsible for glucose metabolism, as well as oxidoreductase activity has been generated using microarray analysis (Wiggin et al., 2008). Pioglitazone has also been shown to be effective at reducing oxidative stress (Majithiya et al., 2005), as well as having a neuroprotective effect on NCV, restoring PKC activity, decreasing levels of ERK activity, and reducing macrophage infiltration in the STZ model (Yamagishi et al., 2008).
Table 4.2 Summary of the effects of PPARγ agonists in various models of neuropathic pain.

i.p: intraperitoneal; p.o: oral; i.t: intrathecal; i.c.v: intracerebroventricular; SNI: spared nerve injury; PNL: partial sciatic nerve ligation; CA: cold allodynia; MH: mechanical hypersensitivity; BADGE and GW9662 are PPARγ antagonists

<table>
<thead>
<tr>
<th>Drug</th>
<th>Model</th>
<th>Behavioural Outcomes</th>
<th>Biochemical outcomes</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>15d-PGJ2</td>
<td>SNI in rats</td>
<td>- Decreased MH and CA</td>
<td>-</td>
<td>(Churi et al., 2008)</td>
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<tr>
<td>100-200µg, i.t.</td>
<td></td>
<td>- Effects blocked by BADGE</td>
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<tr>
<td>Rosiglitazone</td>
<td></td>
<td>- i.p./i.c.v administration were ineffective</td>
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<td>200µg, i.t.</td>
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<td>Acute dose</td>
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<td></td>
<td></td>
<td>7 days pre-SNI and 7 weeks post-SNI prevented mechanical</td>
<td>- Attenuated the increase in</td>
<td>(Morgenweck et al.,</td>
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<td></td>
<td></td>
<td>and cold hypersensitivity</td>
<td>GFAP-positive staining in the spinal cord</td>
<td>2013)</td>
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<td></td>
<td></td>
<td>- A single injection 15 minutes before SNI reduced</td>
<td>- Attenuated the increase in p-ERK in the dorsal horn</td>
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<td></td>
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<td>hyperalgesia for the next 2 weeks.</td>
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<td>- 2 x daily injections for 7 days, 24 hours after SNI,</td>
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<td>decreased established hypersensitivity</td>
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<td>- Pioglitazone was still effective for a week after its</td>
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<td></td>
<td></td>
<td>termination</td>
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<td></td>
<td></td>
<td>- GW9662 blocked the ameliorative effects of pioglitazone</td>
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<tr>
<td>Pioglitazone</td>
<td>SNI in rats</td>
<td>Prevented the development of MH</td>
<td>Attenuated the increase in activated microglia</td>
<td>(Iwai et al., 2008)</td>
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<td>0.3-30mgkg⁻¹, p.o.</td>
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<td>1 - 10 mgkg⁻¹, i.p.</td>
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<tr>
<td>Various</td>
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<tr>
<td>Pioglitazone</td>
<td>PNL in mice</td>
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<td>1-25mgkg⁻¹, p.o.</td>
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<td>4 days</td>
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<tr>
<td>Treatment</td>
<td>Route</td>
<td>Duration</td>
<td>Issue 1</td>
<td>Issue 2</td>
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<td>---------------------------</td>
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<td>-------------------------------------------------------------------------</td>
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<tr>
<td>Pioglitazone</td>
<td>25 mg kg(^{-1}), p.o.</td>
<td>Various</td>
<td>PNL in mice</td>
<td>Prevented the development of MH when administered for one week after PNL, and for a week after administration had ceased.</td>
</tr>
<tr>
<td>Rosiglitazone</td>
<td>10 mg kg(^{-1}), i.p.</td>
<td>Day 1-3, 5-7 or 26-28</td>
<td>PNL in mice</td>
<td>Early administration attenuated the development of MH</td>
</tr>
<tr>
<td>Rosiglitazone</td>
<td>5-10 mg kg(^{-1}), p.o</td>
<td>28 days</td>
<td>Tibial and sural nerve transection in rats</td>
<td>Attenuated mechanical and cold hyperalgesia, but not thermal hyperalgesia</td>
</tr>
<tr>
<td>Pioglitazone</td>
<td>10 mg kg(^{-1}), p.o.</td>
<td>14 days</td>
<td>Spinal nerve transection in rats</td>
<td>Prevented the development of MH and mechanical hyperalgesia</td>
</tr>
</tbody>
</table>
4.1.7.  Aim of the study

The primary aim of the work in this chapter was to characterise the impact of the HFD/STZ model of diabetes on the electrically and mechanically evoked responses of WDR neurones in the dorsal horn of the spinal cord at 7 and 11 weeks after model induction.

The second aim of this study was to investigate the ability of the PPARγ ligand pioglitazone to alter already established mechanical hypersensitivity in the HFD/STZ model, and to determine whether this was associated with changes in the response profiles of WDR neurones in the spinal cord in HFD/STZ rats.
4.2. **Methods**

For detailed methods of induction of diabetes, blood sampling and von Frey testing see Chapter 2.

4.2.1. **Animals**

All experiments were carried out under Home Office Licence 40/3124, in accordance with the UK Home Office Animals (Scientific Procedures) Act 1986 and IASP guidelines. 47 male Sprague-Dawley rats (200-250g), obtained from Charles River (Kent, UK), were individually housed on a normal light cycle (lights on: 07:00 - 19:00) with free access to either normal chow or a high fat diet (60% fat by caloric content; D12492 diet; Research Diets, New Jersey, USA) and water at all times. After three weeks consumption of chow/HFD, the HFD groups were stratified into three groups on the basis of body weight and mechanical withdrawal thresholds, and all rats then received either an i.p. injection of STZ (45mgkg\(^{-1}\)), or citric acid buffer. Blood samples were taken at day 18, 46 and 74. von Frey testing was carried out weekly.

4.2.2. **In vivo electrophysiology**

4.2.2.1. **Induction of anaesthesia**

To induce anaesthesia, the rat was placed in an induction chamber (a transparent plastic box), and isoflurane (Abbott, Kent, UK) was delivered at 3% in a mixture of 67% nitrous oxide and 33% oxygen (both BOC gases, UK) via a Vapotech series 3 vaporiser. Expelled gases were removed and absorbed by a Cardiff aldosorber (Datesand Ltd, Manchester, UK). Once an areflexic state was attained, the level of isoflurane was reduced to 2%. Areflexia was defined as the absence of a righting reflex when the induction chamber was gently tilted to the side, or the lack of a withdrawal reflex to a toe pinch.
4.2.2.2. Tracheal cannulation

The rat was transferred from the induction chamber to a mat, and placed in a nose-cone connected to a Y-connector and attached to the anaesthetic line through silicone Portex tubing. A small piece of skin was removed from the underside of the neck, exposing the muscle layers underneath, which were gently teased apart using blunt dissection to expose the trachea. Pointed forceps were placed under the trachea to support it, and two lengths of suture (Pearsall’s Sutures Ltd., UK) were passed underneath the trachea and tied in loose knots. A small incision was made between two rings of cartilage approximately halfway along the exposed portion of the trachea, between the two threads. A bevelled-edged cannula, approximately 4cm in length and 2.08mm in diameter (Portex Ltd., UK) was inserted approximately 5mm and secured in place using the two sutures, and connected directly to the Y-connector. Response to a toe-pinching stimulus was checked to ensure the rat was sufficiently anaesthetised.

4.2.2.3. Laminectomy

The rat was transferred to a stereotaxic frame (University of Nottingham, Medical Faculty Workshops) and placed into ear bars in order to maintain a fixed head position throughout the experiment. Core body temperature was monitored by insertion of a rectal temperature probe and was maintained at 37±0.5°C by a heating blanket. A midline incision was made through the skin and fur, from approximately 2cm above the base of the ribs. Two parallel incisions were made in the muscle on either side of the vertebral column, corresponding with L1-3, and the top clamp was tightly secured. A tear-drop shaped incision, approximately 1.5-2cm in length was then made along the dorsal surface of the spinal column, so that the centre of the incision lay over the base of the ribs, which approximately corresponds with the location of spinal segments L4-5. Connective tissue was
removed, creating a reservoir to hold future applications of saline, ensuring that the spinal cord was kept moist throughout the experiment.

Rongeurs were inserted gently into the gap between vertebrae, and used to expose segments L4-L5 of the spinal cord, which is innervated by primary afferent input from the hindpaws. The laminectomy was kept as small as possible to ensure stability of later electrophysiological recordings (Stanfa et al., 2004). The dura mater was carefully removed using a pair of sharp forceps, leaving the pia mater intact. A second clamp was positioned around the vertebral column below the laminectomy to ensure that the area was held secure for later electrophysiological recordings. The skin of the rat was pulled tight around the clamps and secured with a crocodile clip to minimise loss of fluid and prevent dehydration of the rat. The level of isoflurane was reduced to 1.5% and maintained at this level for the remainder of the experiment. The rat was allowed a period of 30 minutes to adapt to the new level of anaesthesia. Hindpaw withdrawal and blink reflexes were regularly monitored throughout the rest of the experiment, and the spinal cord was kept moist by application of 50μl of 0.9% NaCl using a Hamilton syringe.

**4.2.2.4. Electrophysiological recordings**

Extracellular single-unit recordings of WDR dorsal horn neurones were made using glass coated tungsten electrodes (Merrill et al., 1972), and a Neurolog system was used for spike discrimination and audio monitoring (Digitimer, Hertfordshire, UK). The system was grounded through the stereotaxic frame. The headstage (Neurolog NL100AK in A-B configuration) received input from the electrode inserted into the spinal cord and from a second indifferent electrode which was attached to the skin of the rat, allowing differential recording, and therefore reducing interference. The voltage signal was amplified (Neurolog NL104 x 2K, Neurolog 106 x 80) and filtered through low and high-pass filters (Neurolog NL125). The filtered signal was fed into a two channel
digital oscilloscope (Tektronix TDS210) providing a visual representation of the responses of the recorded neurones. Analogue spike signals were converted to a digital signal by the spike trigger (Neurolog NL201) with variable threshold, allowing only action potentials of a specified amplitude to be counted. This enabled the separation of action potentials recorded from a single neurone from recordings of other closely located neurones. Evoked firing of neurones was in the mV range with a typical signal to noise ratio of 4:1. The neuronal signals were digitised using a CED micro1401 interface and quantified using Spike 2 data acquisition software (Cambridge Electronic Design, Cambridge, UK).

An electrode was initially inserted level with the base of the ribs, close to the central vessel, and input from the hindpaw was confirmed by tapping the toes. The electrode was slowly withdrawn to the surface of the cord, and then lowered in 10µm steps using a SCAT-01 microdrive and an Epson HX210 Stepper (Digitimer) to a depth of around 500µm from the surface. It was then lowered further, whilst stimulating the toes, until a depth of around 1200µm. WDR neurones were selected if they displayed a sustained response to pinch stimuli, and a graded response to increasing stimulus intensity (Willis et al., 2004). The receptive field was located and marked to allow accurate stimulation of the identified area throughout the experiment.

4.2.2.5. Characterising neurones

WDR neurones were characterised using transcutaneous electrical stimulation. Two metal pins (26 gauge syringe needles), connected to an electrical stimulator isolator (NL800), were inserted intradermally either side of the receptive field (or on adjacent toes), ensuring that the needles did not touch. The stimulus intensity was set to 1mA and the toes were stimulated using a single pulse, and the intensity was increased in 0.1mA steps up to 3mA, until a response with a C-fibre evoked latency was seen (90-300ms after stimulus). Once the threshold
for C-fibre-evoked response was determined, a train of 16 stimuli at 3
times the C-fibre threshold current were delivered using the period
generator (NL304) at a frequency of 0.5Hz, with a 2ms pulse width, in
order to stimulate neuronal wind-up. Using Spike 2, the neuronal
responses were captured and displayed in a post-stimulus time
histogram. The number of spikes evoked by each primary afferent fibre
type were recorded and quantified (Aβ-fibres, 0-20ms; Aδ-fibres, 20-90
ms; C-fibres, 90-300 ms post stimulus), along with the number of post-
discharge responses (300-800ms post-stimulus). Only neurones
displaying ≥100 neuronal events for each fibre type were investigated
further.

After a recovery period of at least ten minutes, the responses of the
neurone to mechanical punctuate stimulation of the peripheral receptive
field of the neurone on the hindpaw were characterised. The centre of
the receptive field was mechanically stimulated with von Frey hairs of
different bending forces (8, 10, 15, 26 and 60g) for 10 seconds in
ascending order, with a 10s interval between each stimulation, and the
mean firing frequency over the 10s stimulation period was recorded.
The noxious withdrawal threshold to mechanical punctuate stimuli in
conscious rats is 15g and so the range of von Frey hairs used included
both innocuous and noxious stimuli (Chaplan et al., 1994). Three sets
of stimulations were recorded, with a 10 minute interval between each
set. An average of 3 neurones were characterised from each rat.

4.2.2.6. Production of glass coated tungsten
microelectrodes
A batch of 30 tungsten wires of equal length (Harvard Apparatus, Kent,
UK) were loaded into a Perspex jig (75 x 50mm) and cleaned by gently
brushing the length of the filament with 100% acetone. A piece of
sellotape was attached to the end of the tungsten filaments, and then
wrapped tightly around a cylindrical brass barrel, to ensure good
contact between the barrel and the electrodes. The metal barrel was
attached to the arm of an electrode etcher (University of Nottingham, Medical Faculty Workshop) and lowered into a potassium nitrate (KNO$_2$; 90g/80 ml) electrolyte solution so that only 10 of the tungsten filaments were in contact with the solution at any one time. The circuit was completed by immersing a carbon electrode in the solution, and a current of 2.5mA was passed through the solution and the electrodes were allowed to etch until the current dropped to 2.0mA. The electrode barrel was then removed and the electrodes gently rinsed with distilled water.

Using a pair of forceps, a single electrode was removed from the barrel, and briefly passed through a burner to remove any sellotape residue. The filament was then placed in a glass capillary tube (Harvard Apparatus), and inserted into an electrode puller (University of Nottingham, Medical Faculty Workshops). A current was passed through a coil, causing the capillary tube to melt and pull apart, coating the filament with glass. The capillary tube with the tungsten filament was then placed into the holder of a light microscope and the tapered end was pushed gently towards a heated borax bead attached to the microscope. The current supply was then turned off, causing contraction of the borax bead, pulling off a small glass fragment to expose about 1-2 mm of the tungsten wire.

4.2.2.7. Choice of anaesthetic
The choice of anaesthetic was important as it was necessary that it would not have any overt effects on the responses of the dorsal horn neurones. Previously, decerebrate animals have often been used in electrophysiological studies (Clarke, 1985; Ogilvie et al., 1999) as this method reduces the confounding analgesic effects of anaesthesia, but the generation of decerebrate animals involves additional surgical procedures and removes the descending pain pathways which modulate spinal dorsal horn neuronal responses.
Inhalation anaesthesia was chosen as it enables tight control of the amount of anaesthetic being delivered, and can be rapidly increased or decreased as required. Halothane was not chosen due to its potential for hepatotoxicity, and at the dose range used in these experiments halothane has a greater depressant effect on neuronal responses than isoflurane (Mitsuyo et al., 2006). Isoflurane has been shown to have a minimal depressant effect on dorsal horn responses to noxious mechanical stimuli in rats in vivo (Antognini et al., 1999; Kim et al., 2007b). Isoflurane was used in combination with nitrous oxide so that a lower concentration of anaesthetic could be used.

### 4.2.3. Administration of drugs

All drug dosing was carried out blind to the treatment groups. Pioglitazone (10mgkg\(^{-1}\)), or 1% methylcellulose vehicle, was orally administered daily from day 21 to day 49 of the study, when the first cohort (n=6 for all groups) were used for electrophysiological experiments. A second cohort of rats (n=6 for lean/Veh, HFD/Veh and HFD/STZ and n=5 for HFD/STZ + pioglitazone) was assessed until day 78, (28 days after dosing with pioglitazone had ceased), when electrophysiological experiments were then conducted. Pioglitazone was purchased from Tocris Cookson (Bristol, UK) and was dissolved in 1% methylcellulose vehicle.
4.2.4. Statistics

Analysis of body weight, food intake and water intake was by an ANCOVA with Tukey’s post-hoc test, with the average of day -7 to 0 as the covariate. Analysis of plasma glucose, plasma insulin, mechanical withdrawal thresholds, mechanically and electrically evoked neuronal responses and electrical thresholds and latencies was by a Kruskal-Wallis test with Dunn’s post-hoc test. In all analyses, a p value of less than 0.05 was considered statistically significant.

Rats were excluded from analysis of pain behaviour if in the two weeks before injection with STZ the average hindpaw mechanical withdrawal threshold was <10g. In this study, this represented 5 rats – 1 lean/Veh, 1 HFD/Veh, 1 HFD/STZ + vehicle and 2 HFD/STZ + pioglitazone.
4.3. Results

4.3.1. Effects of HFD/STZ on hindpaw evoked responses of WDR neurones in the dorsal horn

This study examined the effects of the HFD/STZ model of diabetes on the activity of dorsal horn neurones in vivo, at day 49 and day 78. A total of 64 WDR dorsal horn neurones were characterized in 6 lean/Veh, 6 HFD/Veh, 6 HFD/STZ and 6 pioglitazone-treated HFD/STZ rats at day 49 (9, 18, 18 and 19 neurones per respective group), and a total of 79 WDR dorsal horn neurones were characterized in 6 lean/Veh, 6 HFD/Veh, 5 HFD/STZ and 6 pioglitazone-treated HFD/STZ rats at day 78 (20, 23, 17 and 19 neurones per respective group). The average depth of the dorsal horn neurones recorded from ranged between 756-887μm, which corresponds to laminae V-VI.

Prior to investigating the evoked responses of the WDR dorsal horn neurones, any spontaneous activity was recorded. The vast majority of neurones recorded exhibited negligible or no spontaneous firing activity. Two out of 18 neurones in both the vehicle and the pioglitazone treated HFD/STZ groups at day 49 had spontaneous firing above 1Hz (7.97 and 3.16Hz, and 6.85 and 1.12Hz, respectively), but no significant changes were seen between any of the groups (data not shown).

Both the electrically and mechanically evoked responses of the WDR dorsal horn neurones were quantified. The average latency and threshold values, as well as total number of action potentials produced by Aβ-, Aδ- and C-fibres during a train of 16 electrical stimuli at three times the C-fibre threshold, as well as post-discharge, are presented in Table 4.3. Although there was a trend for the Aβ-fibre evoked response to be lower in the HFD/STZ rats, compared to the lean/Veh controls and HFD/Veh controls, this did not reach significance. An example trace of the response of a typical WDR neurone to the first 8 of a train of 16 electrical stimuli can be seen in Figure 4.2.
Stimulation of the hindpaw receptive field of dorsal horn neurones with a range of von Frey hairs evoked a stimulus intensity-dependant increase in the firing of these neurones in the lean/Veh controls, the HFD/Veh controls and the HFD/STZ group. An example histogram showing the graded response of a single dorsal horn neurone is provided in Figure 4.2. There was a trend towards a decrease in the mechanically-evoked responses of dorsal horn neurones in the HFD/STZ at each different weight at day 49, especially to the noxious stimuli (15-60g), although significance was not reached (Figure 4.3A), and an AUC analysis of the stimulus response functions for the three groups did not reveal a significant difference, perhaps due to the high variability in the data. This difference was not maintained at day 78.

**Table 4.3** Comparison of the C- and A-fibre evoked responses of WDR dorsal horn neurones in the HFD/STZ model of diabetes, compared to HFD/Veh and lean/Veh controls at day 49. There were no significant differences in the C-fibre threshold and latency, total action potentials (APs) for $A_\beta$, $A_\delta$ and C-fibres, and also post-discharge firing, following a train of 16 electrical stimuli in the three groups. Pioglitazone (10mg kg$^{-1}$, p.o.) treatment from day 21-49 did not alter these properties of the dorsal horn neurones in the HFD/STZ model. All data represent mean ± SEM, analysis was by a Kruskal-Wallis test.

<table>
<thead>
<tr>
<th></th>
<th>Lean/Veh n=6</th>
<th>HFD/Veh n=6</th>
<th>HFD/STZ + Vehicle n=6</th>
<th>HFD/STZ + Pioglitazone n=6</th>
</tr>
</thead>
<tbody>
<tr>
<td>C-fibre Threshold (mV)</td>
<td>1.5 ± 0.2</td>
<td>1.3 ± 0.1</td>
<td>1.2 ± 0.1</td>
<td>1.4 ± 0.1</td>
</tr>
<tr>
<td>Latency (ms)</td>
<td>228 ± 13</td>
<td>189 ± 11</td>
<td>192 ± 19</td>
<td>214 ± 14</td>
</tr>
<tr>
<td>$A_\beta$ (Total APs)</td>
<td>138 ± 12</td>
<td>139 ± 8</td>
<td>111 ± 8</td>
<td>118 ± 9</td>
</tr>
<tr>
<td>$A_\delta$ (Total APs)</td>
<td>161 ± 24</td>
<td>123 ± 19</td>
<td>105 ± 21</td>
<td>131 ± 11</td>
</tr>
<tr>
<td>C (Total APs)</td>
<td>392 ± 67</td>
<td>251 ± 37</td>
<td>276 ± 48</td>
<td>266 ± 42</td>
</tr>
<tr>
<td>Post-discharge (Total APs)</td>
<td>440 ± 98</td>
<td>309 ± 48</td>
<td>402 ± 82</td>
<td>378 ± 60</td>
</tr>
</tbody>
</table>
Figure 4.2 (A) Representative trace of electrically-evoked evoked responses of a single wide dynamic range dorsal horn neurone to the first 8 electrical stimuli of the train of 16 stimuli. (B) Representative trace of the evoked response of a single wide dynamic range dorsal horn neurone following mechanical (8, 10, 15, 26 and 60g) stimulation of the hindpaw receptive field in a HFD/Veh rat.
4.3.2. Effects of pioglitazone on mechanically evoked responses of dorsal horn neurones

The effects of pioglitazone (10 mg kg$^{-1}$, p.o., day 21-49) treatment on the magnitude of the mechanically-evoked responses of the WDR dorsal horn neurones in HFD/STZ rats were compared to the effects of vehicle treatment. Immediately following 28 days of pioglitazone treatment (day 49), mechanically evoked responses of dorsal horn neurones were significantly larger than evoked neuronal responses in HFD/STZ rats treated with vehicle. As shown in Figure 4.3B, there was a significant increase in the evoked firing of neurones in the spinal cord of HFD/STZ rats treated with pioglitazone. Twenty-eight days after cessation of pioglitazone treatment in the HFD/STZ rats, mechanically evoked responses of dorsal horn neurones had returned to a similar level to those in the vehicle treated HFD/STZ rats (Figure 4.3B).
Figure 4.3 (A) Mechanically-evoked responses of WDR dorsal horn neurones in the HFD/STZ model of diabetes (n=6), compared to lean/Veh controls (n=6) and HFD/Veh controls (n=6). All data represent mean frequency of firing ± SEM, analysis was by a Kruskal-Wallis test.

(B) Effects of daily pioglitazone treatment (10 mgkg⁻¹, p.o., day 21-49) on mechanically-evoked responses of spinal neurones in HFD/STZ rats at day 49 (n=6 for both groups) and day 78 (n=5 for HFD/STZ, n=6 for HFD/STZ + pioglitazone). Data are mean neuronal firing in HFD/STZ + pioglitazone rats expressed as a % of evoked responses in HFD/STZ + vehicle rats. Analysis of original data, comparing HFD/STZ + vehicle and HFD/STZ + pioglitazone rats, was by a Mann-Whitney test: * p<0.05, ** p<0.01
4.3.3. Effects of pioglitazone on metabolic parameters

As described previously, induction of the HFD/STZ model leads to a threefold increase in plasma glucose levels (p<0.01; Figure 4.4A), and a six-fold decrease in plasma insulin levels (p<0.001; Figure 4.4B), compared to HFD/Veh controls. An increase in insulin levels can also be seen in the HFD/Veh group compared to the lean/Veh controls, as discussed in Chapter 3. Body weight gain was again stunted in the HFD/STZ rats (p<0.001), water intake was increased four-fold (p<0.001), and food intake was increased in all groups eating the HFD, although this was not significantly different between groups (data not shown). Systemic administration of pioglitazone from day 21 to 49 did not alter any of these parameters.

**Figure 4.4** Effects of daily pioglitazone treatment (10 mg kg\(^{-1}\), p.o., day 21-49) versus vehicle on (A) fasting plasma glucose and (B) fasting plasma insulin. Day 18 is pre-pioglitazone administration, day 46 is after 25 days of pioglitazone and day 74 is 25 days after pioglitazone administration had ceased. Day 18 and 46: n=12 for all, except n=11 for HFD/STZ + vehicle. Day 74: n=6 for all, except n=5 for HFD/STZ + vehicle. All data represent mean ± SEM, analysis was by a Kruskal-Wallis test with Dunn’s post-hoc test: (* vs. HFD/Veh)

* p<0.05, ** p<0.01, *** p<0.001
4.3.4. Effects of pioglitazone on mechanical withdrawal thresholds

The mechanical withdrawal thresholds of the HFD/STZ group were significantly reduced compared to HFD/Veh controls from day 14 post-STZ injection, and the mean threshold decreased further up to day 70 (Figure 4.5). At day 49, when the first cohort was taken out for electrophysiological experiments, the mean mechanical withdrawal threshold of the HFD/STZ group was 8.7±1.2g, in comparison to 14.0±0.6g for the lean/Veh controls and 13.8±0.6g for the HFD/Veh controls. At day 70, just before the second set of electrophysiological experiments was performed, the mean mechanical withdrawal threshold of the HFD/STZ group was 7.0±1.2g, in comparison to 13.8±0.8g for the lean/Veh controls and 14.0±1.0g for the HFD/Veh controls.

Rats were dosed with 10mgkg⁻¹ pioglitazone, or 1% methylcellulose vehicle, from day 21-49. Although there appears to be a separation between the decline in mechanical withdrawal thresholds in the HFD/STZ pioglitazone treated group compared to the HFD/STZ control group, there were no significant differences between the two groups over the period of treatment, and an area under the curve (AUC) analysis also revealed no significant difference (Figure 4.5). At the end of dosing with pioglitazone, day 49, the mean mechanical withdrawal threshold for this group was 10.8±1.1g compared to 8.7±1.2g in the HFD/STZ vehicle treated group.
**Figure 4.5** Effects of daily pioglitazone treatment (10 mg kg⁻¹, p.o., day 21-49) versus vehicle on hindpaw mechanical withdrawal thresholds. Up to day 49: n=11 for lean/Veh and HFD/Veh, and n=10 for HFD/STZ + vehicle and HFD/STZ + pioglitazone. Day 49 onwards: n=6 for lean/Veh and HFD/Veh, and n=5 for HFD/STZ + vehicle and HFD/STZ + pioglitazone. All data represent mean ± SEM, analysis was by a Kruskal-Wallis test with Dunn’s post-hoc test: (*) vs. HFD/Veh)

* p<0.05, ** p<0.01, *** p<0.001
4.4. Discussion

In the present study, I have demonstrated that the HFD/STZ model of diabetes, which is associated with mechanical hypersensitivity, is also associated with a trend towards a decrease in mechanically evoked responses of spinal neurones. This model was not associated with any changes in the threshold for electrical activation of C-fibres, nor any significant changes to electrically evoked responses. Although a trend towards a decrease in the electrical evoked Aβ-fibre activity of neurones was evident, significance wasn’t reached. There was no change in spontaneous firing of neurones between any groups.

Pioglitazone treatment from day 21 to 49 did not significantly alter the progression of mechanical hypersensitivity in the HFD/STZ rats. However, electrophysiological studies revealed that the pioglitazone treatment was associated with a significant increase in the magnitude of the mechanically-evoked responses of WDR dorsal horn neurones in the HFD/STZ rats which received pioglitazone, compared to vehicle treatment. This effect was significant immediately following pioglitazone treatment but was not maintained and evoked responses returned to levels similar to that in the untreated HFD/STZ group 4 weeks after pioglitazone treatment had ceased.

4.4.1. Effects of the HFD/STZ model on electrophysiological parameters

Previous studies have investigated the involvement of Aβ-, Aδ- and C-fibres, as well as higher order neurones in diabetic neuropathy, and how these might contribute to the painful symptoms experienced. Hyper-responsiveness, a decrease in mechanical thresholds and an increase in spontaneous activity and wind-up in both primary afferent fibres, as well as higher order neurones has been shown in the STZ model (Ahlgren et al., 1994; Ahlgren et al., 1992; Chen et al., 2002a;
Chen et al., 2003; Chen et al., 2001; Fischer et al., 2009; Khan et al., 2002; Kimura et al., 2005; Suzuki et al., 2002).

This increase in activity has been postulated to be due to sensitisation of the central nervous system due to the aberrant activity in afferent nerves (Kamiya et al., 2005a), and impairments to descending pain modulation (Morgado et al., 2011b). The increased levels of GABA in the STZ model (Malmberg et al., 2006; Morgado et al., 2008) have been shown to have an excitatory rather than an inhibitory effect due to a decrease in the expression of KCC2 (Jolivalt et al., 2008; Morgado et al., 2008), resulting in enhanced activity of spinal neurones, and therefore increased facilitation.

The affect of the STZ model on neurones in the dorsal horn of the spinal cord has previously been examined with contrasting findings. An increase in spontaneous activity, enlarged receptive fields and increased peripherally evoked responses to brush, press, pinch and von Frey stimuli have been observed (Chen et al., 2002a; Ghorbani et al., 2011; Tan et al., 2012). Pertovaara et al. (2001) also found an increase in spontaneous activity, but no change in noxious heat-evoked responses, after discharges, or receptive field size, and a decrease in the responses evoked by mechanical stimulation in STZ treated rats. In the present study, a trend towards lower firing frequencies in response to mechanical stimulation was observed in the HFD/STZ group. A decrease in the evoked neuronal response to mechanical stimulation has also been seen in other models; SNL (Chapman et al., 1998), spinal cord injury (Hao et al., 2004) and cisplatin-induced chemoneuropathy (Cata et al., 2008). However, this mismatch between the mechanical hypersensitivity observed in the HFD/STZ model, and the lowered mechanically evoked responses in this electrophysiology study, which would normally infer sensory deficits, is difficult to explain. Cata et al. (2008) hypothesised that the rats might be experiencing paresthesias such as tingling and numbness, which are routinely observed in humans with diabetic neuropathy (Ziegler, 2008). It was
proposed that these symptoms might result in enhanced vigilance of the rats to von Frey stimulation, rather than them actively becoming more sensitive to lower-threshold stimuli. The processing of pain in neuropathic conditions is very complex, and so there may be a variety of other mechanisms which that are responsible for the hypersensitivity that is observed in this model.

While the observed decrease in evoked responses to mechanical stimulation reported herein is consistent with previous studies, the majority of earlier reports have found an increase in spontaneous activity, both in the diabetic model (Pertovaara et al., 2001; Tan et al., 2012), and in a variety of other models of neuropathic pain (Cata et al., 2008; Chapman et al., 1998; Laird et al., 1993; Palecek et al., 1992). The basis for these differences is unclear, but may relate to the criteria used when searching for neurones. During this process, the neurone had to display three characteristics before it was taken further. It needed to; be responsive to both brush and pinch stimuli; have a graded response to stimulation with von Frey hairs; and display wind-up in response to a train of electrical stimuli. Neurones which displayed a large amount of spontaneous activity may have been disregarded due to the difficulty in making the assessment of these three characteristics. As the main purpose of this study was to determine whether HFD/STZ influenced mechanically-evoked responses, and to compare this to the changes seen in the behavioural experiments, this search criteria was necessary. Therefore it is possible that any increase in spontaneous firing that might have been seen in the HFD/STZ model was lost through the process of selecting neurones to follow, and so in a future study, it would be of great interest to conduct a similar experiment, but to be more inclusive of which neurones were followed, to allow any changes that might have been lost in the present study to be seen.
4.4.2. Metabolic effects of pioglitazone in the HFD/STZ model

The lack of effect of pioglitazone on glucose or insulin levels is in agreement with previous similar studies in STZ treated rats (Majithiya et al., 2005; Wiggin et al., 2008; Yamagishi et al., 2008). In type 2 diabetes, pioglitazone acts as an insulin sensitiser in peripheral tissues, as well as improving β-cell function (Kawasaki et al., 2005; Miyazaki et al., 2001). However, in this model, a large proportion of the β-cells are destroyed by the STZ, and fasting plasma insulin levels are six-fold lower than in the HFD/Veh controls. This means that the rats are insulin-deficient, rather than insulin-resistant, and so improving the peripheral insulin sensitivity is ineffective due to the low levels of circulating insulin. As the insulin levels were also unchanged, this indicates that the β-cells are probably working at full capacity, and pioglitazone was therefore unable to stimulate more β-cell insulin secretion. Previously, Srinivasan et al. (2005) gave 10mgkg\(^{-1}\) of pioglitazone for 7 days to HFD/STZ rats, who had received either 35, 45 or 55mgkg\(^{-1}\) of STZ. In the rats which received the lowest dose of STZ, plasma insulin levels were only reduced to a level seen in rats fed a normal diet, and in these rats, pioglitazone was able to produce a significant reduction in plasma glucose levels. In the rats that had been given a higher dose of STZ (45 or 55mgkg\(^{-1}\)), there was a much greater reduction in insulin levels, and pioglitazone was then ineffective at reducing plasma glucose. This suggests that pioglitazone is most effective when it is able to improve whole body insulin sensitivity by decreasing lipolysis and enhancing insulin-mediated glucose disposal in skeletal muscle (Kahn et al., 2000). However, when insulin levels are reduced beyond a certain level, such as in the current study, pioglitazone is unable to affect levels of glucose or insulin.
4.4.3. Effects of pioglitazone on pain behaviour and neuronal responses in the HFD/STZ model

In the current study, administration of 10mgkg\(^{-1}\) pioglitazone three weeks after injection with STZ had no significant effect on the development of mechanical hypersensitivity, compared to the vehicle controls. The rationale behind administering the drug at this timepoint was that I wanted to model the clinical situation, where the drug would be administered once painful symptoms had first appeared. On the basis of the recent publication by Morgenweck et al. (2013), a higher dose of pioglitazone may be required to produce an analgesic effect once the model is established.

Interestingly, despite the lack of effect on pain behaviour, in my electrophysiological experiments pioglitazone produced a significant increase in evoked neuronal responses in the HFD/STZ rats, with this effect not maintained 4 weeks after cessation of pioglitazone treatment. Pioglitazone treatment effectively restored mechanically evoked responses of spinal neurones in HFD/STZ rats to levels higher than lean/Veh controls. Given that this effect was not associated with a change in mechanical hypersensitivity, the biological relevance of this finding is unclear.

Pioglitazone, and other thiazolidinediones, have been shown to be effective at alleviating mechanical hypersensitivity in a variety of models: carrageenan (Cuzzocrea et al., 2004; Morgenweck et al., 2010; Taylor et al., 2002), post-incisional pain (Hasegawa-Moriyama et al., 2012), spinal cord injury (Park et al., 2007), spinal nerve transection (Jia et al., 2013; Jia et al., 2010), partial sciatic nerve ligation (Iwai et al., 2008; Maeda et al., 2008; Takahashi et al., 2011), tibial and sural nerve transection (Jain et al., 2009), and spared nerve injury (Churi et al., 2008; Morgenweck et al., 2013). Since the levels of glucose and insulin are not altered in these models, TZDs must have an analgesic effect that is not just due to insulin sensitisation.
Indeed, TZDs have marked effects on macrophage recruitment and activation state, and this has profound anti-inflammatory effects in models of inflammatory pain (Hasegawa-Moriyama et al., 2012; Taylor et al., 2002).

TZDs’ analgesic effects in neuropathic pain models also seem to be predominantly mediated by an anti-inflammatory effect. TZDs are able to: decrease astrogliosis and microglial activation (Iwai et al., 2008; Morgenweck et al., 2013; Park et al., 2007), inhibit the activation of NFκB (Costa et al., 2008; Jia et al., 2013; Jia et al., 2010), decrease the expression of various pro-inflammatory factors, such as TNFα and IL-1β (Costa et al., 2008; Jia et al., 2013; Jia et al., 2010; Park et al., 2007; Qiang et al., 1998), increase the expression of anti-oxidant enzymes (Park et al., 2007), and attenuate the decrease in reduced glutathione, and the increase in myeloperoxidase activity (a specific marker of inflammation) (Jain et al., 2009). The decrease in the production of pro-inflammatory cytokines may be partly responsible for the suppression of glial activation. TZDs have also been shown to reduce oxidative stress in the STZ model (Majithiya et al., 2005), perhaps by activating genes with oxidoreductase activity (Wiggin et al., 2008). This ability of pioglitazone to decrease pro-inflammatory cytokines could play an important role in diabetic neuropathy, as levels of NFκB and pro-inflammatory cytokines are increased in both diabetic animals and patients (as reviewed in Wilson et al., 2012a).

Therefore, from all the accumulating evidence as to the effects of pioglitazone in models of pain, it would seem logical that pioglitazone might have had an analgesic effect in the HFD/STZ model. However, many of these studies have shown that the TZDs are most effective when given at the time of injury. Indeed TZD treatment at day 26-28 after PNL is far less effective than when given at days 1-3 (Takahashi et al., 2011). This group hypothesised that rosiglitazone may only be effective if given in the initial phase before macrophages are activated and recruited to the site of injury, where they exacerbate acute
inflammation. As pioglitazone was not seen to be effective in alleviating neuropathic pain in this study, experiments in the final chapter go on to investigate other antidiabetics, and other types of analgesics.
Chapter 5.

Comparison of analgesic versus antidiabetic interventions on aberrant pain responses in the HFD/STZ model
5.1. **Introduction**

Having established that the HFD/STZ model leads to development of mechanical hypersensitivity, and having investigated some of the mechanisms underlying these responses, the next series of experiments investigated the effects of different types of interventions, analgesic versus antidiabetic, on aberrant pain responses in this model.

5.1.1. **Existing and novel analgesics for diabetic neuropathy**

It is generally understood that one of the most important factors in the treatment of diabetic neuropathy is for diabetic patients to maintain tight control of their blood glucose concentration. Maintaining these levels with intensive insulin therapy has been shown to delay, or prevent the development of diabetic neuropathy, especially in type 1 diabetes (DCCT 1995; for review see Callaghan *et al.*, 2012; Gaede *et al.*, 1999), and this effect can still be seen over 10 years later (Albers *et al.*, 2010).

Alternatively, inhibiting the pain responses directly can ameliorate the painful symptoms (Ziegler, 2008). Neuropathic pain, however, has proved difficult to treat, with little efficacy seen from conventional analgesics such as non-steroidal anti-inflammatory drugs and opiates, the latter of which has a number of side effects including nausea, constipation and sedation, and can also be addictive, with tolerance developing with prolonged usage (Benyamin *et al.*, 2008).

There are a variety of drugs that can be prescribed to offer pain relief to diabetic patients. NICE guidelines recommend duloxetine as the first line treatment, followed by either amitriptyline or pregabalin (NICE, 2010), and the FDA has also approved tapentadol (FDA, 2004). A recent in-depth review of the literature recommended pregabalin as the first choice (Bril *et al.*, 2011).
5.1.1.1. Pregabalin

Both gabapentin and pregabalin are licensed for treatment of DPNP, with pregabalin being the gold-standard (Bril et al., 2011). Both drugs alleviate painful symptoms, as well as improving quality of life and sleep problems. They are, however, associated with side effects such as dizziness and somnolence (Freeman et al., 2008; Freynhagen et al., 2005; Quilici et al., 2009; Stacey et al., 2008). Gabapentin and pregabalin are derivatives of the neurotransmitter GABA (but do not interact with the GABA receptor itself) (Lanneau et al., 2001). They bind to the $\alpha_2\delta$-1 auxiliary subunits of presynaptic voltage-gated calcium channels (Field et al., 2006; Gee et al., 1996), with pregabalin having a six-fold higher binding affinity than gabapentin at the $\alpha_2\delta$-1 subunit (Vinik et al., 2013).

The $\alpha_2\delta$ subunit enhances trafficking of $\mathrm{Ca}_{\alpha_1}$ to the plasma membrane, increasing the number of functional channels present, which results in an increase in $\mathrm{Ca}^{2+}$ currents (Davies et al., 2007). The gabapentinoids bind to $\alpha_2\delta$-1, and it has been postulated that their mechanism of action is to displace an endogenous protein ligand that normally acts as a positive modulator of $\alpha_2\delta$-1, impairing its ability to traffic the calcium channel from DRG cell bodies to the plasma membrane of presynaptic terminals in the dorsal horn (Bauer et al., 2009; Hendrich et al., 2008). The consequence of this is less calcium entry into the nociceptive primary afferent fibres via this channel, which is located on these fibres, resulting in a reduction in transmitter release from the primary afferent terminals in the dorsal horn (Taylor, 2004; Taylor, 2009), and decreased activation of dorsal horn neurones in the spinal cord.

Importantly, $\alpha_2\delta$-1 subunit expression has been shown to be up-regulated in the DRGs (Martinez et al., 2012; Yusaf et al., 2001) and dorsal horn of the spinal cord in STZ diabetic rats (Luo et al., 2002). Electron microscopy and quantitative RT-PCR studies have provided
evidence that the elevation in α2δ-1 in the SNL model of neuropathic pain occurs exclusively on the presynaptic terminals of primary sensory afferents (Bauer et al., 2009). Over-expression of the α2δ-1 subunit in mice results in the manifestation of mechanical hypersensitivity and thermal hyperalgesia (Li et al., 2006), illustrating a fundamental role of this channel in influencing nociceptive thresholds.

Both gabapentin and pregabalin attenuate mechanical hypersensitivity in the STZ model of diabetes (Field et al., 1999b; Martinez et al., 2012; Wodarski et al., 2009; Yamamoto et al., 2009; Zhang et al., 2013). In addition, gabapentin also suppressed the flinching response during the formalin test in diabetic rats (Ceseña et al., 1999). Pregabalin led to a decrease in the calcium channels expressing α2δ-1 in the dorsal horn in diabetic rats (Martinez et al., 2012), and gabapentin has been shown to significantly reduce enhanced excitability by decreasing the rise in expression of Naᵥ1.7 and p-ERK1/2 in STZ rats (Zhang et al., 2013).

\[\text{5.1.1.2. Cannabinoid ligands}\]

Another target showing promise in its ability to alleviate pain associated with diabetic neuropathy is the endocannabinoid system. Endocannabinoids exert their effects through two GPCRs; CB₁ and CB₂ (cannabinoid receptors 1 and 2). CB₁ receptors are located in the periphery, but are found most abundantly in the CNS, including the spinal cord, PAG and thalamus (Tsou et al., 1998). CB₂ receptors are primarily expressed by immune cells in the periphery with high concentrations in the spleen (Munro et al., 1993), but are also expressed by microglia in the CNS (Romero-Sandoval et al., 2008b) and neurones in the brain (Gong et al., 2006; Van Sickle et al., 2005). These receptors can be activated by cannabinoids such as Δ⁹-tetrahydrocannabinol (THC) and cannabidiol, and also by endogenous cannabinoids (endocannabinoids) such as anandamide (AEA) and 2-arachidonoylglycerol (2-AG), which are synthesised and released on demand (Booker et al., 2012), and rapidly broken down by the enzymes...
fatty acid amide hydrolase (FAAH) and monoacylglycerol lipase (MAGL) respectively (for review see Muccioli, 2010). Figure 5.1 summaries the breakdown of these endocannabinoids, and the receptors that they are ligands for.

The effects of cannabinoids on pain responses in models of diabetes have been fairly widely studied. Systemic administration of WIN55212-2 (a mixed CB\textsubscript{1} and CB\textsubscript{2} receptor agonist) attenuated mechanical hypersensitivity in STZ mice (Dogrul et al., 2004; Toth et al., 2010), STZ rats (Ulugol et al., 2004; Vera et al., 2012) and ZDF rats (Vera et al., 2012). Cannabidiol, which has a multitude of low potency targets including receptors CB\textsubscript{1} and CB\textsubscript{2}, and inhibition of FAAH (Pertwee, 2004), was effective at preventing the development of mechanical hypersensitivity and thermal hyperalgesia in STZ mice when administered at the onset of diabetes, and for a further 2 months after discontinuation of the drug, although it was without effect when administered therapeutically once mechanical hypersensitivity was established (Toth et al., 2010). In a more complicated behavioural assay, diabetic rats exhibited increased flinching behaviour compared to normoglycemic rats in the formalin test, and peripheral AM404 (an AEA reuptake inhibitor), AEA itself, and ACEA (a CB\textsubscript{1} receptor agonist) all attenuated flinching behaviour during the first and second phase of the formalin test in the diabetic rats (Schreiber et al., 2012). Systemic administration of a cannabis extract decreased mechanical hypersensitivity, protected against oxidative stress (as evidenced by increased glutathione levels and decreased liver lipid peroxidation) and restored NGF levels in the sciatic nerve in the STZ model (Comelli et al., 2009). Another study reported that the CB\textsubscript{1} receptor antagonist rimonabant was also able to attenuate mechanical hypersensitivity in diabetic mice (Comelli et al., 2010).
Figure 5.1. The key features of the endocannabinoid receptors and their breakdown. Both AEA and 2-AG can also be metabolised to form biologically activated metabolites. AA - arachidonic acid. Adapted from (Sagar et al., 2009).
5.1.1.2.1. MAGL inhibitors

2-AG, is formed from DAG and phospholipase-C (Horváth et al., 2012), and activates both CB₁ and CB₂ receptors, but binds with highest affinity to the CB₂ receptor (Mechoulam et al., 1995). MAGL is one of the key enzymes responsible for its hydrolysis, and breaks 2-AG down to fatty acid and glycerol (Dinh et al., 2002).

JZL184 is a selective, irreversible inhibitor of MAGL, effective at alleviating mechanical and cold allodynia in the neuropathic CCI mouse model (Schlosburg et al., 2010). This effect was not seen in CB₁ receptor knock-out mice, but was present in CB₂ receptor knock-out mice (Kinsey et al., 2010), suggesting a CB₁ receptor-selective mechanism of action is responsible for the inhibitory effects mediated by increased 2-AG. Interestingly, the ameliorative effect of FAAH inhibition on mechanical hypersensitivity was not present in either CB₁ or CB₂ receptor knockouts, suggesting that both receptors are required for the action of anandamide (see 5.1.2.2 for more on FAAH inhibition). This hypothesis was confirmed in a later study which demonstrated that the analgesic effects of JZL184 in the CCI mouse model were only blocked by a CB₁ receptor antagonist (Kinsey et al., 2009).

An issue facing the use of JZL184 is that repeated administration of a high dose (40 mg/kg, i.p) caused tolerance, with mice showing similar responses to those of vehicle-treated mice in pain assays (Schlosburg et al., 2010). However recent studies, using lower doses, have shown that repeated administration of JZL184 is effective at alleviating mechanical hypersensitivity in the carrageenan model, with only repeated high doses leading to tolerance (Ghosh et al., 2013). This was substantiated with the demonstration that low doses of JZL184 increased levels of 2-AG in the brain, and decreased cold and mechanical hypersensitivity, with no tolerance developing with repeated dosing, an effect not seen with higher doses (Kinsey et al., 2013).
Another problem with JZL184 is that it displays a 10-fold lower potency in the rat (Long et al., 2009a). However a new compound, MJN110, has been developed that displays high selectivity for MAGL (IC$_{50}$ in rats <100nm, whereas the IC$_{50}$ for FAAH >10μM), and has a similar potency in both rat and mouse (Niphakis et al., 2013), and so may be able to play a role in alleviating mechanical hypersensitivity in the HFD/STZ model.

5.1.1.2.2. FAAH inhibitors

FAAH is a membrane-bound serine hydrolase enzyme that breaks down fatty-acid ethanolamides (FAEs) such as AEA, N-palmitoylethanolamine (PEA) and oleoylethanolamide (OEA) (Cravatt et al., 1996). AEA is broken down to arachidonic acid and ethanolamine (Devane et al., 1992). It binds with a four-fold higher affinity to the CB$_1$ receptor than the CB$_2$ receptor (Pertwee et al., 1995), and is also an agonist at TRPV1 (Tognetto et al., 2001).

AEA was shown to have analgesic effects in models of inflammatory pain (Calignano et al., 1998). PEA, which acts as a PPARα ligand, has also been shown to have both analgesic and anti-inflammatory effects (Calignano et al., 1998; Conti et al., 2002; Jaggar et al., 1998; LoVerme et al., 2006), as well as having an antinociceptive effect in the CCI model (Costa et al., 2008).

The importance of FAAH has been demonstrated in knock-out mice (FAAH $^{-/}$), which show a 15-fold increase in brain levels of AEA, and also exhibit reduced thermal and chemical pain sensation, which can be reversed by a CB$_1$ receptor antagonist (Cravatt et al., 2001). Inhibitors of FAAH have been developed, such as URB597 (cyclohexyl carbamic acid 3’-carbamoyl-biphenyl-3-yl ester), which is a rapidly binding irreversible FAAH inhibitor, with no activity at cannabinoid receptors or MAGL (IC$_{50}$ in rats = 5nm for FAAH, >10μM for MAGL) (Piomelli et al., 2006). Systemic administration of URB597 leads to profound inhibition of FAAH in the brain resulting in an increased accumulation of AEA in
the brain and spinal cord (Fegley et al., 2005; Russo et al., 2007). When administered to FAAH−/− mice, the already increased levels of FAEs were not elevated further (Fegley et al., 2005).

Repeated administration of URB597 causes a significant reduction in mechanical hypersensitivity and thermal hyperalgesia in the CCI model, and these effects were completely blocked by both CB1 and CB2 receptor antagonists (Kinsey et al., 2009; Russo et al., 2007). URB597 has antinociceptive efficacy in a variety of other models of pain, such as; the monosodium iodoacetate model of arthritis, and in Dunkin-Hartley guinea pigs where arthritis naturally occurs (Schuelert et al., 2011); a model of cholestasis (Hasanein et al., 2008); and the inflammatory carrageenan model (Okine et al., 2012), where it blocked the expansion of the peripheral receptive field of WDR neurones in the spinal cord (Sagar et al., 2008). URB597 has been shown to suppress the mechanically evoked responses of WDR neurones in sham-operated rats, but had no effect on these responses in the carrageenan (Sagar et al., 2008) or the SNL model (Jhaveri et al., 2006). Finally, it was also effective in alleviating mechanical hypersensitivity and thermal hyperalgesia in the complete Freund’s adjuvant model (Jayamanne et al., 2006), but conversely it had no effect in the PNL model.

Other FAAH inhibitors that have also been shown to have analgesic effects include OL135, a selective, reversible inhibitor, which caused substantial reversal of mechanical hypersensitivity in the mild thermal injury and SNL model (Chang et al., 2006), as well as in the tail immersion, hot-plate and formalin tests, which were blocked by a CB1 receptor antagonist (Lichtman et al., 2004a). The effects of URB597 have also been investigated in the STZ model. URB597 produced an analgesic effect: lowering nociceptive scores in both phases of the formalin test, as well as increasing tail-flick latencies (Hasanein et al., 2009a). ST4070, another FAAH inhibitor, alleviated established mechanical hypersensitivity in a dose-dependent manner in the STZ model (Caprioli et al., 2012).
URB937, a peripherally restricted FAAH inhibitor, significantly reversed mechanical and thermal hyperalgesia in the carrageenan and SNL model, as well as the complete Freund's adjuvant model (Sasso et al., 2012). Finally, a dual FAAH/MAGL inhibitor, JZL195, which causes a 10-fold elevation in both AEA and 2-AG in the brain, has a greater antinociceptive effect in the tail-flick test, than either JZL184 or PF-3845 (a FAAH inhibitor) alone (Long et al., 2009b).

5.1.2. Antidiabetic drugs

5.1.2.1. Metformin

Metformin is an activator of AMPK, which can also be activated by low levels of cellular nutrients, or by other compounds such as AICAR or resveratrol. Its activation leads to the inhibition of mammalian target of rapamycin (mTOR) and ERK signalling (Tillu et al., 2012), which results in a decrease in signalling to the translational machinery (Zoncu et al., 2011), and decreased protein synthesis. The mTOR and ERK pathways (Ji et al., 2009) have been linked to pathology in several animal models of pain. Norsted-Gregory et al. (2010) demonstrated an increase in downstream targets of mTOR in the ipsilateral dorsal horn in the carrageenan model of inflammatory pain, suggesting an increase in mTOR related signalling.

Metformin is effective in alleviating mechanical hypersensitivity, inhibiting translation regulation pathways and decreasing sensory neuronal excitability (Melemedjian et al., 2011). In addition, resveratrol has been shown to reduce mechanical hypersensitivity in a model of post-surgery induced pain (Tillu et al., 2012), as well as the formalin model (Torres-Lopez et al., 2002), and the carrageenan model of inflammation (Gentilli et al., 2001). Another method of inhibiting one of the mTOR complexes, mTORC1 (mammalian target of rapamycin complex 1), is through use of rapamycin itself, which alleviated mechanical hypersensitivity when applied locally in both an
inflammatory model (Geranton et al., 2009) and a model of neuropathic pain (Jiménez-Díaz et al., 2008), emphasising the important role the mTOR pathway plays in nociceptor sensitivity. Intrathecal administration of rapamycin was also effective at alleviating tactile and thermal hyperalgesia in the carrageenan model (Norsted Gregory et al., 2010), and pain behaviour in the SNI (Geranton et al., 2009) and formalin model (Asante et al., 2010; Price et al., 2007).

Obara et al. (2011), used temsirolimus (CCI-779), a rapamycin derivative, and Torin1, an inhibitor of both mTORC1 and mTORC2, and found that they were both effective in alleviating mechanical and cold hypersensitivity in the neuropathic SNI model, and mechanical hypersensitivity in the carrageenan model. As mTOR is mainly expressed in myelinated A-fibres in the peripheral nerve and dorsal roots, they postulated that this effect was mediated through A-fibres, leading to a decreased input to the dorsal horn. This hypothesis is supported by the observation that the carrageenan-induced thermal hypersensitivity, which is associated with peripheral sensitisation of C-fibres, was not altered by CCI-779.

Collectively there is strong evidence that metformin, through its activation of AMPK, may be able to play a role in alleviating the painful systems of diabetic neuropathy. One of the aims of the present study was to evaluate the potential analgesic effects of metformin in the HFD/STZ model.

5.1.2.2. Linagliptin

Preliminary evidence so far suggests that DPP-4 inhibitors, such as linagliptin, may also be able to play a role in alleviating painful symptoms. Two studies have investigated the effect of DDP-4 inhibitors on thermal/mechanical thresholds in the STZ model; PKF275-055 reversed thermal hypoalgesia and mechanical hypersensitivity (Bianchi
et al., 2012), and alogliptin improved thermal nociception (Davidson et al., 2011a).

5.1.3. Aim of the Study

The aim of the first study was to investigate the ability of a new, more potent MAGL inhibitor, MJN110, to alter the already established mechanical hypersensitivity associated with the HFD/STZ model, as it has not yet been investigated in a neuropathic pain model. The inhibitory effects of this compound were compared to a well-studied FAAH inhibitor, URB597, as well as pregabalin, the gold standard treatment for DPNP, in the HFD/STZ model of diabetes. The aim of the second study was to determine whether two currently prescribed oral antidiabetics (metformin and linagliptin) are able to alter the manifestation of mechanical hypersensitivity in the HFD/STZ model.
5.2. Methods

For detailed methods of induction of diabetes, blood sampling and von Frey testing see Chapter 2.

5.2.1. Animals

All experiments were carried out in accordance with the UK Home Office Animals (Scientific Procedures) Act 1986. 78 male Sprague-Dawley rats (200-250g), obtained from Charles River (Kent, UK), were individually housed on a normal light cycle (lights on: 07:00 - 19:00) with free access to a high fat diet (60% fat by caloric content; D12492 diet; Research Diets, New Jersey, USA) and water at all times. Food and water intake, and body weight were monitored twice weekly. After three weeks consumption of the HFD, rats received either an i.p. injection of STZ (45mgkg⁻¹), or citric acid buffer.

As specified in Chapter 2, any HFD/STZ rat with a plasma glucose concentration of <15mM was to be excluded from the study, and two rats met this criteria in the present study and were excluded.

5.2.2. Administration of drugs

MJN110, URB597 and Pregabalin

The rats were divided into five stratified groups on the basis of body weight, blood glucose concentration and mechanical withdrawal thresholds. To assess the effect of systemic MJN110, URB597 and pregabalin on established pain behaviour, baseline von Frey testing was carried out 30 minutes before administration of the drug, and further testing was carried out at 1 hour and 3 hours after administration. MJN110 (5mgkg⁻¹) and URB597 (0.3mgkg⁻¹) were administered via i.p. injection, whereas pregabalin (10mgkg⁻¹) was administered orally, all at a volume of 1ml/kg. MJN110 and URB597 were dissolved in a vehicle of ethanol, Emulphor-620, and saline in a
ratio of 1:1:18, and pregabalin was dissolved in saline. Drug administration was carried out by two assistants to ensure that subsequent behaviour was assessed blind to treatment.

URB597 was given by i.p. injection in accordance with previous literature where it tends to be given via this route (or through local administration) (Hasanein et al., 2009b; Jayamanne et al., 2006; Kinsey et al., 2009; Okine et al., 2012), and MJN110 was therefore given via the same route, as has been shown to be effective in mice (Niphakis et al., 2013). There are numerous literature reports on the delivery of pregabalin, and in the majority it is given orally, and so the oral route was used in this study (Field et al., 1999b; Hahm et al., 2012; Miyazaki et al., 2012; Wodarski et al., 2009; Yamamoto et al., 2009).

Metformin and Linagliptin

HFD/STZ rats were divided into three stratified groups on the basis of body weight, blood glucose concentration and mechanical withdrawal thresholds. To assess the effect of systemic linagliptin (3mgkg⁻¹) and metformin (200mgkg⁻¹) on development of pain behaviour, animals were orally dosed daily with the drug, or saline vehicle, from day 4 until the conclusion of the study at day 40. All dosing was carried out blind to the treatment groups.

Both linagliptin and metformin were given orally in accordance with previous studies (Cheng et al., 2006; Kern et al., 2012; Kim et al., 2012a; Klein et al., 2012; Reed et al., 2000; Vickers et al., 2012). The dose of 3mgkg⁻¹ of linagliptin was used as this dose is reported to improve glucose control when given once daily in animal models of diabetes (Hocher et al., 2012), and it has been shown to significantly increase plasma GLP-1 in diet-induced obese rats and mice (Kern et al., 2012; Vickers et al., 2012), and to cause 67-80% DPP-4 inhibition (Kern et al., 2012).
5.2.3. Quantification of endocannabinoids in spinal cord using liquid chromatography/tandem mass spectrometry (LC-MS/MS)

LC-MS/MS analysis was carried out to look at the changes induced in endocannabinoid levels in the spinal cord by URB597 and MJN110, compared to the 1:1:18 vehicle. Analysis was carried out by Dr Sarir Samad. Spinal cords were removed and stored at -80°C before analysis, and the extraction was performed on ice. Samples were weighed and transferred to homogenisation tubes. Internal standards (100µl of 2-AG-d8 (10µM) and 15 µl of AEA-d8 (28 µM); Cambridge Biosciences, Cambridge, UK) were added to each sample, blank sample, and endocannabinoid standard (Cambridge Biosciences). 5ml of ethyl acetate:hexane (9:1 vol./vol.) was added to each sample and homogenised thoroughly, then 3ml of deionised distilled water was added and the samples were homogenised further. Samples were then centrifuged (13000rpm, 10mins, 4 °C). The supernatants were transferred to glass tubes, and the procedure was repeated two more times and the supernatants pooled and then evaporated in a centrifugal evaporator. Prior to analysis, each sample extract was reconstituted in 200µl of acetonitrile. The injection volume was 5µl. Reproducibility was checked by repeated injections (n=6) of a mixed standard (1µM).

The HPLC system used was an Agilent 1100 series (Agilent Technologies, Germany). The HPLC Column used was a BDS Hypersil C8 column with BDS Hypersil C8 precolumn (100 x 2.1mm, 3µm) with guard column. Mobile phase A was water + 1g/L ammonium acetate +0.1% formic acid +10% ACN and mobile phase B was acetonitrile + 1g/L ammonium acetate +0.1% formic acid +10% H2O. The starting flow rate was 300µL/min. The MS system used was a Micromass Quattro Ultima™ triple quadrupole mass spectrometer (Waters, Manchester, UK) equipped with an electro spray ionisation interface.
Quantification of the endocannabinoids was done using fully extracted calibration standards for each of the analytes. Quantification was performed using QuanLynx v4.1. Identification of each compound in plasma was confirmed by LC retention times of each standard and precursor and product ion m/z ratios. The peak area of each analyte was compared to a known amount of standard to determine the amount of target compound present. Measured concentrations of AEA, OEA, PEA and 2-AG in each sample were corrected for sample weight.

The standards used were:

**Arachidonyl ethanolamide** (N-(2-hydroxyethyl)-5Z,8Z,11Z,14Z-eicosatetraenamide, anandamide, AEA)

**2-arachidonyl glycerol** (2-AG, (5Z,8Z,11Z,14Z)-5,8,11,14-eicosatetraenoic acid, 2-hydroxy-1-(hydroxymethyl)ethyl ester)

**Palmitoyl ethanolamide** (PEA, N-(2-hydroxyethyl)-hexadecanamide)

**Oleoyl ethanolamide** (OEA, N-(2-hydroxyethyl)-9Z-octadecenamide)

**Arachidonyl ethanolamide-d8** (N-(2-Hydroxyethyl)-5Z,8Z,11Z,14Z-eicosatetraenamide-d8, AEA-d8)

**2-arachidonyl glycerol-d8** (2-AG-d8, (5Z,8Z,11Z,14Z)-5,8,11,14-Eicosatetraenoic acid-d8, 2-hydroxy-1-(hydroxymethyl)ethyl ester-d8)

### 5.2.4. Drugs

URB597 was purchased from Sigma Aldrich (Poole, UK), pregabalin was kindly provided by Pfizer (Cambridge, UK), and MJN110 was a kind gift from Micah Niphakis and Ben Cravatt (Scripps Research Institute, San Diego).

Metformin hydrochloride was purchased from Sigma Aldrich (Poole, UK), and linagliptin was a kind gift from Boehringer Ingelheim Pharmaceuticals (Ingelheim, Germany).
5.2.5. Statistics

MJN110, URB597 and Pregabalin
Analysis of plasma glucose was by a Repeated Measures ANOVA with Dunnett’s post-hoc test. Analysis of changes in mechanical withdrawal thresholds, and plasma insulin was by Friedman test with Dunn’s post-hoc test. Effects of drugs on mechanical withdrawal thresholds were analysed with a Kruskal-Wallis test with Dunn’s post-hoc test.

Two rats were excluded from this study as the STZ injection did not cause an increase in plasma glucose concentration and so they could not be considered diabetic.

Metformin and Linagliptin
Analysis of plasma glucose and insulin, and mechanical withdrawal thresholds was by a Kruskal-Wallis test with Dunn’s post-hoc test. Analysis of body weight, food intake and water intake was by an ANCOVA with Tukey’s post-hoc test, with the average of day -7 to 0 as the covariate. In all analyses, a p value of less than 0.05 was considered statistically significant.

Two rats were excluded from this study as the STZ injection did not cause an increase in plasma glucose concentration and so they could not be considered diabetic. Additional rats were excluded from analysis of pain behaviour if in the week before injection with STZ the average hindpaw mechanical withdrawal threshold was < 10g. In this study, this represented 10 rats – 1 HFD/Veh, 3 HFD/STZ + vehicle, 3 HFD/STZ + metformin and 3 HFD/STZ + linagliptin.
5.3. Results

5.3.1. Acute effects of MJN110, URB597 and Pregabalin on established mechanical hypersensitivity

As described previously, induction of the HFD/STZ model leads to a significant increase (p<0.001) in plasma glucose (Figure 5.2A), which is maintained throughout the study, and a significant decrease (p<0.001) in plasma insulin at day 3, which decreased further by day 31 (Figure 5.2B). In addition, rats had a lower body weight following the induction of diabetes compared to basal body weight, and significantly increased water consumption (p<0.001, data not shown).

By day 15 of the model, HFD/STZ rats exhibited lowered mechanical withdrawal thresholds to stimulation of the hindpaw (Figure 5.3A). At day 37 following model induction, the mechanical withdrawal threshold of the hindpaws was reduced to 6.7±0.6g, compared to basal values of 13.5±0.4g (p<0.001). Systemic administration of MJN110 (5mgkg⁻¹, i.p.), URB597 (0.3mgkg⁻¹, i.p.) and pregabalin (10mgkg⁻¹, p.o.) reversed this decrease in mechanical withdrawal thresholds compared to the effects of vehicle treatment (Figure 5.3B). The effects of MJN110 and URB597 followed a similar pattern: an increase in the mechanical withdrawal thresholds was seen at 1 hour after administration of the drug, and this effect was further increased at 3 hours, although only the effects of MJN110 were significant. Pregabalin, however, had a maximal inhibitory effect at 1 hour post-administration, which was maintained, but not further increased at 3 hours post-administration.
Figure 5.2 Fasting plasma (A) glucose and (B) insulin in HFD/STZ rats (n=36). All data represent mean ± SEM, analysis of glucose was by a Repeated Measures ANOVA with Dunnett’s Multiple Comparison post-hoc test, and analysis of plasma insulin was by a Friedman test with Dunn’s post-hoc test:

*** p<0.001, compared to baseline (day -5).
Figure 5.3 (A) Mechanical withdrawal thresholds of the hindpaw in HFD/STZ rats (n=36). All data represent mean ± SEM, analysis was by a Friedman test with Dunn’s post-hoc test: ** p<0.01, *** p<0.001, compared to baseline (day -2). (B) Effects of MJN110 (5mg/kg, i.p., n=8), URB597 (0.3mg/kg, i.p., n=8) and pregabalin (10mg/kg, p.o., n=9) on mechanical withdrawal thresholds in HFD/STZ rats (at day 37 post model induction) at 1 and 3 hours following drug administration. All data represent mechanical withdrawal thresholds expressed as a percentage of baseline values ± SEM, analysis was by a Kruskal-Wallis test with Dunn’s post-hoc test: * p<0.05, ** p<0.01
5.3.2. Acute effects of MNJ110 and URB597 on endocannabinoid levels in spinal cord and brain

URB597 caused a significant increase in PEA and OEA levels in the spinal cord in comparison with the 1:1:18 vehicle (p<0.05), and there was also a trend towards an increase in the level of AEA (Figure 5.4A-C). The same pattern is seen in the mid-brain where it caused a significant increase in all three FAEs (Figure 5.5A-C; p<0.01). This indicates that URB597 was able to block FAAH, the enzyme responsible for degrading PEA, OEA and AEA, resulting in an increase in the levels of these endocannabinoids in both the brain and the spinal cord. MJN110, however, did not cause a significant increase in 2-AG in the spinal cord (Figure 5.4D), but a significant increase was seen in the mid-brain (Figure 5.5D; p<0.05). This suggests that MJN110 was able to block MAGL, the enzyme responsible for breaking down 2-AG, resulting in an increase in the level of this endocannabinoid in the mid-brain.
Figure 5.4 Effects of MJN110 (5mgkg⁻¹, i.p., n=8), URB597 (0.3mgkg⁻¹, i.p., n=8) and 1:1:18 vehicle (n=5) on levels of (A) AEA (B) PEA (C) OEA and (D) 2-AG in the spinal cord of HFD/STZ rats (at day 37 post model induction), approximately 4 hours after drug administration. All data represent mean ± SEM, analysis was by a 1-way ANOVA with Tukey’s post-hoc test: * p<0.05
Figure 5.5 Effects of MJN110 (5mgkg\(^{-1}\), i.p., n=8), URB597 (0.3mgkg\(^{-1}\), i.p., n=8) and 1:1:18 vehicle (n=5) on levels of (A) AEA (B) PEA (C) OEA and (D) 2-AG in the mid-brain of HFD/STZ rats (at day 37 post model induction), approximately 4 hours after drug administration. All data represent mean ± SEM, analysis was by a 1-way ANOVA with Tukey’s post-hoc test:

* p<0.05, ** p<0.01, *** p<0.001
5.3.3. Effects of Metformin and Linagliptin on metabolic parameters

As previously described there was a threefold increase in plasma glucose in all three HFD/STZ groups, in comparison to the HFD/Veh group (Figure 5.6A). Neither linagliptin (3mgkg\(^{-1}\)) nor metformin (200mgkg\(^{-1}\)) altered plasma glucose in HFD/STZ rats. The threefold decrease in plasma insulin in all the HFD/STZ rats, compared with the HFD/Veh group, was also not attenuated by linagliptin or metformin treatment (Figure 5.6B).

The growth rate of the HFD/STZ rats was severely stunted in comparison to the HFD/Veh animals (Figure 5.7A), with no effect of intervention with linagliptin or metformin. There was no significant change in food intake in the HFD/STZ rats compared to HFD/Veh controls, and this was also not altered by either antidiabetic drug (Figure 5.7B). Finally, the water intake in the HFD/STZ rats was significantly increased compared to the HFD/Veh rats (Figure 5.7C), with no effect of treatment except for around day 31 when the water intake was significantly higher in the linagliptin group, in comparison to the metformin group (p<0.05).
Figure 5.6 Effects of linagliptin (3mgkg\(^{-1}\), p.o.; n=10) and metformin (200mgkg\(^{-1}\), p.o.; n=9), given daily from day 4 onwards, on (A) fasting plasma glucose and (B) fasting plasma insulin, in comparison with vehicle treated HFD/Veh (n=9) and HFD/STZ (n=11) rats. All data represent mean ± SEM, analysis was by a Kruskal-Wallis test with Dunn’s post-hoc test: * p<0.05, ** p<0.01, *** p<0.001
Figure 5.7 Effect of linagliptin (3mgkg$^{-1}$, p.o.; n=10) and metformin (200mgkg$^{-1}$, p.o.; n=9) on (A) body weight, (B) water intake, and (C) food intake, in comparison with vehicle treated HFD/Veh (n=9) and HFD/STZ (n=11) rats. All data represent mean ± SEM, analysis was by an ANCOVA (with the average of day -7 to 0 as a covariate) with Tukey's post-hoc test: # p<0.05.

In comparison to HFD/Veh controls, body weight and water intake, p<0.001 from day 3 for all HFD/STZ rats.
5.3.4. Effects of Metformin and Linagliptin on the development of mechanical hypersensitivity

Consistent with my earlier studies, HFD/STZ caused a decrease in mechanical withdrawal thresholds compared to HFD/Veh rats, which became significant at day 21 (Figure 5.8). Both linagliptin and metformin (treatment from day 4) prevented the decrease in mechanical withdrawal thresholds in HFD/STZ rats. The withdrawal thresholds of these rats were not significantly different from the HFD/Veh rats at any timepoint, but were significantly different from the vehicle treated HFD/STZ rats from day 24, with this significance increasing as the study progressed.

Figure 5.8 Effects of linagliptin (3mgkg$^{-1}$, p.o.; n=7) and metformin (200mgkg$^{-1}$, p.o.; n=6) on mechanical withdrawal thresholds of the hindpaws, in comparison with vehicle treated HFD/Veh (n=8) and HFD/STZ (n=8) rats. All data represent mean ± SEM, analysis was by a Kruskal-Wallis test with Dunn’s post-hoc test:
* p<0.05, ** p<0.01, in comparison with HFD/Veh + Vehicle
# p<0.05, ## p<0.01, in comparison with HFD/STZ + Vehicle
5.4. **Discussion**

One of the problems facing patients with diabetic neuropathy today is the lack of medication that is effective at alleviating the neuropathic pain that can accompany this disease. One of the key objectives is therefore to develop new drugs, or to find alternative uses of current drugs, that are able to provide symptomatic relief of pain. In the present study it was demonstrated that MJN110, a novel MAGL inhibitor, was as effective as pregabalin at alleviating established mechanical hypersensitivity in the HFD/STZ model, highlighting a possible role of endocannabinoids in providing pain relief in diabetes. It was also demonstrated that two antidiabetic drugs, metformin and linagliptin, showed promise in preventing the development of mechanical hypersensitivity in this model when administered early on. It is worth investigating these findings further as both of these drugs are already licensed and have undergone all necessary safety testing, and so they could rapidly be put to use if effective.

5.4.1. **Cannabinoids in the HFD/STZ model**

The first study investigated the effects of two modulators of the endocannabinoids: MJN110 – a novel MAGL inhibitor, and URB597 – a FAAH inhibitor, in the HFD/STZ model of diabetes, and compared their effects to those of pregabalin, one of the first-line treatments for pain in diabetic neuropathy.

Mechanical hypersensitivity was well established by day 37, when a single acute administration of MJN110 produced a significant inhibition of mechanical hypersensitivity. Indeed, hindpaw withdrawal thresholds were returned close to control values in the presence of MJN110, demonstrating that it can block established hypersensitivity in this model of diabetic neuropathy. The inhibitory effects of MJN110 were comparable to those produced by the gold standard treatment, pregabalin, and even became more significant at the 3 hour timepoint.
URB597 was also effective, and showed the same response pattern as the other two drugs, but its effects did not reach significance at either timepoint, suggesting that significance could likely be reached with a slightly higher dose. LC-MS/MS analysis showed that URB597 significantly increased levels of the three FAEs in the spinal cord and mid-brain, and that MJN110 significantly increased levels of 2-AG in the mid-brain. These results indicate that endocannabinoid modulation may have a promising future in the treatment of diabetic neuropathy.

The analgesic effects of a variety of cannabinoids have previously been investigated in the STZ model (as discussed in the introduction), including WIN55212-2 (Dogrul et al., 2004; Toth et al., 2010; Ulugol et al., 2004; Vera et al., 2012), cannabidiol (Toth et al., 2010) and cannabis extract (Comelli et al., 2009). However the usefulness of these cannabinoid agonists is often limited clinically by the occurrence of unwanted psychotropic side effects.

My findings are consistent with previous reports that FAAH inhibitors possess analgesic activity in a wide variety of rodent models of nociception (Cravatt et al., 2001). URB597 has shown analgesic properties in two models of hyperalgesia in STZ rats (Hasanein et al., 2009a), and ST4070, another FAAH inhibitor, increased mechanical thresholds in STZ rats (Caprioli et al., 2012). In the same study, they showed ST4070 to be more effective than URB597 or pregabalin in the CCI model.

One of the limitations of my study was that only a single acute dose of each drug was studied, which does not accurately reflect the situation in the clinic where the correct dose is titrated up, and long-term exposure may be required to see the full clinical efficacy (Berge, 2011). A single high dose may produce a different drug distribution and lead to unexpected effects, such as recruitment of antinociceptive mechanisms that would not be activated by a repeated dosing regime with a lower dose, and this could explain why drugs that seem efficacious in animal
models often fail in the clinic (Berge, 2011). It is therefore important to investigate the effect of repeated administration, to see whether the same effects would be seen, and if these could be maintained, or whether any tolerance would develop. Furthermore, if given from an earlier timepoint, it could be investigated whether either of these inhibitors would be able to prevent the development of neuropathic pain.

The effects of repeated administration of a FAAH inhibitor has been examined in several models with mixed results. In the CCI model, administration of URB597 (10mgkg\(^{-1}\) p.o.) for four days was more effective at alleviating hypersensitivity than a single administration (Russo et al., 2007), and the same group found that URB937 (1mgkg\(^{-1}\) i.p.) given daily for 7 days was indistinguishable from single drug dosing (Clapper et al., 2010). In agreement with this, PF3845, another FAAH inhibitor, maintained its anti-allodynic effect in the CCI model when given for 6 days (Schlosburg et al., 2010), but, in the carrageenan model, 4 days of URB597 (0.3mgkg\(^{-1}\) i.p.) was unable to reduce inflammatory hyperalgesia compared to a single acute dose (Okine et al., 2012). Additionally, FAAH \(-/-\) mice exhibit reduced pain behaviour in the tail immersion, hot-plate and formalin tests (Cravatt et al., 2001), and the carrageenan model, but not in the CCI model, which Lichtman et al., (2004b) postulated may be due to adaptive changes caused by nerve injury itself. From these results, it would appear that FAAH inhibitors are able to maintain their efficacy following repeated dosing in neuropathic models of pain, but studies with longer duration would be needed to see what the effects of long-time use might be.

Conversely, repeated dosing of the MAGL inhibitor JZL184 for six days, seems to lead to tolerance when given at high doses (40mgkg\(^{-1}\)). It loses its analgesic effects in both the CCI model (Kinsey et al., 2013; Schlosburg et al., 2010) and the carrageenan model (Ghosh et al., 2013), but when given at a lower dose (4mgkg\(^{-1}\)) it is able to maintain its effectiveness in both models (Ghosh et al., 2013; Kinsey et al., 2013).
Furthermore, Mgl1/− mice, although displaying a 10-fold increase in 2-AG levels in the brain, display similar tail-withdrawal latencies to wild-type mice. These studies help to reinforce the importance of selecting an appropriate dose when planning any future studies with repeated dosing to avoid the possibility of tolerance developing.

Modulation of the endocannabinoid system is also showing promise in other areas of diabetes such as diabetic nephropathy, retinopathy and also cardiovascular complications (as reviewed by Horváth et al., 2012). Additionally, with obesity becoming a growing problem, blockade of CB1 receptors has shown promise, but its use so far has been limited due to its effect of increasing anxiety in patients. Several trials have found that in obese patients, rimonabant (a CB1 receptor antagonist) is not only able to promote weight loss, but also decreases weight circumference and produces significant improvements in HDL-cholesterol, triglycerides and fasting insulin (Despres et al., 2005; Pi-Sunyer et al., 2006; Rosenstock et al., 2008; Scheen et al., 2006; Van Gaal et al., 2005). However, a more recent trial had to be stopped prematurely as rimonabant was found to have serious neuropsychiatric side-effects, causing an increased risk of suicide (Topol et al., 2010). This study highlights the importance of evaluating the risk of side-effects, and emphasises that perhaps modulation of levels of endocannabinoids may be a better way of tackling the problems associated with diabetes.

5.4.2. Antidiabetics in the HFD/STZ model

In the previous study in Chapter 4, the antidiabetic pioglitazone was administered 21 days after injection with STZ, and no significant alleviation of mechanical hypersensitivity was seen. As this drug was administered once pain behaviour was established, it was decided to administer the antidiabetic drugs in this study from day 4 after injection with STZ to see whether they could slow or prevent the development of mechanical hypersensitivity.
The two currently prescribed antidiabetics drugs investigated in this study were metformin and linagliptin, both of which significantly prevented the development of mechanical hypersensitivity. These findings are consistent with the report of analgesic effects of metformin in the SNI and SNL models (Melemedjian et al., 2011; Melemedjian et al., 2013). Resveratrol, another AMPK activator, has also been shown to be effective in acute, inflammatory, and chronic rodent pain models (Gentilli et al., 2001; Tillu et al., 2012; Torres-Lopez et al., 2002).

Metformin is currently prescribed in diabetes for its ability to improve glycemic control and decrease blood sugar levels through multiple mechanisms, and in this study it was shown to also be effective at attenuating the development of mechanical alldynia. As metformin and other AMPK activators are effective in models of pain which do not have metabolic syndrome associated with them, I would hypothesise that it has a direct analgesic effect through activation of AMPK, and the inhibition of mTOR and ERK signalling pathways (Melemedjian et al., 2011; Melemedjian et al., 2013; Soares et al., 2013). Inhibition of mTOR leads to inhibition of local protein synthesis (Jiménez-Díaz et al., 2008), and blockade of ERK signalling has a multitude of effects, including decreased phosphorylation of Na\(_{1.7}\), (which prevents the changes in channel gating properties toward a hyperexcitable state (Stamboulian et al., 2010)) resulting in a decrease in sensory neuronal excitability.

Further evidence of the effectiveness of inhibiting mTOR as a way to alleviate pain comes from the use of rapamycin, which inhibits mTORC1, and has been shown to alleviate mechanical hypersensitivity in preclinical models of inflammation (Geranton et al., 2009) and neuropathic pain (Jiménez-Díaz et al., 2008) when applied locally. CCI-779 and Torin1 (a rapamycin derivative, and an inhibitor of both mTORC1 and mTORC2 respectively) both reduced mechanical hypersensitivity in a mouse model of neuropathic pain when given systemically (Obara et al., 2011). They hypothesised that the effects of mTORC1 inhibitors are mediated through A-fibres, where mTOR and its
active form (P-mTOR) are localised (Jiménez-Díaz et al., 2008; Obara et al., 2011).

Although metformin crosses the blood-brain-barrier, it appears that this drug and other AMPK activators, as well as direct mTORC1 inhibitors, have their effects on mechanical hypersensitivity through a peripheral mechanism of action. Both local (intraplantar) and systemic injections of CCI-779 produced comparable reductions in neuropathic sensitivity and systemic Torin1, which has limited access to the CNS, reduced mechanical and cold hypersensitivity (Obara et al., 2011). Metformin caused a reversal of PNI-induced enhanced nascent protein synthesis, implying a direct action on the injured peripheral nervous system (Melemedjian et al., 2011).

The findings of current studies suggest that AMPK activators may be a novel solution for the current problem of neuropathic pain, including that of painful diabetic neuropathy, and they warrant further investigation for the role they may be able to play clinically. Attention should also be paid to the development of more efficacious AMPK activators.

An unexpected outcome of this study was the inability of metformin to reduce blood glucose levels after prolonged administration. Other studies have found that dosing with metformin for four weeks causes a significant decrease in glucose levels in diabetic animals (Alhaider et al., 2011; Erejuwa et al., 2011). However only the higher dose of 500mgkg$^{-1}$ is effective after 4 weeks of administration, and 100mgkg$^{-1}$ does not have a significant effect until after 8 weeks (Alhaider et al., 2011). Further studies have shown that long-term daily dosing with 300-350mgkg$^{-1}$ metformin did not cause a change in blood glucose (Hauton, 2011; Kim et al., 2012a), and finally, in other studies where metformin causes a decrease in glucose, blood samples were only taken shortly after an acute dose of metformin (Cheng et al., 2006; Reed et al., 2000; Wilson et al., 2012b). It is possible that an acute effect of metformin on blood glucose levels was missed because dosing of metformin was
always carried out before blood samples were taken, or that a higher
dose of metformin was needed in these rats to have a significant effect
on blood glucose. Metformin’s effect on AMPK, and the activation of the
downstream signalling pathways, would still account for its analgesic
properties.

To date, the effects of DPP4-inhibitors on pain behaviour have not been
widely studied, with only two groups showing their ability to improve
thermal nociception and reverse mechanical hypersensitivity (Bianchi et
al., 2012; Davidson et al., 2011a). The findings in this chapter build on
these previous studies, highlighting the ability of linagliptin to prevent
the development of mechanical hypersensitivity in the HFD/STZ model.

The mechanism of action through which linagliptin is able to alleviate
mechanical hypersensitivity has not yet been fully elucidated. Treatment
with a DPP-4 inhibitor for 32 weeks was able to improve sensory
thresholds to pressure, vibration, pain and temperature in the current
perception threshold test in the STZ model, as well as decreasing the
IENF loss (Jin et al., 2009). This suggests that the GLP-1 pathway may
play a role in attenuating nerve damage, as well as its metabolic effects
on lowering glucose levels.

GLP-1 receptors are present in sciatic nerve and DRGs (Himeno et al.,
2011; Jolivalt et al., 2011; Kan et al., 2012; Liu et al., 2011), and these
receptors have been shown to have a neuroprotective effect (During et
al., 2003). Exendin-4, which functions as a GLP-1R agonist is able to
attenuate cutaneous nerve fibre damage, alleviate hypoesthesia as
implied by the current perception threshold, protect Schwann cells and
reduce the loss of IENFs in the STZ model without lowering glucose
levels, suggesting that it a mechanism independent of glycemic control
is responsible for these effects (Liu et al., 2011). Other studies using
exendin-4 showed it was able to ameliorate impaired neurite outgrowth
of DRGs under high-glucose conditions in vitro (Himeno et al., 2011;
Perry et al., 2002b), as well as improving: reduced sensory perception,
slowed NCV, and decreased IENF density in the plantar skin in vivo (Himeno et al., 2011; Jolivalt et al., 2011). Exendin-4 also significantly improved slowing of sensory NCV in type 1 diabetic STZ mice and motor NCV in type 2 diabetic db/db mice, and was also able to improve thermal withdrawal latencies and restore mechanical sensitivity in the STZ mice (Kan et al., 2012). However, in the db/db mice, exendin-4 caused a lowering of the thermal withdrawal latency, and had no effect on the loss of mechanical sensation (Kan et al., 2012). Finally, GLP-1 and exendin-4 were also able to improve indices of pyridoxine-induced sensory peripheral neuropathy in rats (Perry et al., 2007). It has been hypothesised that the neuroprotective effects of GLP-1 may be mediated by a cascade involving cAMP, and work through increasing trophic support (Kan et al., 2012; Perry et al., 2002a; Perry et al., 2002b), or by coupling to anti-apoptotic signalling pathways (Li et al., 2003).

In this study, linagliptin did not change either fasting glucose or insulin levels, which is consistent with other studies of DPP-4 inhibitors (Poucher et al., 2012). Inhibition of DPP-4, and changes in GLP-1 were not measured in this study, but previous studies have reported decreased DPP-4 activity (Davidson et al., 2011a), and an increase in GLP-1 (Jin et al., 2009; Klein et al., 2012; Pipatpiboon et al., 2013).

My data suggest that the increase in GLP-1 by DPP-4 inhibition may contribute to the prevention of the development of mechanical hypersensitivity, but other substrates of DPP-4, such as stromal cell-derived factor-1a have also been shown to modulate neuropathic pain behaviour (Oh et al., 2001). Further consolidation of evidence showing how DPP-4 inhibitors and GLP-1 agonists modulate altered fibre function and pain responses is needed to identify whether this treatment has any promise for diabetic neuropathic pain.

In conclusion, the results of the present study demonstrated that modulation of levels of endocannabinoids through use of a MAGL
inhibitor was as effective at alleviating the pain behaviour in the HFD/STZ model as the commonly prescribed first-line treatment pregabalin. These data provide an interesting first look at how these compounds might have a future in the treatment of painful diabetic neuropathy, but the long term effects of dosing with these compounds has yet to be investigated. Furthermore, metformin and linagliptin, two antidiabetic treatments, also showed promise in preventing the development of mechanical hypersensitivity in the HFD/STZ model, and this, combined with results from other recent studies, suggests they may be able to play a bigger role in diabetes than just their current role in glucose control.
Chapter 6.

General Discussion
The aim of this thesis was to assess the validity of the HFD/STZ model as one of type 2 diabetes, and also of diabetic neuropathy. The phenotype of the HFD/STZ model is summarised in Table 6.1. The model was found to produce some symptoms similar to the STZ-alone model: a rapid rise in plasma glucose and a rapid fall in plasma insulin, coupled with a huge increase in water intake and urine excretion. HFD/STZ was also found to produce a robust decrease in mechanical withdrawal thresholds, a behavioural correlate of mechanical hypersensitivity, compared to both lean/Veh and HFD/Veh controls. As the HFD/STZ combination resulted in a reproducible model of diabetic neuropathy, various aspects were examined further. There was no evidence for neuronal degeneration in DRGs or the spinal cord up to 50 days after model induction, but there was a decrease in GFAP expression, and in activated microglia in the spinal cord at this timepoint. Furthermore, there was a trend towards a decrease in the mechanically evoked responses of dorsal horn WDR neurones, but no changes in spontaneous firing or electrically evoked responses of these neurones. The pain behaviour associated with the HFD/STZ model of diabetic neuropathy was responsive to the gold standard analgesic gabapentin, antidiabetic treatments and two novel analgesic approaches.
Table 6.1 Summary of major findings

MWT – Mechanical withdrawal threshold

↔ no change ↑ or ↓ trend towards an increase/decrease
↑↑ or ↓↓ significant increase/decrease

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Immunohistochemistry:

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Electrophysiology:

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6.1. HFD/STZ: a model of type 2 diabetes?

The HFD/STZ model has emerged as an interesting alternative to the STZ-alone model, which has been widely characterised and produces a robust model of type 1 diabetes (for review see King, 2012). As the vast majority of diabetic patients suffer from type 2 diabetes (Cheng, 2005), and as there have been some reports that diabetic neuropathy can vary between type 1 and type 2 diabetes (Arnold et al., 2013; Loseth et al.,
2010; Sima et al., 2006), it is important that we use animal models that are relevant to the clinical situation.

The HFD/STZ model is often referred to as a model of type 2 diabetes, but I think the model used in this thesis could be further refined to more closely reflect the clinical situation. The current model is based on feeding a high fat diet for a three week period before injection with STZ, but in reality this does not mimic the duration of the pre-diabetic stage in humans, which has been shown to last years before full-blown diabetes develops (Meigs et al., 2003). β-cell dysfunction also develops slowly as the body becomes less able to compensate for insulin resistance (Rydén et al., 2007), and during this period plasma insulin levels are fairly comparable to those seen in non-diabetic individuals (Reaven et al., 1993). To further improve the model, a lower dose of STZ could also be used so that only a proportion of the β-cells are destroyed, allowing the rat to maintain a relatively normal level of insulin.

However, there has only been one previous report of pain assessment in the HFD/STZ model, and in this study, which used a lower dose of STZ (35mgkg⁻¹), there was no change in mechanical withdrawal thresholds (Ferhatovic et al., 2013). This may not be surprising since the diabetic symptoms were much milder, with lower blood glucose concentrations, and greater gains in body mass (Ferhatovic et al., 2013). Since the aim of this thesis was to investigate the signs of mechanical hypersensitivity that are associated with diabetic neuropathy and to explore the effects of a variety of therapeutic interventions on mechanical hypersensitivity, I selected the 45mgkg⁻¹ dose of STZ. However, it is feasible that with a longer period of exposure to HFD prior to STZ treatment, a lower dose of STZ would then produce significant changes in pain behaviour.

Although the HFD/STZ model does not exactly reproduce diabetic neuropathy as it develops in humans, it aids in the understanding of some of the complex mechanisms underlying the development of
chronic pain associated with the disease, and it is important to remember that diabetic patients are themselves a heterogeneous population. It also highlights the importance of choosing an appropriate animal model for the endpoint you are interested in. If the goal of research is to specifically model the progression of type 2 diabetes, this would best be achieved with genetic models. However, if the aim is to investigate the mechanisms of chronic pain associated with type 2 diabetes, then the HFD/STZ (45mgkg\(^{-1}\)) model which mimics aspects of type 2 diabetes and exhibits robust pain behaviour is appropriate.

6.2. Assessment of mechanical hypersensitivity in the HFD/STZ model

Assessment of the development of mechanical hypersensitivity in this model used calibrated von Frey hairs. It has been suggested that these tests are not a direct measure of pain itself, but that they are a reflection of the hypersensitivity that develops alongside pain (Le Bars et al., 2001; Mogil, 2009). Whilst allodynia and hyperalgesia are both associated with diabetic neuropathy, spontaneous pain is also an important symptom. There are a variety of proposed methods to assess spontaneous pain in animal models, but their use in the diabetic model is limited.

A video-tape can be used to monitor spontaneous, unprovoked pain behaviour, looking at factors such as immobility, locomotion, grooming, rearing and elevation of the paw, which can be scored by a blinded observer. While this method minimises handling, which may influence the behavioural response itself, it is very time consuming, and large numbers of rats are needed due to the high variability in behaviour (Olmarker et al., 2002). It is also an indirect measure of pain, as while immobility, elevation of the paw and rearing can be interpreted as signs of spontaneous pain, they could also be altered by a variety of other factors. This method may prove useful in surgical models where
development of pain is rapid and very pronounced; but its application to the slower development of pain in the diabetic model is more questionable. Rats are prey animals and so any behaviour indicating pain which could be interpreted as weakness must be hidden, even though the underlying pain state may persist. The Rat Grimace Scale has recently been proposed as a method of quantifying pain through facial expressions such as orbital tightening, nose/cheek flattening, ear changes, and whisker changes (Sotocinal et al., 2011). However it has only been shown to be effective up to 48 hours after the induction of inflammatory pain (Sotocinal et al., 2011), and the SNI model in mice, which is of longer duration, is not associated with a ‘pain face’ (Langford et al., 2010). Therefore the limited duration of facial grimacing is not applicable for models of neuropathic pain, such as diabetic neuropathy. These methods could therefore provide utility in other animal models, but in this thesis the effect of HFD/STZ was only assessed on evoked responses, as it was considered impractical to use any of the current methods that may be able to assess spontaneous pain in other shorter-term models.

In future studies, it would be interesting to quantify dynamic mechanical hypersensitivity in the HFD/STZ model, as this symptom is more often observed clinically, such as when clothing brushes against the skin. Static mechanical hypersensitivity is measured by the change in withdrawal threshold induced by von Frey hairs, whereas dynamic mechanical hypersensitivity is studied by light stroking with a cotton bud and measuring the withdrawal latency (Field et al., 1999a). Field et al. (1999b) reported static mechanical hypersensitivity in the majority of diabetic rats within 10 days after injection with STZ, whereas the development of dynamic mechanical hypersensitivity had a slower onset, with fewer rats displaying sensitivity to stimulation with the cotton bud. They postulated that static mechanical hypersensitivity could be caused by the activation of Aδ- and C-fibres, whereas dynamic mechanical hypersensitivity may be due to inappropriate activation of Aβ-fibres, and may be the result of more severe nerve damage. This
has been confirmed by studies in humans which have also shown that
dynamic mechanical hypersensitivity is signalled by large myelinated
Aβ-fibres, whereas the static component of mechanical hypersensitivity
is signalled by unmyelinated fibres (Koltzenburg et al., 1992). In the
future, it would be valuable to determine whether the same pattern is
observed in the HFD/STZ model, and whether any drug intervention is
effective against both of these parameters, to ensure any results are
more likely to show relevance in the clinical situation.

6.3. Mechanisms underlying the development of mechanical hypersensitivity

It is important to consider how the temporal development of the model
is related to the progression of pain behaviour. Figure 6.1 shows a
timeline of the progression of the HFD/STZ model, which brings about
the question: what causes the switch to the development of mechanical
hypersensitivity?
Figure 6.1 Temporal development of the HFD/STZ model of diabetes

- HFD causes an increase in plasma glucose and insulin levels.
- Increase in plasma glucose.
- Increase in water consumption.
- Decrease in plasma insulin.

- Decrease in GFAP intensity in dorsal horn, ventral horn and central region.
- No neuronal loss in spinal cord or DRGs.

- Decrease in activated microglia in dorsal horn.
- Body weight is significantly decreased by the end of a study.

- Trend towards a decrease in mechanically evoked responses of WDR neurones at both timepoints.
- Further decrease in mechanical withdrawal threshold to ~7 g.

- First decrease in mechanical withdrawal threshold to ~10 g.
- Mechanical withdrawal threshold maintained at ~7 g.
As can be seen in Figure 6.1, it is not the rapid rise in plasma glucose, or the rapid decrease in plasma insulin that is directly responsible for the development of mechanical hypersensitivity, but it must be longer-term changes that underlie the later development of diabetic neuropathy. This would suggest that pain is not a direct consequence of hyperglycaemia, but it is the result of a variety of slower and longer-term molecular changes that are brought into play by elevated blood glucose and/or decreased insulin. Mechanisms, such as an increase in oxidative stress, may eventually lead to damage to neurones and altered function. On the basis of the findings of previous studies, it is likely that damage to these neurones induces a whole raft of changes, such as an increase in sodium channels and ectopic discharges, and neurochemical changes at the spinal cord level, which both lead to, and are influenced by, activation of glia. All of these slower changes are known to contribute to the manifestation of hypersensitivity in models of neuropathy, as well as other aberrant pain responses that are experienced in humans with diabetic neuropathy. Therefore it makes sense that the painful symptoms in this model take a few weeks to develop. A number of possible underlying mechanisms were investigated in this thesis.

The potential contribution of changes in spinal excitability to the manifestation of mechanical hypersensitivity was determined using electrophysiology. There was a trend towards a decrease in evoked responses of WDR dorsal horn neurones to mechanical stimulation, which has been observed previously in both the diabetic (Pertovaara et al., 2001), SNL (Chapman et al., 1998), spinal cord injury (Hao et al., 2004) and cisplatin-induced chemoneuropathy (Cata et al., 2008) models of neuropathic pain. Fluoro-Jade B staining was examined in both the DRGs and spinal cord to assess whether neuronal death might be responsible for this decrease in evoked responses, but very little positive staining was observed in any of the groups, with no increase in Fluoro-Jade B staining in the HFD/STZ group. However, it is possible that the neurones are already in an early damaged state, but have not
yet started to degenerate and produce the molecule that is detected by Fluoro-Jade B. It is feasible that in this state they are unable to function properly, resulting in the trend towards a decrease in evoked neuronal responses. If the model was taken out to a much later stage, I would expect an increase in the number of Fluoro-Jade B positive cells in the DRGs, consistent with previous studies of later stage apoptosis in the STZ animal model (Russell et al., 1999; Schmeichel et al., 2003; Zochodne et al., 2001).

The importance of the role of astrocytes and microglia in the development and maintenance of neuropathic pain has been widely studied, and the results from the HFD/STZ model complement what has been reported so far. While an increase in astrocytes has been observed in many neuropathic pain models (Garrison et al., 1991; Obata et al., 2006; Raghavendra et al., 2004; Sweitzer et al., 1999; Wang et al., 2009), in diabetic models a decrease in the amount of GFAP staining in the spinal cord is generally reported (Afsari et al., 2008; Wodarski et al., 2009). In my hands, a significant decrease in the mean grey intensity of GFAP staining was observed in both the dorsal and the ventral horn, as well as the central region, with greater changes seen in the dorsal and ventral horn at day 50 compared to the other timepoints. It has been hypothesised that this decrease is due to the reduction in the levels of circulating plasma insulin, as insulin has been shown to be important in the development of astrocytes (Aizenman et al., 1987), and so a decrease may contribute to the reduction in the amount of GFAP staining in diabetic models. A decrease in glutamate transporters is observed in activated astrocytes in various pain models (Sung et al., 2003; Wang et al., 2006; Xin et al., 2009). It would be interesting to investigate whether the decrease in the amount of GFAP staining is associated with a decrease in the expression of glutamate transporters, as increased levels of glutamate could lead to excitotoxicity (Nakagawa et al., 2010), which could be one of the factors responsible for the pain experienced in diabetic neuropathy. As well as effects on the development of astrocytes, prolonged low levels of
insulin, as well as hyperglycaemia, have been proposed to contribute to the development of painful diabetic neuropathy. Insulin treatment has been shown to prevent or reverse mechanical hypersensitivity (Calcutt et al., 1996; Hoybergs et al., 2007; Otto et al., 2011), and levels of insulin have been shown to be correlated with mechanical hypersensitivity (Romanovsky et al., 2006). The impact of insulin deficiency on the function of sensory afferent fibres warrants further investigation.

Whilst the decrease in GFAP staining was as expected, the decrease in the number of activated microglia in the spinal cord was not. My data emphasise the importance of not just relying on phenotypic changes in microglia to assess whether they are activated, but to measure the change in markers, such as iNOS and CD16/32 for classically activated M1 microglia, and arginase-1 and CD206 for alternatively activated M2 microglia (Hirai et al., 2013; Mantovani et al., 2004). Another option would be to stain with p-erbB2, the receptor for the growth factor NRG1, which has been shown to be upregulated within activated microglia in the SNL model, correlating with the development of microgliosis (Calvo et al., 2010), and also activates the ERK pathway (Calvo et al., 2011). It would therefore be beneficial to double-label cells with markers for phospho-ERK (Morgado et al., 2011a; Sweitzer et al., 2004; Tsuda et al., 2008) and phospho-p38 (Morgado et al., 2011a; Sweitzer et al., 2004), to see whether these pathways, which are switched on by microglia, are also activated in the HFD/STZ model. Further investigations would help to tease apart whether the numbers of classically activated, pro-inflammatory microglia are increased, regardless of whether they would be assessed as activated through morphology alone, helping to explain why an initial decrease was observed in this model.

If further studies were to be carried out in this model, it would be beneficial to examine the changes in sensory neurone morphology, in order to be able to make more conclusive statements about what is
happening at the level of the nerve, as in this thesis the main focus was the spinal cord.

6.4. Possible treatments for diabetic neuropathy

The current treatments for diabetic neuropathic pain are limited, and are often ineffective. It is therefore of major clinical importance to investigate the analgesic potential of current treatments as well as investigating the effects of novel compounds on diabetic neuropathic pain responses. This thesis was able to investigate both of these possibilities.

Pioglitazone, linagliptin and metformin, or drugs that bind to/activate the same target, have all recently shown promise at alleviating painful symptoms in animal models of neuropathic pain, through a variety of different mechanisms (Bianchi et al., 2012; Churi et al., 2008; Iwai et al., 2008; Jain et al., 2009; Jia et al., 2013; Jia et al., 2010; Maeda et al., 2008; Melemedjian et al., 2011; Morgenweck et al., 2010; Morgenweck et al., 2013; Takahashi et al., 2011; Tillu et al., 2012).

Both linagliptin and metformin, two currently prescribed antidiabetics, prevented the development of mechanical hypersensitivity in the HFD/STZ model when given 4 days after injection with STZ, without altering glucose or insulin levels. Whether these interventions can influence established pain behaviour requires future investigation. Given the large number of people currently being treated with these types of drugs, an epidemiological investigation of the prevalence of neuropathic pain in diabetic patients being treated with these different classes of compounds may help to provide much needed clinical evidence for whether these antidiabetic drugs alter the manifestation of chronic neuropathic pain. As both of these drugs were able to prevent the development of mechanical hypersensitivity without altering the changes in plasma glucose and insulin, this suggests that their effects must arise through their influence on mechanisms independent of
glycemic control. This lends further support to the hypothesis that it is not just the altered plasma glucose and insulin levels themselves which are directly responsible for the development of mechanical hypersensitivity, but other slower, molecular changes.

As discussed in Chapter 5, the analgesic properties of metformin have been demonstrated in other rodent models of neuropathic pain, suggesting that in the HFD/STZ model these effects may also be due to activation of AMPK. AMPK activation results in the inhibition of mTOR and ERK signalling pathways and insulin receptor substrate (IRS)-mediated feedback signalling, causing multiple effects such as inhibition of local protein synthesis and decreased phosphorylation of the Na\textsubscript{v}1.7 channel, and it is thought that these effects are due to a peripheral mechanism of action. DPP-4 inhibitors such as linagliptin are also thought to have a peripheral action, as they improve sensory thresholds, and decrease nerve fibre loss (Jin et al., 2009), suggesting an attenuation of nerve damage through the GLP-1 pathway. This is strengthened by the fact that GLP-1R agonists are able to attenuate nerve damage without lowering glucose levels, suggesting a mechanism independent of glycemic control (Himeno et al., 2011; Jolivalt et al., 2011; Liu et al., 2011).

Further studies should be carried out to confirm whether these are the mechanisms by which these drugs are effective. For example, the effects of GLP-1R agonists could be investigated in this model, as well as quantifying changes in IENF density in the HFD/STZ model, and the effects of DPP-4 inhibitors and GLP-1R agonists on this parameter. Experiments to determine the localisation of GLP-1 receptors in peripheral nerve would also be advisable. To further consolidate the evidence, it would be important to quantify changes in: the activity of mTOR and ERK; phosphorylation of their downstream targets; and the levels of proteins involved in RNA processing and transport in the sciatic nerve of HFD/STZ rats; as well as the level of eIF4F complex formation and nascent protein synthesis. From here it would be possible
to investigate whether administration of metformin, or other AMPK activators such as resveratrol or A769662, is able to change these levels, helping to identify whether it is the activation of AMPK, and the inhibition of mTOR and ERK, that is responsible for the changes in pain behaviour. If these changes in the activity of mTOR and nascent protein synthesis are partly responsible for the development of pain behaviour in this model, it would help to explain why the slower changes in the development of mechanical hypersensitivity do not happen in parallel with the rapid changes in glucose and insulin.

Previous studies have reported that early intervention with pioglitazone can also alter neuropathic pain symptoms in rodent models of peripheral nerve injury or spinal nerve transection (Iwai et al., 2008; Jia et al., 2013; Jia et al., 2010; Maeda et al., 2008; Morgenweck et al., 2013). Treatment with the PPARγ ligand pioglitazone once pain behaviour was established (3 weeks after STZ injection) was unable to reverse decreases in mechanical withdrawal thresholds. This raises the important issue that while identifying drugs that are able to prevent the development of mechanical hypersensitivity in an animal model may be a promising first step, whether they will show any efficacy when given to a diabetic patient who may have had the condition for many years before it was diagnosed, is unknown. This was the rationale behind giving pioglitazone at a relatively late timepoint, as it seemed that it would give a better indication of whether it would produce a clinically relevant result. It does highlight that whilst the results obtained from the antidiabetic drugs may show some promise, rigorous testing must be undertaken to see if they can be effective in patients when not administered under ideal conditions.

In the last study, an acute dose of pregabalin was shown to alleviate the well-established mechanical hypersensitivity at day 37 in the model. Pregabalin is one of the gold standard drugs prescribed for the treatment of neuropathic pain (Bril et al., 2011). It has been shown to be effective at attenuating mechanical hypersensitivity in the STZ model of
diabetes (Field et al., 1999b; Martinez et al., 2012; Yamamoto et al., 2009; Zhang et al., 2013), as well as alleviating painful symptoms in diabetic patients, where it has been shown to be beneficial even in those patients who have had an unsatisfactory response to other treatments (Freeman et al., 2008; Freynhagen et al., 2005; Quilici et al., 2009; Stacey et al., 2008). My observation that gabapentin can alleviate established pain behaviour in the HFD/STZ model provides important new evidence of the translational value of this model for diabetic neuropathic pain. This is promising for the results that were obtained with the novel MAGL inhibitor, MJN110, and hopefully forward translation of this work might result in another effective treatment being made available to patients. MJN110 was found to be as effective as pregabalin at attenuating mechanical hypersensitivity in this study, and at 3 hours after administration it caused a greater attenuation of mechanical withdrawal thresholds than pregabalin itself. The FAAH inhibitor, URB597, also showed a trend towards increasing withdrawal thresholds, but this did not reach significance.

6.5. Conclusions

In conclusion, this thesis has highlighted the role that the HFD/STZ model can play in investigating underlying mechanisms of diabetic peripheral neuropathic pain, and its use in exploring potential new therapeutic options for alleviating this pain. There is a potential role of endocannabinoid modulators such as MJN110, and currently prescribed drugs such as linagliptin and metformin in the future treatment of the pain associated with this disease, as a diverse range and a combination of treatments will prove to be important in the future management of DPNP.
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