IB4(+) nociceptors mediate persistent muscle pain induced by GDNF

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Alvarez P, Chen X, Bogen O, Green PG, Levine JD. IB4(+) nociceptors mediate persistent muscle pain induced by GDNF. J Neurophysiol 108: 2545–2553, 2012. First published August 22, 2012; doi:10.1152/jn.00576.2012.—Skeletal muscle is a well-known source of glial cell line-derived neurotrophic factor (GDNF), which can produce mechanical hyperalgesia. Since some neuromuscular diseases are associated with both increased release of GDNF and intense muscle pain, we explored the role of GDNF as an endogenous mediator in muscle pain. Intramuscularly injected GDNF induced a dose-dependent (0.1–10 ng/20 μl) persistent (up to 3 wk) mechanical hyperalgesia in the rat. Once hyperalgesia subsided, injection of prostaglandin E2, at the site induced a prolonged mechanical hyperalgesia (>72 h) compared with naïve rats (<4 h; hyperalgesic priming). Selective neurotoxic destruction of IB4(+) nociceptors attenuated both GDNF hyperalgesia and hyperalgesic priming. Ergonomic muscular injury induced by eccentric exercise or mechanical vibration increased muscle GDNF levels at 24 h, a time point where rats also exhibited marked muscle hyperalgesia. Intrathecal antisense oligodeoxynucleotides to miRNA encoding GFRα1, the canonical binding receptor for GDNF, reversibly inhibited eccentric exercise- and mechanical vibration-induced muscle hyperalgesia. Finally, electrophysiological recordings from nociceptors innervating the gastrocnemius muscle in anesthetized rats, revealed significant increase in response to sustained mechanical stimulation after local GDNF injection. In conclusion, these data indicate that GDNF plays a role as an endogenous mediator in acute and induction of chronic muscle pain, an effect likely to be produced by GDNF action at GFRα1 receptors located in IB4(+) nociceptors.

isolectin B4; ergonomic injury; chronic pain; rat

MUSCLE PAIN IS AN EXTREMELY common symptom that considerably impacts on quality of life, generating huge direct and indirect economic loses. Muscle pain is different in many aspects from cutaneous pain (Mense 2003); one of its most problematic characteristics is that, regardless of etiology, it often persists for a much longer period of time (Sluka 2002). Furthermore, after inflammatory injury both skin (Aley et al. 2000) and muscle (Dina et al. 2008; Alvarez et al. 2012) exhibit a long lasting mechanical hyperalgesia to prostaglandin E2 but such a response persists for much longer time in muscle (Dina et al. 2008; Alvarez et al. 2012). As many muscle pain syndromes are in fact chronic, elucidating the mechanisms by which they persist could be important to the development of appropriate mechanism-based analgesic therapies.

Small diameter nociceptors have been divided into two major classes according to their dependence on nerve growth factor (NGF) or glial cell line-derived neurotrophic factor (GDNF; Molliver et al. 1997; Snider and McMahon 1998). The trophic effects of GDNF depend on receptor complexes formed by one subunit involved in ligand binding and one subunit specialized in transmembrane signaling, the receptor tyrosine kinase rearranged during transfection (Ret; Bespalov and Saarma 2007). Almost 50% of all Ret-expressing nociceptors also express the GDNF family receptor α1 (GFRα1), the canonical GDNF receptor. As distinctive features, this subpopulation of nociceptors also binds the plant lectin isolectin B4 (IB4; Molliver et al. 1997; Silverman and Kruger 1990; Streit et al. 1986) and their central projections reach the inner part of lamina II in the dorsal horn (Kitchener et al. 1993; Snider and McMahon 1998). The IB4(+) GFRα1/Ret-expressing nociceptors are not only dependent on the neurotrophic effects of GDNF (Matheson et al. 1997; Moore et al. 1996) but also display increased responsiveness to thermal (Malin et al. 2006) and mechanical (Bogen et al. 2008; Ferrari et al. 2010; Joseph and Levine 2010) stimuli after acute exposure to this neurotrophic factor. In contrast to reports indicating that GDNF enhances mechanical and thermal nociception, it has also been observed that intrathecal administration of GDNF (Boucher et al. 2000) or intraspinal delivery of viral vectors expressing GDNF (Pezet et al. 2006) attenuate cutaneous allodynia/hyperalgesia in models of neuropathic pain. Furthermore, intrathecal GDNF did not affect cutaneous mechanical or thermal nociceptive thresholds in normal rats (Boucher et al. 2000). Altogether, these reports underline the complexity of the role played by GDNF in nociception and may reflect site-specific actions exerted by this neurotrophin.

Skeletal muscle is an important source of GDNF, which provides essential trophic support for normal development, differentiation, and function of sensory neurons, motoneurons, skeletal muscle cells, and neuromuscular synapses (Cacalano et al. 1998; Henderson et al. 1994; Sakuma and Yamaguchi 2011; Yang and Nelson 2004). Highly expressed in the vicinity of the plasma membrane of skeletal muscle cells (Suzuki et al. 1998a, 1998b; Wehrwein et al. 2002), GDNF content is increased as an adaptive consequence of muscle training (Wehrwein et al. 2002).

Although GDNF is indispensable for skeletal muscle function, patients affected by painful neuromuscular diseases such as polymyositis and Duchenne type neuromuscular dystrophy exhibit increased levels of GDNF in regenerating muscle fibers (Suzuki et al. 1998a) and complain of persistent pain in affected muscles (Engel et al. 2009; Zebracki and Drotar 2008), suggesting a possible role for GDNF as an endogenous mediator of their pain. Consistent with this are reports of cutaneous mechanical hyperalgesia observed after local injection of GDNF in rats (Bogen et al. 2008; Ferrari et al. 2010;
Joseph and Levine 2010) or in mice overexpressing GDNF (Albers et al. 2006). Finally, recent evidence indicates that IB4 (+) nociceptors are involved in mechanical hyperalgesia induced by the inflammatory carrageenan or muscle damage induced by ergonomic interventions (Alvarez et al. 2012). While the contribution of GDNF as an endogenous mediator in persistent cutaneous pain seems to be well established, its contribution in the induction of muscle pain remains unknown. Therefore, in the present study we explored the role of GDNF and its putative targets, the IB4 (GFRα1/Ret-expressing nociceptors, in persistent muscle pain.

MATERIALS AND METHODS

Animals. Adult male Sprague-Dawley rats (250–330 g; Charles River, Hollister, CA) were used in these experiments. They were housed in the Animal Care Facility at the University of California San Francisco under environmentally controlled conditions (lights on 0700–1900; room temperature 21–23°C) with food and water available ad libitum. Upon completion of experiments, rats were killed by 150 mg/kg pentobarbital followed by cervical dislocation, in accordance with University of California, San Francisco, Institutional Animal Care and Use Committee standard euthanasia guidelines. The University of California, San Francisco, Committee on Animal Research approved all experimental protocols, which adhered to the ethical guidelines published by the International Association for the Study of Pain (Zimmermann 1983). Every effort was made to minimize number and suffering of animals used in the experiments.

Drugs. Unless otherwise stated, all chemicals were obtained from Sigma-Aldrich (St. Louis, MO).

Measurement of muscle mechanical hyperalgesia. Mechanical nociceptive threshold in the gastrocnemius muscle was quantified using a digital force transducer (Chatillon DFI2; Amtek, Largo, FL) with a custom-made 7-mm-diameter probe (Alvarez et al. 2010). Rats were lightly restrained in a cylindrical acrylic holder with lateral slats that allow for easy access to the hindlimb and application of the transducer probe to the belly of the gastrocnemius muscle. The nociceptive threshold was defined as the force, in millinewtons (mN), required to produce a flexion reflex in the hind leg. Baseline limb-withdrawal threshold was defined as the mean of three readings taken at 5-min intervals. Each hindlimb was treated as an independent measure, and each experiment was performed on a separate group of rats.

Eccentric exercise-induced muscle pain. The method used to eccentrically exercise the rat hindlimb (Alvarez et al. 2010) was similar to that described by Kano et al. (2004) and Mizumura and colleagues (2007). The method used to eccentrically exercise the rat hindlimb was previously described by Kano et al. (2004) and Mizumura and colleagues (2007). The destruction of the IB4 (+) population of dorsal root ganglion neurons by intrathecal injection of a cytotoxin, saporin, conjugated to IB4 (IB4-saporin) has been established previously by us (Bogen et al. 2009; Bogen et al. 2008; Joseph et al. 2008; Joseph and Levine 2010) and others (Nishiguchi et al. 2004; Vulchanova et al. 2001). IB4-saporin (Advanced Targeting Systems, San Diego, CA) was diluted with saline and a dose of 3.2 μg in 20 μl administered intrathecally 10 days before experiments (Joseph et al. 2008; Joseph and Levine 2010).

An oligodeoxyxynucleotide (ODNs) antisense (AS) to GFRα1, shown previously to knockdown GFRα1 protein in the rat glialoma cell line C6 (Wiesenhofer et al. 2000) and to decrease GFRα1 protein, mRNA, and immunostaining in rat DRG cells (Dong et al. 2006), was synthesized by Invitrogen (San Francisco, CA). The AS ODN (5′-TAG GAA CAT GGT GCC-3′) was directed against a unique sequence of GFRα1. The mismatch (MM) ODN (5′-TAG AGA CAT GGT GCC-3′) is the AS sequence with two bases, denoted in bold face, switched. A search of the EMBL and NCBI GenBank Rattus norvegicus databases identified no homologous sequences. Before use, the ODNs were lyophilized and reconstituted in 0.9% NaCl to a concentration of 2 μg/μl. A dose of 40 μg of AS or MM ODN was administered intrathecally in a volume of 20 μl once daily for 3 consecutive days.

Measurement of GDNF levels in gastrocnemius muscle. Twenty-four hours after either eccentric exercise or mechanical vibration, animals were deeply anesthetized with isoflurane and the ipsilateral gastrocnemius muscle was removed and flash frozen on dry ice. Each frozen muscle was cut into serial cross sections (<0.5 g) and stored at −80°C until further processing. All muscle samples were pulverized in a porcelain mortar in the presence of liquid nitrogen and transferred into 0.1 M PBS (0.225 M NaCl, 0.02 M NaH2PO4, and 0.08 M Na2HPO4) containing 0.1% Tween 20 and 0.05% BSA and supplemented with a 2× complete protease inhibitor cocktail (Roche Diagnostics, Mannheim, Germany) and homogenized with a tissue tearor (Biospec Products, Bartlesville, OK). Solubilized proteins were extracted by a 15 min centrifugation at 4°C and 20,000 g. The total protein concentration of each sample was determined by using the micro Pierce BCA protein assay kit (Pierce Biotechnology, Rockford, IL), whereas GDNF concentration was determined using an ELISA performed with the GDNF Emax ImmunoAssay System (Promega, Madison, WI) according to the manufacturer’s instructions. Absorbencies of protein extracts were measured at 450 nm for full-strength solutions and 1:10 or 1:100 dilutions by using a microplate reader (Wallac 1420 multilabel counter; Perkin Elmer, Vernon Hills, IL). The concentration of GDNF in each sample was adjusted for the
dilution factor, and the results from triplicates were averaged to obtain the final concentration of GDNF per milligram of protein extracted from each muscle sample.

Single fiber in vivo electrophysiology. The in vivo single fiber electrophysiology technique for studying muscle afferents has been described in detail previously (Chen et al. 2010). In brief, rats were anesthetized with pentobarbital sodium (initially 50 mg/kg ip with additional doses given throughout the experiment to maintain a-reflexia), their trachea was cannulated, and their heart rate was monitored. Anesthetized animals were positioned on their right side and an incision was made on the dorsal skin of the left leg between the mid-thigh and calf. Then, the biceps femoris muscle was partially removed to expose the sciatic nerve and gastrocnemius muscle. The edges of the incised skin were fixed to a metal loop to provide a pool that was filled with warm mineral oil that bathed the sciatic nerve and gastrocnemius muscle.

The sciatic nerve was transected proximal to the recording site to avoid the effects of reflex arc activation. While stimulation of muscular receptive field led to muscle contraction, it did not impact the recording; i.e., neural activity was still recorded. Fine fascicles of axons were then dissected from the distal stump and placed on a recording electrode. Single units were first detected by mechanical stimulation of the gastrocnemius muscle with a small blunt-tipped glass bar. Bipolar stimulating electrodes were then placed and held on the center of the receptive field of the muscle afferent by a micromanipulator (model MM-3; Narishige, Tokyo, Japan). Subsequently, electrical stimulation allowed confirmation of the mechanical receptive field according to the amplitude and duration of action potentials. Finally, the unit discharge was discriminated by Spike 2 software (CED, Cambridge, UK). Most neural activity was recorded from one or two units, no more than three units, which were significantly different from the amplitude and/or duration. The conduction velocity of each fiber was calculated by dividing the distance between the stimulating and recording electrodes by the latency of the electrically evoked action potential. Mechanical threshold, determined with calibrated von Frey filaments (VFH Ainsworth, London, UK), was defined as the lowest force that elicited at least two spikes within 1 s in at least 50% of trials. Sustained suprathreshold (10 g) mechanical stimulation was accomplished by use of a mechanical stimulator that consisted of a force-measuring transducer (Entran, Fairfield, NJ) with a blunt plastic tip that was applied by a micromanipulator (BC-3 and BE-8; Narishige) on the center of the afferent’s receptive field for 60 s. Neural activity and timing of stimulus onset and termination were monitored and stored on a computer with a Micro 1401 interface (CED) and analyzed offline with Spike2 software (CED).

Statistical analysis. Group data are expressed as means ± SE of n independent observations. Statistical comparisons were made using GraphPad Prism 5.0 statistical software (GraphPad Software, La Jolla, CA). The Student’s t-test was used to compare one or two independent samples, whereas ANOVA followed by Dunnett’s or Tukey’s multiple comparison tests was used for comparing three or more samples. Data were tested for normality using the D’Agostino and Pearson omnibus normality test; if data did not pass the normality test for Gaussian distribution, Welch correction for the Student’s t-test, with Welch’s correction for the Student’s t-test was used. Nonparametric data were analyzed using Wilcoxon’s signed rank test. P < 0.05 was considered statistically significant.

RESULTS

GDNF produces acute and chronic hyperalgesia. The unilateral injection of GDNF into the gastrocnemius muscle significantly reduced mechanical nociceptive threshold. Compared with their baselines, readings obtained 1 h after intramuscular GDNF (doses of 0.1 ng, 1 ng or 10 ng) in the injected (ipsilateral) gastrocnemius muscle (Fig. 1A), but the untreated (contralateral) gastrocnemius muscle, exhibited a marked decrease in mechanical nociceptive threshold (hyperalgesia). The amplitude and duration of this mechanical hyperalgesia were dose dependent. The lowest dose assayed (0.1 ng/20 μl) produced a significant mechanical hyperalgesia lasting >1 wk (Fig. 1B), whereas the highest dose (10 ng/20 μl) induced hyperalgesia that lasted ≥3 wk (Fig. 1B). Of note, GDNF vehicle has no effect on mechanical nociceptive threshold (Fig. 2A).

Ten days after the nociceptive thresholds returned to baseline, rats were assessed for hyperalgesic priming. The inflammatory cytokine PGE2 (1 μg/20 μl) was injected bilaterally into the gastrocnemius muscle, and nociceptive threshold was measured after 1, 4, 24, and 72 h. PGE2 (1 μg) injected into the gastrocnemius muscle contralateral to the previous injection of GDNF (doses of 0.1, 1, or 10 ng) produced a marked diminution of mechanical threshold (1 h after PGE2 injection) that was significantly reversed by 4 h (Fig. 1C). In the GDNF-treated side, however, PGE2 induced a prolonged diminution in mechanical threshold that was unattenuated at 72 h (Fig. 1C), indicating the induction of hyperalgesic priming (Aley et al. 2000; Alvarez et al. 2012; Dina et al. 2008) by GDNF.

Local injection of GDNF sensitizes muscle nociceptors. The set of analyzed fibers was composed for 44% Aδ (type III) fibers and 56% C (type IV) fibers. The ranges of Aδ fiber conduction velocity were between 2.57 and 5.00 m/s. The mean value of Aδ fibers was 3.83 m/s. The ranges of C-fiber conduction velocity were between 0.36 and 2.46 m/s. The mean value of C-fibers was 1.72 m/s. Before and 30 min after injection of GDNF (10 ng/5 μl; n = 16), a time at which muscle mechanical hyperalgesia is observed (Fig. 2A) (Hendrich et al. 2012), the peripheral receptive field of sensory neurons innervating the gastrocnemius muscle was tested using von Frey monofilaments. The mechanical threshold of muscle afferents recorded before GDNF treatment (1.15 ± 0.17 mN) was not significantly modified by the injection of GDNF (1.01 ± 0.16 mN; n = 16; Wilcoxon signed rank test). The conduction velocity of muscle afferents recorded before treatment (2.64 ± 0.33 m/s) was also not significantly modified by the injection of GDNF (2.63 ± 0.33 m/s; Student’s t-test, with Welch’s correction; n = 16).

To examine excitability in muscle nociceptors from GDNF-injected rats, we evaluated their response to a sustained (60 s) suprathreshold (10 g) von Frey filament stimulus. A baseline response of muscle afferents recorded before GDNF injection (1.15 ± 0.17 mN) was recorded before GDNF treatment (1.15 ± 0.17 mN). This response was significantly increased (Fig. 2, B–D, 924.3 ± 375.9 action potentials/60-s stimulus). After GDNF injection, this response was significantly increased (Fig. 2, B–D, 421.4 ± 180.5 action potentials/60-s stimulus). The conduction velocity of muscle afferents recorded before treatment (2.64 ± 0.33 m/s) was also not significantly modified by the injection of GDNF (2.63 ± 0.33 m/s; Student’s t-test, with Welch’s correction; n = 16).

The time course of the response to sustained mechanical stimulation shows a significant increase in the number of spikes during the first 10 s after application of the stimulus (Fig. 2, B–D; 247.6 ± 108.5 action potentials/10-s stimulus; n = 16; Student’s t-test with Welch’s correction). The analysis of the time course of the response to sustained mechanical stimulation shows a significant increase in the number of spikes during the first 10 s after application of the stimulus (Fig. 2, B–D; 247.6 ± 108.5 action potentials/10-s stimulus; n = 16; Student’s t-test with Welch’s correction) compared with pretreatment control (166.4 ± 40.9 action potentials/10-s stimulus; n = 16). The number of spikes recorded during the last 10 s of the stimulus application was also significantly increased (Fig. 2, B–D; 122.38 ± 61.74 action potentials/50 to 60-s stimulus; n = 16; Student’s t-test with Welch’s correction) compared with pretreatment control (42 ± 27.09 action potentials/50 to 60-s stimulus; n = 16).

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Ergonomic insults increase GDNF in muscle. Since the level of GDNF is upregulated in an activity-dependent manner in rat skeletal muscle (Wehrwein et al. 2002), and patients afflicted by painful neuromuscular conditions exhibit increased levels of GDNF in regenerating muscle fibers (Suzuki et al. 1998a), we hypothesized that nociceptive ergonomic stimuli might cause increased levels of GDNF in muscle, which could act to produce acute hyperalgesia and/or chronic hyperalgesic priming. Therefore, we measured GDNF levels in rats submitted to two ergonomic pain models at a time point characterized by frank muscle mechanical hyperalgesia (Alvarez et al. 2010; Dina et al. 2010). Both nociceptive ergonomic stimuli, mechanical vibration and eccentric exercise, caused increased levels of GDNF (measured as pg/mg protein) in gastrocnemius muscle compared with control animals (Fig. 3).

Hyperalgesic effects of endogenously released GDNF depend on GFRα1. Next we assessed whether the nociceptive effects of GDNF released after ergonomic insults depend on its canonical receptor, the GFRα1 receptor, to produce muscle mechanical hyperalgesia. Rats received daily intrathecal injections of ODN AS or MM to GFRα1 for 3 days, and then their hindlimbs were either vibrated or eccentrically exercised to produce long-lasting muscle mechanical hyperalgesia (Alvarez et al. 2010; Dina et al. 2010). Compared with MM ODN, AS ODN treatment significantly reduced the mechanical muscle hyperalgesia measured on days 1, 2, and 3 after vibration (Fig. 4A) or eccentric exercise (Fig. 4B).

Hyperalgesic effects of GDNF depend on IB4(+) nociceptors. To determine whether IB4(+) nociceptors, the target of GDNF, play a role in GDNF-induced muscle hyperalgesia, rats were pretreated intrathecally with IB4-saporin (n = 6) to reduce the population of IB4(+) neurons and naïve rats were used as a control (n = 5). Ten days later, all rats received a unilateral GDNF intramuscular injection (10 ng/20 μl). Before the administration of GDNF, rats were tested to determine if IB4-saporin treatment produced a change in muscle mechanical nociceptive thresholds. Consistent with our previous reports (Alvarez et al. 2012), no significant effect of IB4-saporin with respect to baseline nociceptive threshold was observed.

One hour after unilateral injection of GDNF a significant reduction in mechanical nociceptive threshold was observed in naïve rats, which persisted unchanged in amplitude for at least 3 days (Fig. 5A). In contrast, only a modest hyperalgesia was observed in IB4-saporin-treated rats the first hour after GDNF injection (Fig. 5A), which then declined to baseline values in the next readings (Fig. 5A). The contralateral side did not show

![Fig. 1. Intramuscular injection of glial cell line-derived neurotrophic factor (GDNF) produces acute and chronic pain.](http://jn.physiology.org/)

Fig. 1. Intramuscular injection of glial cell line-derived neurotrophic factor (GDNF) produces acute and chronic pain. A: 1 h after unilateral injection of GDNF (0.1–10 ng/20 μl im; n = 6/dose), a marked mechanical hyperalgesia was observed in the injected (ipsilateral) gastrocnemius muscle (0.1 ng: 2696.2 ± 6.2 vs. 2038.3 ± 38.9 mN, P < 0.001; 1 ng: 2671.7 ± 4 vs. 1994 ± 11.5 mN, P < 0.001; 10 ng: 2677.2 ± 7.9 vs. 1647.2 ± 43.6 mN, P < 0.001, ANOVA followed by Dunnett’s test) but not the contralateral muscle (0.1 ng: 2697.2 ± 7.8 vs. 2686.3 ± 16.6 mN, P > 0.05; 1 ng: 2680.8 ± 2.9 vs. 2634.3 ± 18.8 mN, P > 0.05; 10 ng: 2677.5 ± 4.4 vs. 2600.8 ± 17.2 mN, P > 0.05, ANOVA followed by Dunnett’s test, respectively). Data are plotted as %change in mechanical nociceptive threshold of GDNF-injected (ipsilateral) and noninjected (contralateral) hindlimbs compared with baseline and differences are represented by ***P < 0.001. B: GDNF-induced muscle hyperalgesia exhibited dose-dependent amplitude and duration, persisting for >1 wk at 0.1 ng (9th day 2474.8 ± 19.5 mN, P < 0.001, ANOVA followed by Dunnett’s test) and up to 3 wk at 10 ng (21st day 2419.3 ± 15.5 mN, P < 0.001, ANOVA followed by Dunnett’s test) after injection. Data are plotted as %change in mechanical nociceptive threshold compared with baseline (n = 6/group). Solid symbols represent P < 0.05 respect to baseline. C: when nociceptive thresholds returned to pre-GDNF baseline, groups were tested for the presence of hyperalgesic priming. After bilateral PGE2 administration (1 μg/20 μl im), nociceptive thresholds were tested at 1, 4, 24, and 72 h. One hour after PGE2 injection, bilateral mechanical hyperalgesia was observed. Regardless the dose of GDNF, such hyperalgesia remained unchanged in hindlimbs ipsilateral to GDNF injection after 72 h (0.1 ng: 1534.8 ± 28.9 vs. 1638.8 ± 39.3 mN, P > 0.05; 1 ng: 1526.3 ± 25.9 vs. 1603 ± 38.9 mN, P > 0.05; 10 ng: 1490.3 ± 14 vs. 1600.3 ± 20 mN, P > 0.05, ANOVA followed by Tukey’s test, respectively). However, indicating hyperalgesic priming, in hindlimbs contralateral to GDNF injection, mechanical hyperalgesia was significantly decreased 4 h after PGE2 injection (0.1 ng: 1635 ± 2.9 vs. 2470.8 ± 15.4 mN, P < 0.001; 1 ng: 1569 ± 40.9 vs. 2384.3 ± 39.6 mN, P < 0.001; 10 ng: 1505.5 ± 19.5 vs. 2409.2 ± 77.5 mN, P < 0.001, ANOVA followed by Tukey’s test, respectively). Data are plotted as %change in mechanical nociceptive threshold compared with baseline (n = 6/group). Differences in nociceptive responses between readings taken at 1, and 4, 24, and 72 h in hindlimbs ipsi or contralateral to previous GDNF injection are represented by ***P < 0.001.

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statistically significant changes in either IB4-saporin-treated or naïve rats (Fig. 5A).

Three weeks after GDNF administration, when nociceptive thresholds returned to baseline, the inflammatory cytokine PGE2 (1 μg/20 μl) was injected into the gastrocnemius muscles bilaterally. In control rats, PGE2 injected into the gastrocnemius muscle contralateral to the injection of GDNF produced a marked acute hyperalgesia (1 h after PGE2 injection) that was significantly decreased by 4 h (Fig. 5B). However, in the GDNF-treated muscle PGE2 induced a prolonged hyperalgesia that lasted at least 24 h, indicating the induction of hyperalgesic priming (Fig. 5B). In IB4-saporin-treated rats PGE2 also induced a mechanical hyperalgesia that was significantly attenuated within 4 h on both the nontreated and the GDNF-treated (Fig. 5B) hindlimbs, indicating that GDNF-induced hyperalgesic priming in muscle depends on IB4(+) nociceptors.

DISCUSSION

While cutaneous GDNF-induced hyperalgesia is a well-established phenomenon (Albers et al. 2006; Bogen et al. 2008, 2009; Ferrari et al. 2010; Joseph and Levine 2010) and high levels of GDNF have been reported in painful neuromuscular diseases, studies of the role of GDNF in skeletal muscle nociception are lacking. The results of the present study indicate that GDNF produces a long-lasting muscle hyperalgesia mediated by action at IB4(+) nociceptors.

GDNF-induced mechanical hyperalgesia and hyperalgesic priming. Consistent with reports of GDNF-induced cutaneous hyperalgesia (Bogen et al. 2009; Bogen et al. 2008; Ferrari et al. 2010; Joseph and Levine 2010), a single intramuscular injection of GDNF produced a robust mechanical hyperalgesia, which lasted for at least 21 days. This hyperalgesia is mediated, at least in part, by nociceptor sensitization, since intramuscular injection of GDNF into the mechanical receptive field of

Fig. 2. GDNF produces mechanical hyperalgesia and sensitizes muscle nociceptors. A: compared with baseline (2,649.2 ± 2.8 mN) GDNF (n = 6), but not vehicle (n = 6), produced a significant decrease in mechanical muscle threshold at 15 (2,037.3 ± 10.4 mN, P < 0.001, ANOVA followed by Dunnett’s test), 30 (1,762.8 ± 18.6 mN, P < 0.001, ANOVA followed by Dunnett’s test), and 45 (1,676.3 ± 8.3 mN, P < 0.001, ANOVA followed by Dunnett’s test) min. after intramuscular injection. Also, 30 min after injection, GDNF significantly enhanced the nociceptor response to sustained mechanical stimulation, as revealed by increased cumulative number of spikes in recordings obtained during early (first 10 s) and late (last 10 s) parts of the stimulation period (B), as well as total response (60 s) compared with pre-GDNF control values (C). This was also evident in time-course histograms of the nociceptor response, representing recordings obtained before (D) and after (E) GDNF injection (10 ng/5 μl im; n = 16). Comparisons between pre- and post-GDNF treatment were made using one-tail Student’s t-test for paired samples; *P < 0.05; **P < 0.01; ***P < 0.001.

Fig. 3. Ergonomic insults increase GDNF content in affected skeletal muscle. Rats were submitted to a hindlimb vibration or eccentric exercise. Twenty four hours later, a time point where both interventions produce muscle hyperalgesia (Alvarez et al. 2010; Alvarez et al. 2012; Dina et al. 2010), the gastrocnemius muscle was excised and GDNF content (pg/mg protein) determined by means of an ELISA procedure and compared with those exhibited by naïve rats. Both ergonomic interventions produced a significant increase in muscular content of GDNF. Comparisons between GDNF values obtained from naïve rats (white bar, n = 12) and rats submitted to vibration (grey bar, n = 7) or eccentric exercise (black bar, n = 5) were made by using a one-way ANOVA followed by a Dunnett’s multiple comparisons test. ***P < 0.001.
C-nociceptors in the gastrocnemius muscle induced a large increase in their response to sustained mechanical stimulation. However, in contrast to its effects on cutaneous nociceptors, intramuscular GDNF did not affect mechanical threshold (Albers et al. 2006; Bogen et al. 2008) or conduction velocity (Albers et al. 2006) in muscle nociceptors. While we do not have a complete explanation for this difference, it might reflect a particular sensitivity of muscle nociceptors to GDNF. Indeed, while GDNF potentiates the activation of the mechanosensitive transient receptor potential channel subfamily A, member 1 (Kwan et al. 2006, 2009; Vileceanu and Stucky 2010) in skeletal muscle nociceptors, such a potentiation is absent in nociceptors innervating the skin (Malin et al. 2011).

We (Hendrich et al. 2012) have recently reported that GDNF produces sensitization of cultured IB4(+) neurons innervating muscle by reducing large-conductance voltage and calcium-activated potassium (BK) channel currents, whereas local injection of the BK inhibitor iberiotoxin increased nociceptor firing to muscle mechanical stimulation and mechanical hyperalgesia. In addition, the pretreatment with the BK activator DiI (unpublished observations). Since most IB4(+) nociceptors also express the canonical GDNF receptor complex for GFRα1 (Joseph and Levine 2010). Since GDNF can also act as a low affinity agonist on the GFRα2/Ret complex receptor (Bespakov and Saarma 2007), the remaining hyperalgesic response might be due to the effect of GDNF on GFRα2/Ret expressing nociceptors unaffected by the IB4-saporin treatment. In agreement with this, a recent report indicates that ~25% of muscle sensory neurons express GFRα2 (Malin et al. 2011).

In addition to acute hyperalgesia at the GDNF injection site, intramuscular GDNF also induced a long-lasting nociceptive response to PGE₂ at that site. We have previously shown that such a change, referred to as hyperalgesic priming, is induced in skeletal muscle after intramuscular injection of the inflammatory carrageenan (Dina et al. 2008) or ergonomic interventions such as eccentric exercise (Alvarez et al. 2010) or vibration (Dina et al. 2010). There is evidence that hyperalgesic priming depends on the recruitment of PKCe signaling in addition to the normal prepriming signaling via cAMP/PKA, to produce prolonged mechanical hyperalgesia to an otherwise short-lasting proalgesic effect of PGE₂ (Aley et al. 2000; Alvarez et al. 2010; Dina et al. 2008, 2010; Parada et al. 2003). On the other hand, GDNF-induced hyperalgesic priming was prevented by IB4-saporin pretreatment, which is consistent with the role of IB4(+) nociceptors in hyperalgesic priming.

**Fig. 4.** Intrathecal antiseense to GFRα1 inhibits ergonomic insult-induced mechanical hyperalgesia. Rats received a daily intrathecal treatment of antisense (●) or mismatch (○) oligodeoxynucleotide (ODNs) to GFRα1 [40 μg, antisense (AS) or mismatch (MM)] during three consecutive days. They were then submitted to a hindlimb vibration (n = 9/ODN treatment) or eccentric exercise (n = 6/ODN treatment). A: preventive AS, but not MM, treatment inhibited mechanical hyperalgesia after hindlimb vibration on days 1 (AS: 2.376 ± 36.3 mN vs. MM: 2.025 ± 35.3 mN, P < 0.05), 2 (AS: 2.228 ± 37 mN vs. MM: 1.784 ± 33.1 mN, P < 0.05), and 3 (AS: 2.108 ± 55.7 mN vs. MM: 1.735 ± 41.3 mN, P < 0.05) after ergonomic insult. B: preventive AS, but not MM, treatment inhibited mechanical hyperalgesia after hindlimb eccentric exercise on days 1 (AS: 2.132 ± 0.16 mN vs. MM: 1.680 ± 41.8 mN vs. P < 0.05), 2 (AS: 2.319 ± 337.5 mN vs. MM: 1.689 ± 0.16 mN, P < 0.05), and 3 (AS: 2.296 ± 39.2 mN vs. MM: 1.970 ± 53.8 mN, P < 0.05) after ergonomic insult. Comparisons to baseline were made using two-way repeated measures ANOVA (time and ODN treatment) followed by Tukey’s multiple comparisons test. *P < 0.05.
induced by the intradermal injection of GDNF (Ferrari et al. 2010; Joseph and Levine 2010).

\textit{Endogenous GDNF mediates ergonomically induced pain.} Ergonomically induced musculare pain is a well-recognized common clinical entity, related to activities such as inappropriate exposure of extremities to vibration (Heaver et al. 2011; Necking et al. 2004) or eccentric muscle activity (Sesto et al. 2005). Notably, vibration (Okada et al. 1985; Okada 1986) and eccentric muscle activity (McNeil and Khakee 1992) can induce extensive damage of muscle fibers, especially to the sarcolemma. Indeed, sarcolemma disruption observed after exposure to these insults induces the release of cytoplasmic elements from muscle fibers (Okada et al. 1985; Okada 1986; Schwane et al. 1983). Given that GDNF is highly expressed in the vicinity of the sarcolemma (Suzuki et al. 1998a, 1998b; Wehrwein et al. 2002) and that muscle content of GDNF is increased by physical activity (Wehrwein et al. 2002), we hypothesized that ergonomic interventions should induce an acute increase in muscle content of GDNF at a time point where muscle pain is observed. Measurements of GDNF in muscle of rats exposed to either vibration or eccentric exercise confirmed this hypothesis. Importantly, pretreatment with an AS ODN to GFRα1 markedly inhibited the muscle hyperalgesia induced by these ergonomic insults. Although some mechanisms contributing to muscle pain have been identified, those underlying eccentric exercise-induced pain have remained elusive. For instance, the interplay between lactic acid and ATP (depending on P2X5/ASIC3 channels interaction) observed in muscle ischemia/acidosis seems to play a role in ischemic muscle pain induced by acute oxygen deprivation and the associated increase of local anaerobic metabolism (Birdsong et al. 2010). However, in our experimental protocol the nociceptive responses to eccentric exercise were measured at time points where local high levels of lactic acid due to muscular anaerobic metabolism are no longer present (Mense 1993). Indeed, it has been shown that basol microvascular oxygen supply to skeletal muscle is similar between control rats and 1 or 3 days after eccentric exercise (Kano et al. 2005). Furthermore, in contrast to our observations, putative nociceptive responses induced by P2X5-ASIC3 interaction were evoked in absence of any mechanical stimuli (Birdsong et al. 2010). Also, the dorsal root ganglion neuronal subset exhibiting P2X5 and ASIC3 coexpression is mostly composed of large-diameter cells (≈50 μm) (Birdsong et al. 2010), which contrasts with the main target of GDNF: the IB4(+) subset, essentially composed by medium to small-diameter cells (≈25 μm) (Price and Flores, 2007). Thus, while local low pH is present in many conditions related to muscle injury and pain (e.g., ischemia and inflammation), the interaction between lactic acid and ATP seems not to play a role in eccentric exercise-induced mechanical hyperalgesia. In contrast, it has been recently reported that the main target for IB4 binding, the extracellular proteoglycan versican, plays a role in the sensitization of mechanosensitive currents at physiological low pH (Kubo et al. 2012a). This is in line with our previous observations regarding the involvement of IB4(+) nociceptors in eccentric exercise-induced mechanical hyperalgesia (Alvarez et al. 2012). Finally, since a large proportion of IB4(+) nociceptors also express the capsainceptor TRPV1 in rats (Price and Flores 2007), it is not surprising that neonatal treatment with capsaiacin, which irreversibly destroys TRPV1-expressing neurons, is able to abolish eccentric exercise-induced mechanical hyperalgesia (Kubo et al. 2012b).

Taken together, these observations strongly suggest that GDNF released by muscle damage induces sensitization of IB4(+-)GFRα1/Ret nociceptors, contributing to the induction of acute persistent mechanical hyperalgesia and to hyperalgesic priming.

\textit{Clinical implications.} In spite of the fact that historically muscle pain has been not well recognized as a major symptom in neuromuscular disease (Engel et al. 2009), a growing number of studies indicate that chronic muscle pain is a common symptom in patients affected by this group of diseases (Carter et al. 2006; Engel et al. 2009; Zebracki and Drotar 2008). Findings in humans and in animal models point to disruption of the sarcolemma as a main cause of neuromuscular disease (Mendell et al. 1995; Straub et al. 1997). Consistent with this, patients affected by Duchenne type neuromuscular dystrophy exhibit increased plasma levels of some muscle fiber content, including enzymes (McMillan et al. 2011) and growth factors (D’Amore et al. 1994). Of note with respect to our findings, it has been reported that patients affected by painful neuromuscular diseases such as polymyositis and Duchenne type neuromuscular dystrophy exhibit increased expression of GDNF in regenerating muscle fibers (Suzuki et al. 1998a). It is thus
tempting to speculate that in these conditions an abnormal leakage of GDNF from affected fibers might sensitize muscle nociceptors, leading to a persistent pain (Engel et al. 2009; Zebracki and Drotar 2008). Finally, it is interesting to note that muscle pain was a common complaint in patients submitted to a long-term therapy with human recombinant GDNF in a clinical trial for Parkinson disease (Nutt et al. 2003).

In summary, our data support the idea that GDNF induces acute and chronic muscle pain. Increased levels of GDNF in muscle concomitant with mechanical hyperalgesia suggest that GDNF plays a role as an endogenous mediator in muscle pain. The nociceptive effects of GDNF in skeletal muscle are likely to be produced by action at GFRα1 receptors located in IB4(+) nociceptors. These findings contribute to our understanding of chronic musculoskeletal pain syndromes.

REFERENCES


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