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Ghrelin enhances gastric emptying in diabetic gastroparesis: a double blind, placebo controlled, crossover study

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Background: Diabetic gastroparesis is a disabling condition with no consistently effective treatment. In animals, ghrelin increases gastric emptying and reverses postoperative ileus. We present the results of a double blind, placebo controlled, crossover study of ghrelin in gastric emptying in patients with diabetic gastroparesis.

Methods: Ten insulin requiring diabetic patients (five men, six type I) referred with symptoms indicative of gastroparesis received a two hour infusion of either ghrelin (5 pmol/kg/min) or saline on two occasions. Blood glucose was controlled by euglycaemic clamp. Gastric emptying rate (GER) was calculated by real time ultrasound following a test meal. Blood was sampled for ghrelin, growth hormone (GH), and pancreatic polypeptide (PP) levels. Cardiovagal neuropathy was assessed using the Mayo Clinic composite autonomic severity score (range 0 (normal)–3).

Results: Baseline ghrelin levels were mean 445 (SEM 36) pmol/l. Ghrelin infusion achieved a peak plasma level of 2786 (188) pmol/l at 90 minutes, corresponding to a peak GH of 70.9 (19.8) pmol/l. Ghrelin increased gastric emptying in seven of 10 patients (30 (6)% to 43 (5)%; p = 0.04). Impaired cardiovagal tone correlated inversely with peak postprandial PP values (p < 0.05) but did not correlate with GER.

Conclusions: Ghrelin increases gastric emptying in patients with diabetic gastroparesis. This is independent of vagal tone. We propose that analogues of ghrelin may represent a new class of prokinetic agents.
METHODS

Patient selection
The aim of the study was to investigate whether ghrelin improved gastric emptying in patients with diabetic gastroparesis. The primary outcome was change in gastric emptying rate (GER). The study was approved by the Northwick Park and St Mark’s committee and was performed in accordance with the Declaration of Helsinki. Ten diabetic patients (five men, mean age 46 (range 36–63) years) were recruited from the outpatients department of a secondary and tertiary referral specialist gastroenterology hospital where they had been referred with persistent upper gastrointestinal symptoms, including bloating. Six were type I diabetics and all were insulin treated. Since the accuracy of gastric emptying studies has been questioned by some authors,18–20 recruitment to this trial was based primarily on symptoms. Recently, the symptom of bloating has been identified as a reliable predictor of gastroparesis.21 Subjects were therefore recruited on the presence of bloating plus two other upper gastrointestinal symptoms on a validated questionnaire.22

All patients had undergone normal upper gastrointestinal endoscopies within six months of enrolment into the study to rule out gastric outlet obstruction or other pathology. Based on a negative CLO test, all patients were Helicobacter pylori negative at the time of the study (three after previous eradication therapy which had been confirmed with subsequent urea breath test before enrolment). All patients had a negative hydrogen breath test for bacterial overgrowth. Patients were asked to stop using proton pump inhibitors, any prokinetic medication, and any autonomically active drugs for at least one week prior to the study. Clinical data were collected for all subjects, including body mass index (BMI), duration of diabetes, and presence of diabetic complications. Symptoms of peripheral neuropathy were assessed using a validated questionnaire.23 Baseline creatinine, HbA1c, urea and electrolytes, full blood count, and thyroid function were all assessed.

Test meal
The test meal of rice pudding (330 kcal, 10% protein, 58% carbohydrate, 32% fat) was given at t = 60 minutes and subjects were asked to consume it within five minutes.

Ultrasound assessment of gastric emptying rate (GER)
The methods for this procedure have been previously described and have been validated in healthy controls and diabetic patients, correlating well with scintigraphic measurement.24–25 Real time ultrasound scanning was carried out using a 5.2 mHz curved array probe using SonoSite 180plus (SonoSite, Herts, UK). Gastric emptying was monitored indirectly by determining the longitudinal (D1) and antero-posterior (D2) diameters of a single section of gastric antrum, using the abdominal aorta and the left lobe of the liver as internal landmarks.24 For both the longitudinal (D1) and antero-posterior (D2) diameters, three measurements were done using the mean values of the longitudinal (D1mean) and anteroposterior (D2mean) diameters to calculate the antral area. The antral cross sectional area (A_antrum) was calculated in all subjects using the formula:

\[ A_{antrum} = \pi \times D_{1mean} \times D_{2mean}/4 \]

Measurements were made at 15 and 90 minutes postprandially. GER was estimated and expressed as the percentage reduction in cross sectional area from 15 to 90 minutes, calculated as follows:

\[ \text{GER} = \left\{ \left( A_{area^{90min}}/A_{area^{15min}} \right) - 1 \right\} \times 100 \]

All of the ultrasound measurements were made by a single radiologist (ST) who was also blinded to the infusion order.

Glycaemic clamp
Blood glucose was maintained between 5 and 8 mmol/l in all subjects throughout each study. Patients omitted their dose of insulin on the morning of the study. Human Actrapid (Novo Nordisk, Crawley, West Sussex, UK), used in all patients (apart from one patient who used Hypurin Porcine neutral (CP)), was diluted in saline and infused at a constant basal rate, equal to the patient’s total daily insulin dose divided by 24. To maintain euglycaemia, saline was infused at 80 ml/h together with a variable infusion of 20% glucose to maintain blood glucose at concentrations of 5–8 mmol/l according to blood glucose measurements using a glucometer (Medisense Optimum; Abbott Laboratories Ltd, Maidenhead, UK) every 15 minutes.

Preparation of ghrelin
Synthetic human ghrelin was purchased from Bachem (UK) Ltd (Merseyside, UK). The Limulus amoebocyte lysate assay test for pyrogen was negative (Associates of Cape Cod, Liverpool, UK), and the peptide was sterile on culture. Vials of ghrelin and saline were indistinguishable visually; they were labelled by subject and infusion numbers and stored in a sealed container.25 Patients and investigators were blinded to the infusion order until study completion.

Infusions
The study was a randomised, double blinded, crossover design. The order of infusions was randomised using the statistics package Sigmasat version 2.0 (SPSS, Inc., Chicago, Illinois, USA). Five patients had ghrelin first and five had saline first. On infusion days, patients attended hospital after an eight hour fast and had three intravenous cannulae sited in their forearms at 0800 h. Ghrelin was infused at a rate of 5 pmol/kg/min, which has been shown previously to stimulate appetite and growth hormone (GH) secretion.11–14 Each infusion continued for 120 minutes. Subjects were continuously attached to a cardiac monitor with blood pressure and heart rate recorded every 30 minutes (Dinamap; GE Medical Systems, Freiburg, Germany).

Autonomic assessment
The degree of autonomic neuropathy was assessed using an adapted Mayo Clinic composite autonomic severity score (CASS).26 CASS assesses postganglionic pseudomotor, adrenergic, and cardiovagal function: in the study, we assessed the latter two. Sympathetic adrenergic function was assessed by beat to beat blood pressure and heart rate responses to head-up tilt and the Valsalva manoeuvre (score 0–4). Cardiovagal function was evaluated by heart rate responses to deep breathing and the Valsalva manoeuvre (score 0–3). An increased score is correlated with loss of function.

Blood sampling
Blood samples were drawn at −75, 0, 30, 60, 90, 120, 150, and 180 minutes during the study. Samples (10 ml) were collected into plastic lithium heparin tubes containing 0.6 mg aprotonin. Samples were immediately centrifuged, and plasma separated and stored at −80°C until assay.

Plasma GH concentration
Plasma GH was analysed using Advantage automated chemiluminescent immunoassay (Nichols Institute Diagnostics, San Juan Capistrano, California, USA).

Plasma PP concentrations
Plasma PP concentrations were measured with a specific and sensitive radioimmunoassay, as previously described.27 The assay cross reacted fully (100%) with human PP and did not cross react with any other member of the PP family or

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gastrointestinal hormone. Antisera against human PP was produced in rabbits and used at a final dilution of 1: 560 000. $^{125}$I PP was prepared by the iodogen method and purified by high pressure liquid chromatography. The specific activity of the $^{125}$I PP label was 54 Bq/fmol. The assay was performed in a total volume of 0.7 ml of 0.06 M phosphate buffer, pH 7.2, containing 0.3% bovine serum albumin. The assay was incubated for three days at 4°C before separation of the free and antibody bound label by charcoal absorption. The detection limit of the assay was 3.5 pmol/l and the intra-assay coefficient of variation was 5.7%. All samples were measured in one assay to avoid interassay variation.

**Plasma ghrelin**

Ghrelin-like immunoreactivity was measured with a specific and sensitive radioimmunoassay, as previously described. 28 Briefly, the assay cross reacts fully (100%) with both octanoyl and desoctanoyl ghrelin and does not cross react with any other known gastrointestinal or pancreatic hormone. The antisera (SC-10368) was obtained from Santa Cruz Biotechnology and used at a final dilution of 1:50 000. $^{125}$I ghrelin was prepared with Bolton and Hunter reagent (Amersham International, UK) and purified by high pressure liquid chromatography using a linear gradient from 10% to 40% acetonitrile, 0.05% TFA over 90 minutes. The specific activity of the ghrelin label was 48 Bq/fmol. The assay was performed in a total volume of 0.7 ml of 0.06 M phosphate buffer, pH 7.2 containing 0.3% bovine serum albumin, and was incubated for three days at 4°C before separation of free and bound antibody label by charcoal absorption. The assay detected changes of 20 pmol/l of plasma ghrelin with a 95% confidence limit. The intra-assay coefficient of variation was 5.5%. All samples were measured in one assay to avoid interassay variation.

**Symptom scores**

On both infusion days, visual analogue scores of the symptoms of bloating, hunger, and nausea were assessed at baseline and thereafter at 30 minute intervals until 180 minutes.

**Statistical analysis**

Statistical analysis was carried out using SPSS software version 12.0 (SPSS Inc., Chicago, Illinois, USA). Differences in peptide levels were measured by analysis of variance. GER data were found to be normally distributed. GER results from the first study day were subtracted from the results of the second study day to remove the effect of order from the analysis. The treatment effect was then evaluated by comparing the differences between treatment orders using a two sample test. Correlations were carried out using Pearson’s correlation. Symptom scores were assessed using analysis of variance. GER and peptide data are presented as mean (SEM) unless otherwise stated.

**RESULTS**

**Patients**

Ten patients were studied on two separate occasions. The demographics of the patient group are outlined in table 1.

**Gastric emptying**

GER did not correlate with duration of diabetes ($r = -0.128$, $p = 0.807$) or HbA1c ($r = 0.48$, $p = 0.161$). Ghrelin significantly

**Table 1** Demographic details and diabetic history

<table>
<thead>
<tr>
<th>Patient No</th>
<th>Sex</th>
<th>Age (y)</th>
<th>BMI (kg/m$^2$)</th>
<th>Duration diabetes (y)</th>
<th>HbA1C (%)</th>
<th>Creatinine (mmol/l)</th>
<th>Retinopathy</th>
<th>Peripheral neuropathy score</th>
<th>Cardiovagal function score (0–3)</th>
<th>Adrenergic function score (0–4)</th>
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<tr>
<td>1</td>
<td>F</td>
<td>51</td>
<td>25.6</td>
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<td>2</td>
<td>F</td>
<td>48</td>
<td>33.6</td>
<td>8</td>
<td>10</td>
<td>97</td>
<td>Yes</td>
<td>0</td>
<td>2</td>
<td>2</td>
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<tr>
<td>3</td>
<td>F</td>
<td>45</td>
<td>22.3</td>
<td>28</td>
<td>9</td>
<td>110</td>
<td>Yes</td>
<td>2</td>
<td>2</td>
<td>3</td>
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<tr>
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<td>F</td>
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<td>22.6</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>5</td>
<td>M</td>
<td>56</td>
<td>31.1</td>
<td>21</td>
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<tr>
<td>8</td>
<td>M</td>
<td>43</td>
<td>25.9</td>
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<td>11</td>
<td>78</td>
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<tr>
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<td>M</td>
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<td>35.4</td>
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<td>9.2</td>
<td>164</td>
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<td>1</td>
<td>2</td>
</tr>
<tr>
<td>10</td>
<td>M</td>
<td>44</td>
<td>23.8</td>
<td>5</td>
<td>11</td>
<td>104</td>
<td>No</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

BMI, body mass index.
increased gastric emptying in seven of 10 patients, from 30 (6)% to 43 (5)% (p = 0.04) (fig 1). Figure 1 shows that the three patients with the highest levels of gastric emptying with saline infusion had the least response to ghrelin.

Cardiovascular autonomic neuropathy (CAN) score
CAN scores are included in table 1. There was an inverse correlation between peak PP level and CAN score during both saline (r = −0.702, p = 0.024) and ghrelin (r = −0.851, p = 0.002) infusions (fig 2). There was no correlation between cardiovascular score and peak GH following ghrelin infusion (r = −0.179, p = 0.620). There was no correlation between GER with ghrelin and CAN score (r = −0.089, p = 0.807).

Plasma ghrelin and PP
Effect of ghrelin and saline infusion
Mean fasting plasma ghrelin concentration was 445 (36) pmol/l (mean (SEM)), with levels ranging from 120 to 1020 pmol/l. Fasting ghrelin levels inversely correlated with BMI (r = −0.71, p = 0.023). Fasting ghrelin levels correlated inversely with BMI (r = −0.71, p = 0.023). Ghrelin infusion achieved steady state at 90 minutes (table 2). GH levels did not increase significantly above baseline during saline infusion (table 3).

Effect of test meal
Ghrelin levels during euglycaemia did not change significantly following the test meal. Plasma PP peaked within 30 minutes of the meal and did not differ between the two infusions (p = 0.07) (fig 3). Peak plasma PP did not correlate with GER during either saline (r = −0.172, p = 0.634) or ghrelin (r = 0.062, p = 0.864) administration.

Symptoms
There were no significant differences between ghrelin and saline in any of the symptoms of bloating, hunger, or nausea during the infusions (p>0.05) (fig 4).

DISCUSSION
We have demonstrated for the first time that ghrelin improves gastric emptying in diabetic gastroparesis. To date, the only previous study to assess the effects of ghrelin on gastric emptying in humans employed the relatively insensitive method of the paracetamol absorption test. The potential of ghrelin as a prokinetic agent has been shown previously in vitro and in vivo studies. In vitro tissue bath studies have demonstrated that ghrelin increases neurally induced contractions secondary to electrical field stimulation in rodents fundus and antrum. In both anaesthetised and conscious rats and mice, an increase in gastric emptying has been demonstrated after ghrelin administration.4 Ghrelin has also been shown to be able to reverse postoperative ileus in the rat and dog.5 6 In the former study, it did so even though motilin and its analogue erythromycin had no effect, suggesting a potent prokinetic action. This ability to reverse ileus has been supported recently in a rodent model of septic ileus where low doses of ghrelin were effective at reversing the ileus induced in rats by injection of lipopolysaccharide endotoxin.7

The mechanism by which ghrelin exerts enterokinetogenic effects is unclear. Ghrelin is an endogenous ligand for the growth hormone secretagogue receptor (GHS-R). In the rat, GHS-R is expressed in the vagal afferent neurones of the nodose ganglion and migrates caudally.8 9 Immunohistochemistry studies have also demonstrated the presence of GHS-R in the myenteric plexus of the stomach and colon in both rats and humans10 and in guinea pig ileum.11 Centrally, GHS-R is also found in the hypothalamus and pituitary.12 Hence it is likely that ghrelin can act at both central and peripheral levels. The structural homology of ghrelin with motilin, and indeed the similarities between the human motilin receptor (GPR-38) and motility are via the motilin receptor. This was not supported by a recent study showing that ghrelin interacted only weakly with the rabbit motilin receptor.13

Recent studies have demonstrated that the vagus may be important in mediating the effects of ghrelin on gastrointestinal motility.14 15 Fujino et al have shown that the stimulatory effects of peripheral ghrelin on antral and duodenal motility in rats are greater in vagotomised rats than in intact rats.16 This suggests that vagotomy may upregulate ghrelin receptors in the myenteric plexus.

Ghrelin may be exacting its effect by altering autonomic tone to the gut. The increase in PP levels after either a sham or test meal is known be a marker of vagal integrity.7 However, this PP response may be blunted in diabetic patients with CAN.16 Nevertheless, delayed gastric emptying

Table 2 Plasma ghrelin levels with saline and ghrelin infusions at 0, 60, 90, 120, and 180 minutes

<table>
<thead>
<tr>
<th>Treatment</th>
<th>0 min (infusion starts)</th>
<th>60 min (pre-meal)</th>
<th>90 min (post-meal)</th>
<th>120 min</th>
<th>180 min</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saline</td>
<td>404 (64)</td>
<td>383 (73)</td>
<td>447 (67)</td>
<td>419 (64)</td>
<td>399 (72)</td>
</tr>
<tr>
<td>Ghrelin</td>
<td>431 (70)</td>
<td>2543 (147)</td>
<td>2786 (188)</td>
<td>2772 (234)</td>
<td>1717 (131)</td>
</tr>
<tr>
<td>p Value</td>
<td>0.29</td>
<td>&lt;0.0001</td>
<td>&lt;0.0001</td>
<td>&lt;0.0001</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

Table 3 Plasma growth hormone (GH) levels with saline and ghrelin infusions at 0, 90, 120, and 180 minutes

<table>
<thead>
<tr>
<th>Treatment</th>
<th>0 min (infusion starts)</th>
<th>90 min</th>
<th>120 min</th>
<th>180 min</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saline</td>
<td>1.6 (1.3)</td>
<td>6.9 (5)</td>
<td>2.5 (1.8)</td>
<td>1.5 (0.8)</td>
</tr>
<tr>
<td>Ghrelin</td>
<td>3.5 (2.7)</td>
<td>70.9 (19.8)</td>
<td>45.4 (13)</td>
<td>10.6 (3.4)</td>
</tr>
<tr>
<td>p Value</td>
<td>0.18</td>
<td>0.008</td>
<td>0.005</td>
<td>0.02</td>
</tr>
</tbody>
</table>
Ghrelin and diabetic gastroparesis

represents the test meal, and the straight bar the period of infusion.

previously been shown that an intravenous bolus of ghrelin

demonstrate any significant changes in preprandial or

response, in terms of peak plasma PP level, correlated with

decreased PP response following a test meal, this was

study has shown that although diabetics with CAN had a
decreased PP response following a test meal, this was

independent of gastric emptying. Our results are consistent
with these findings. In the present study, PP secretory
response, in terms of peak plasma PP level, correlated with
the presence of CAN, but not with GER. We did not
demonstrate any significant changes in preprandial or
postprandial PP levels during ghrelin administration. It has
previously been shown that an intravenous bolus of ghrelin
in fasted healthy subjects increases plasma PP levels, but
currently there are no comparative studies of the effects of
continuous ghrelin infusion on PP levels in either healthy or
diabetic subjects.

In agreement with previous studies, ghrelin increased GH
secretion. Takeno et al have recently described a normal GH
response to continuous intravenous ghrelin administration in
vagotomised humans. In support of this, in the current
study, all subjects showed a significant GH secretory response
to intravenous ghrelin with no correlation between CAN and
GH levels.

We did not observe the expected fall in plasma ghrelin levels
in our diabetic patients following the test meal. The meal was
330 kcal and of mixed macronutrient composition, which
would be expected to elicit a fall in levels in healthy controls.
To control for the effects of hypo- and hyperglycaemia on gastric
emptying, we employed a euglycaemic clamp throughout the
studies. However, this did not control for circulating insulin
levels which may have inhibitory effects on ghrelin release. In
the current study, we measured total ghrelin, whereas differing
levels in diabetic patients may also be affected by excretion and
metabolism of the peptide. Some of our patients had renal
impairment, which may lead to variable or delayed clearance of
ghrelin as it has been shown that patients with renal failure
have increased ghrelin levels. It is unlikely that our observation
is due to the presence of vagal neuropathy as it has been
demonstrated that vagotomy does not affect the nutrient
induced suppression of ghrelin levels.

Despite the evident increase in gastric emptying, ghrelin
did not favourably improve symptoms in patients with
diabetic gastroparesis. This phenomenon of enhanced gastric
emptying not being accompanied by symptomatic improve-
ment has been previously observed and remains unexplained.
Symptoms of hunger, bloating, and nausea relate to a complex
interplay of cortical and peripheral factors, and it seems that a simple effect at a gastric level is insufficient to alter symptom perception.

Conflict of interest: None declared.

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We would like to thank Paul Bassett for his statistical advice.

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Hertfordshire, UK

Figure 3. Effect of ghrelin and saline infusions on pancreatic
polypeptide (PP) release. PP levels increased significantly within
30 minutes of the test meal in all patients during both infusions
(p<0.05). There were no significant differences in peak PP levels
between the saline and ghrelin study days (p>0.05). The arrow
represents the test meal, and the straight bar the period of infusion.

Figure 4. There were no significant differences over time in
symptoms of bloating (A), hunger (B), or nausea (C) between the two
infusion days (p>0.05, ANOVA), as measured by visual analogue scales (VAS).

In conclusion, we have presented novel data that ghrelin
increases gastric emptying in patients with diabetic gastro-
paresis. Although further studies are needed to investigate
the mechanism by which this occurs, we propose that ghrelin
and/or its analogues may represent a new class of prokinetic
agents for the treatment of diabetic gastroparesis. Following
confirmation of acute efficacy in improving gastric emptying
from this study, longer term studies of these compounds are
indicated.

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