Research Article

Evaluation of Antidiabetic Effects of the Traditional Medicinal Plant Gynostemma pentaphyllum and the Possible Mechanisms of Insulin Release

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Aims. To evaluate the antidiabetic effects of Gynostemma pentaphyllum (GP) in Goto-Kakizaki (GK) rat, an animal model of type 2 diabetes, and to investigate the mechanisms of insulin release. Methods. Oral glucose tolerance test was performed and plasma insulin levels were measured. Results. An oral treatment with GP (0.3 g/kg of body weight daily) for two weeks in GK rats improved glucose tolerance versus placebo group (𝑃<0.01). Plasma insulin levels were significantly increased in the GP-treated group. The insulin release from GP-treated GK rats was 1.9-fold higher as compared to the control group (𝑃<0.001). GP stimulated insulin release in isolated GK rat islets at high glucose. Opening of ATP-sensitive potassium (K-ATP) channels by diazoxide and inhibition of calcium channels by nifedipine significantly decreased insulin response to GP. Furthermore, the protein kinase A (PKA) inhibitor H89 decreased the insulin response to GP (𝑃<0.05). In addition, GP-induced insulin secretion was decreased after preincubation of GK islets with pertussis toxin to inhibit exocytotic G proteins (𝑃<0.05). Conclusion. The antidiabetic effect of GP is associated with the stimulation of insulin release from the islets. GP-induced insulin release is partly mediated via K-ATP and L-type Ca2+ channels, the PKA system and also dependent on pertussis toxin sensitive Gc-protein.

1. Introduction

The concern over efficacy and side effects of currently available therapies in the treatment of type 2 diabetes has promoted interest in discovery and development of antidiabetic drugs from traditional plants [1]. Several herbs with antidiabetic properties exert their effects by improving insulin secretion, glucose uptake by adipose and skeletal muscle tissues, or suppressing intestinal glucose absorption and hepatic glucose output [2].

Gynostemma pentaphyllum (GP) Makino, also known as Jiaogulan, is a climbing, perennial vine plant which grows in several parts of Asia countries including China, Vietnam, Japan, and Malaysia [3, 4]. Consumed as tea or food, the traditional uses of GP as a medicinal herb as claimed by practitioners have been pharmacologically and clinically proven in several studies. GP has been reported previously to have high radical scavenging capacity, antiproliferative, anti-inflammatory [3, 5, 6], hypoglycemic [7, 8], anticancer [9, 10], and antimicrobial effects [11].

The antidiabetic effects of GP have been clearly demonstrated in animal models of diabetes and randomly assigned type 2 diabetic patients. Thus, administration of GP tea in diabetic patients improves glucose tolerance by enhancing insulin sensitivity [12–14]. A similar effect was observed in the Goto-Kakizaki rat, an animal model of type 2 diabetes, showing that GP extract reduces the hepatic glucose output [15]. In other studies, an active gypenoside compound known as phanoside, isolated from GP, exhibited a potent insulin-releasing activity [16–18]. Furthermore, using diabetic rat
models, GP saponins induce hypoglycemia, hypolipidemia, and immunocompetence effects associated with antioxidant activities [19, 20].

Several studies have been carried out to identify the antidiabetic effects of GP; however, these actions have not been elucidated in detail. In this study, the effects of GP water extract on GK rat blood glucose and serum insulin levels were studied. In addition, GP extract effects on mechanisms behind insulin secretion from GK rat islets were investigated.

2. Materials and Methods

2.1. Animals. Male spontaneous type 2 diabetic Goto-Kakizaki (GK) rats (150–350 g) were used in this study. GK rats, originating from Wistar (W) rats, were bred in our department. The rats were kept at 22°C with an alternating 12-hour light-dark cycle (6 am–6 pm) and were allowed access to food and water before being anesthetized for isolation of pancreatic islets. The study was approved by the Laboratory Animal Ethics Committee of the Karolinska Institutet.

2.2. Preparation of Gynostemma pentaphyllum (GP) Extract. GP water extracts were prepared according to standardized procedures from the whole herb obtained from China (Legosan AB, Kumla, Sweden). The standardized extract contained 98% gypenosides (German LEFO-Institut für Lebensmittel und Umwelt GmbH, Ahrensburg, Germany). The dried extract was suspended in ratio of 0.85 g to 20 ml in water for the use in the animal study and was prepared fresh daily. GP powder was diluted in distilled water and filtered with a 0.2 μM filter.

2.3. Treatment with GP. The GK rats were divided into 2 groups: controls (n = 5) and GP-treated (n = 5). The rats were fasted overnight (14-15 hours), allowing access only to plain drinking water. For the treatment group, GP (0.3 g/kg of body weight) was administrated daily by oral gavage for 2 weeks whereas control group was given water only.

2.4. Oral Glucose Tolerance Test (OGTT). An OGTT was performed to determine the effect of GP on blood glucose and insulin levels. Blood for glucose determination was obtained by tail-prick method at different time points: 0 minute (before glucose load of 0.2 g/100 g body weight), 30, 60, and 120 minutes. Blood glucose levels were measured using a glucometer, Accu-check Aviva (Roche Diagnostic GmbH, USA). Blood samples were also collected for the measurement of plasma insulin level at 0, 30, and 120 min. After two weeks’ treatment with GP, the animals were killed using CO₂. Pancreas was collected immediately for isolation of pancreatic islets and insulin secretion measurements.

2.5. Effect of Different Concentrations of GP on the Insulin Secretion from Isolated Islets. The isolation of islets was performed using collagenase method as described in previous protocols [16, 21, 22], and batch incubation of islets was performed as previously described [16, 21]. The medium used was Krebs-Ringer bicarbonate (KRB) buffer solution supplemented with 2 mg/mL of bovine albumin 10 mM HEPES and either 3.3 mM or 16.7 mM glucose. Following overnight incubation, the islets were preincubated at 3.3 mM glucose for 30–45 min at 37°C with an atmosphere of 5% CO₂-95% air. Batches of three islets were incubated for 1 hour in 300 μL Krebs-Ringer bicarbonate (KRB) buffer, at 37°C, with or without GP at different concentrations (1, 5, 10, and 15 mg/mL) at either 3.3 mM or 16.7 mM glucose. Aliquots obtained from batch incubations were further analyzed for insulin content using radioimmunoassay (RIA) [23].

2.6. Mechanisms of GP-Induced Insulin Release. To investigate how GP stimulates insulin release, we explored the ATP-sensitive potassium (KATP) channels. GK rat islets were incubated in Krebs-Ringer bicarbonate buffer (KRB) containing either 3.3 mM or 16.7 mM glucose. The medium was added with different incubation mixtures: 0.25 mM diazoxide (Sigma-Aldrich, USA) only (to open the K-ATP channels), 10 mg/mL of GP only, 50 mM of KCl (for depolarization of beta cells), and 10 mg/mL of GP. To investigate the effect of GP on L-type Ca²⁺ channels in beta cells, GK rat islets were incubated in KRB containing 16.7 mM glucose with addition of the L-type Ca²⁺ channel inhibitor, nifedipine (Sigma-Aldrich, USA). To investigate the effects of protein kinase A (PKA) and protein kinase C (PKC) on GP-induced insulin release, GK rat islets were incubated with or without GP and the PKA-inhibitor, H89 (10 μM, Sigma-Aldrich, USA), or the PKC inhibitor, calphostin-C (1.5 μM, Sigma-Aldrich, USA), for 60 min in KRB containing 3.3 mM and 16.7 mM glucose.

To assess the possible involvement of exocytotic G-protein, Gₛ-protein, in GP-induced insulin release, GK rat islets were pretreated at 37°C overnight with 100 ng/mL pertussis toxin in RPMI 1640 culture medium (SVA, Sweden) containing 11 mM glucose, 30 mg L-glutamine, 10% heat-activated fetal calf serum, and antibiotics (100 IU/mL penicillin and 0.1 mg/mL streptomycin, Invirogen, USA). After exposure overnight with or without pertussis toxin, islets were incubated with 10 mg/mL of GP at 3.3 mM and 16.7 mM glucose. Aliquots of the medium were analyzed for insulin content using RIA [23].

2.7. Statistical Analysis. The results are presented as mean ± SEM. Differences between experimental groups for OGTT and insulin secretion experiments were analyzed using unpaired t-test. The differences between means in the batch incubations and the mechanisms of insulin release via the K-ATP channels and Ca²⁺ channel as well as PKA and PKC mediators were analyzed for significance using one-way ANOVA, followed by Bonferroni’s Multiple Comparison Post Hoc Test. All data were analyzed using Prism Graph Pad Software (CA, USA). A P value of less than 0.05 was considered to be significant.

3. Results

3.1. Oral Glucose Tolerance Test (OGTT). At baseline (day 0), glucose tolerance test was similar in both placebo and treatment groups with the area under the curves (AUCs)
for glucose during 120 min (0–120 min) being 883.5 ± 63.4 versus 955.5 ± 74.1 mM, respectively. However, after two-week treatment with GP, glucose tolerance was significantly improved. The mean blood glucose levels at 120 min were found to decrease in the treated group as compared to the placebo group (11.0 ± 1.1 versus 13.9 ± 1.1 mM, resp.) (Figure I(a)) with AUCs (0–120 min) being 639.6 ± 38.5 versus 842.4 ± 43.8 mM (P < 0.01) (Figure I(b)). Plasma insulin levels after GP treatment were significantly increased both at 0 min (P < 0.01) and after glucose stimulation at 30 and 120 min (P < 0.001) when compared with the control group (Figure I(c)). The body weights of GP- and placebo-treated GK rats showed comparable increase from day 0 to day 14 (data not shown).

3.2. Effects of GP on Insulin Secretion in GK Rat Islets. To identify if the oral administration of GP has an effect on the insulin release in the islets, the pancreas of the rats treated with GP for two weeks were collected (Figure I(d)). At 3.3 mM glucose, insulin release was not significantly different between islets of GK rats treated with GP as compared to islets from control GK rats (14.6 ± 1 versus 14.3 ± 1.9 μU/islet/hour). However, insulin release at 16.7 mM glucose was higher in islets from GP-treated rats as compared to islets from control rats (61.8 ± 4.9 versus 32.7 ± 2.8 μU/islet/hour; P < 0.001).

In separate in vitro experiments, isolated GK rat islets were incubated with different concentrations of GP to identify the insulin-stimulatory effect. At 3.3 mM glucose, GP at any concentration did not stimulate insulin release when
compared to the control incubations (Figure 2). At 16.7 mM glucose, the addition of GP at 5, 10 and 15 mg/mL increased insulin release by 1.6, 2.2 (P < 0.01) and 3.6-fold (P < 0.001), respectively, when compared to the control group.

3.3. Effects of GP on the Exocytosis of Insulin Islets. The closure of K-ATP channels in pancreatic β-cells leads to membrane depolarization and the stimulation of insulin release. Therefore, to understand if GP stimulates insulin release via the K-ATP channels, we used diazoxide. The addition of diazoxide inhibits insulin release by opening the K-ATP channels in pancreatic β-cells [24]. KCl was used for membrane depolarization. GP significantly increased insulin release 3.4-fold (P < 0.001) compared to the control group at 16.7 mM glucose (Figure 3). The opening of K-ATP channels by adding diazoxide (0.25 mM) inhibited insulin release by 63% at 16.7 mM glucose. In addition, at 16.7 mM glucose, diazoxide decreased insulin response to GP from 78.1 ± 15.6 to 26 ± 17.0 μU/islet/hour (P < 0.001). The addition of potassium chloride (KCl) to islets incubated with diazoxide to depolarize the β-cells increased insulin release at both 3.3 mM and 16.7 mM glucose compared to the control group. At 16.7 mM, the insulin response to GP + diazoxide and KCl was significantly higher compared to islets incubated with diazoxide + KCl (at P < 0.05).

To further understand if GP exerts its effect via L-type Ca²⁺ channel, nifedipine was used as an inhibitor of these channels [25]. At 16.7 mM glucose, GP stimulated insulin release by 2.6-fold (P < 0.001) compared to the control (Figure 4). The addition of nifedipine (10 μM) decreased insulin release from 12.6 ± 1.7 to 6.5 ± 1.3 (μU/islet/hour). Incubation with nifedipine and GP at 16.7 mM glucose decreased insulin secretion significantly compared to secretion induced by GP only, from 32.8 ± 4.5 to 19.4 ± 1.3 μU/islet/hour (P < 0.01).

PKA or PKC pathways potentiate the insulin response to a metabolic stimulus [26]. To understand if GP exerts its effect via the PKA and PKC pathways, H89 (PKA inhibitor) and calphostin C (PKC inhibitor) were used. Incubation of islets with GP at 16.7 mM glucose stimulated insulin release by 2.2-fold (P < 0.01) (Figure 5). H89 (10 μM) and calphostin C (10 μM) decreased insulin release from 22.1 ± 2.8 to 7.7 ± 3.9 μU/islet/hour (P < 0.01).
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4. Discussion

We have demonstrated treatment of GK rats, an animal model of type 2 diabetes, with GP extract for two weeks significantly improved glucose tolerance, increased plasma insulin levels, and increased insulin secretion from islets isolated from the treated rats. Furthermore, when tested in vitro, the GP extract stimulated insulin release from the isolated rat islets at high glucose only. GP-induced insulin release was partly mediated via K-ATP and L-type Ca\(^{2+}\) channels. The effects of GP were also mediated via the PKA system and partly dependent on pertussis toxin sensitive G\(_s\)-protein at high glucose.

An oral administration of GP extract for 3 weeks in GK rats, which was done in the previous study, improved glucose tolerance and suppressed hepatic glucose output [15]. In addition to the effect of GP on the improvement of insulin sensitivity reported in the previous studies [12–15], the reduction of glucose levels observed in this study might be associated with a stimulatory effect on insulin release from the pancreatic islets. This observation is in concert with previous findings with phanoside, a compound isolated from GP [16–18]. The stimulated insulin secretion by GP is of importance since insulin controls the regulation of blood glucose level by increasing glucose uptake in the muscle and fat and suppressing glucose output in the liver [28].

Our findings have shown that GP has a potent insulin-stimulating activity in the GK rat islets. Therefore, to further understand the mechanisms behind GP-stimulated insulin release, we have explored the different sequences of pancreatic \(\beta\)-cell stimulus-secretion coupling for glucose [16]. We first elucidated the role of the ATP-sensitive potassium (K-ATP) channels. In pancreatic \(\beta\)-cells, the involvement of the K-ATP channel in regulation of glucose-dependent insulin secretion is a key factor. When blood glucose levels are elevated, glucose will be transported into the pancreatic \(\beta\)-cell by GLUT2 glucose transporters and is then metabolized via glycolysis and glucose oxidation to ATP. The increase of ATP/ADP ratio in the \(\beta\)-cells leads to closure of cell-surface ATP-sensitive K\(^{+}\) (K-ATP) channels. This in turn will lead to cell membrane depolarization, causing the opening of voltage-gated Ca\(^{2+}\) channels, cytosolic Ca\(^{2+}\) accumulation, and eventually insulin will be released [29–31]. In addition, activation of cAMP-dependent protein kinase PKA pathway is important for the insulin secretion signals in pancreatic \(\beta\)-cells, whereas PKC signal pathways play an important role in potentiating the insulin response to glucose and incretins [26]. Our present findings suggest that GP-induced insulin secretion is modified by the PKA, but not the PKC, pathway.

Guanine nucleotide-binding proteins (G proteins) control several important sites regulating stimulus-secretion coupling and insulin secretion from pancreatic beta cells. G\(_s\)-proteins mediate increases in intracellular cAMP associated with hormone-induced stimulation of insulin secretion, and G\(_i\)-proteins mediate decreases in intracellular cAMP caused by inhibitors of insulin secretion, for example, epinephrine, somatostatin, prostaglandin E2, and galanin. G proteins also regulate ion channels, phospholipases, and distal sites in exocytosis, that is, by G\(_{\text{protein}}\) [32]. It seems plausible and to 5.4±0.2 \(\mu\)U/islet/hour, respectively, at 16.7 mM glucose compared to the control group. H89 decreased the insulin response to GP from 48.8 ± 0.9 to 26.07 ± 3.2 \(\mu\)U/islet/hour \((P < 0.05)\). Calphostin C inhibitor did not affect the insulin response to GP at 16.7 mM glucose.

To understand if GP stimulates insulin release via exocytotic G\(_s\) proteins, pertussis toxin (PTX) was used as an inhibitor. PTX prevents the G proteins from interacting with their associated G protein-coupled receptors [27]. The preincubation of GK rat islets with pertussis toxin in the presence of GP at 11.1 mM glucose decreased the insulin secretion compared to the control group, from 29.6 ± 2.2 to 13.8 ± 0.7 \(\mu\)U/islet/hour at 16.7 mM glucose \((P < 0.05)\) (Figure 6).
that GP, at least partly, exerts its stimulatory effects on insulin exocytosis, since preincubation of islets with the G-protein inhibitor pertussis toxin also decreased GP-induced insulin release. Our findings have shown that the effects of GP, at least to some extent, are most likely exerted by phanoside, a gypenoside that has been purified from GP [13-15]. Phanoside was also shown to exert its insulin-stimulatory effect distal to K-ATP channels and L-type Ca\(^{2+}\) channels, that is, mainly on the exocytotic machinery of the beta cells [16,18].

5. Conclusions

We demonstrate that GP has antidiabetic properties mainly due to its stimulation of insulin release from the GKR pancreatic islets. GP-induced insulin release is partly mediated via K-ATP and L-type Ca\(^{2+}\) channels. In addition, GP seems to interact with the PKA system and partially via exocytotic G\(_{\text{c}}\)-proteins.

Conflict of Interests

The authors declare no conflict of interests.

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