Corticotropin-releasing factor receptors and stress-related alterations of gut motor function

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Over the past few decades, corticotropin-releasing factor (CRF) signaling pathways have been shown to be the main coordinators of the endocrine, behavioral, and visceral functions of the gastrointestinal system. We also examine how these mechanisms translate into the development of new approaches for irritable bowel syndrome, a multifactorial disorder for which stress has been implicated in the etiology of irritable bowel syndrome (IBS), which is characterized by altered bowel movements, bloating, and visceral pain (10–13). Cyclic vomiting syndrome is another brain-gut disorder manifested by recurrent, stereotyped episodes of nausea and vomiting in the pediatric population, which is triggered by stressors related to heightened emotional state, fasting, exercise, and infection in 80% of the patients (14).

A big step forward in our understanding of the neurocircuits and biochemical effectors that coordinate the physiological response to stress came from the identification in the hypothalamus of the 41-aa peptide corticotropin-releasing factor (CRF) by Vale et al. in 1981 (15). Since then, experimental studies in nonprimates and primates have supported the notion that CRF signaling is a key component of the multifaceted acute response to stress and that overactivity of this pathway has a role in the pathophysiology of various neuroendocrine and psychiatric illnesses related to stress, including anxiety and depression (16–18). Consequently, emphasis has been placed on elucidating the level of involvement of CRF signaling pathways, in both the brain and the gut, in the alterations of gut motor function known to be associated with stress (5, 19).

In addition, the clinical relevance of overactive CRF signaling in the brain and periphery in functional bowel diseases is receiving increasing interest (20, 21), particularly because of the high prevalence of coexisting psychiatric disorders, prominently anxiety and depression, in IBS patients (22).

In this Review, we first discuss recent advances in our knowledge of CRF signaling as it relates to CRF family members and their receptors, as well as the insight provided by the development of CRF receptor antagonists. Preclinical studies supporting a primary role for CRF receptor activation in the brain and gut in mediating the alterations of gastric and colonic motor function associated with exposure to various stressors are outlined. The potential relevance of CRF signaling pathways in the pathogenesis and treatment of IBS is also addressed (20, 23).

CRF signaling pathways

CRF family members and receptors. CRF was the first peptide isolated (15) of a family of mammalian CRF-related peptides that now includes urocortin 1, urocortin 2 (also known as stresscopin-related peptide), and urocortin 3 (also known as strescopin)
Figure 1
Overview of the family of peptides related to CRF and their receptors and receptor antagonists. CRF was the first peptide isolated of a family of mammalian CRF-related peptides that now includes urocortin 1, urocortin 2, and urocortin 3. CRF can bind either of 2 CRF receptors, CRF receptor type 1 (CRF₁) or CRF receptor type 2 (CRF₂), although it has a preferential affinity for CRF₁. By contrast, urocortin 1 has equal affinity for both receptors, and urocortin 2 and urocortin 3 are selective ligands for CRF₂ receptors. Both CRF receptors share 70% similarity and belong to the 7-transmembrane-G protein-coupled superfamily. CRF₁-selective antagonists are small nonpeptide molecules, while nonselective and CRF₂ antagonists are peptides.

(24) (Figure 1). Consistent with a role for this family of peptides in survival and adaptation, the structures of CRF and urocortin 1 are highly conserved across mammalian species and during evolution, as shown by the 45%–48% similarity with the nonmammalian CRF-related peptides sauvagine (which has been isolated from the amphibian Phyllomedusa sauvagii) and urotensin I (which has been isolated from fish) (25).

CRF and the urocortins exert their biological actions on target cells through activation of 2 receptors, known as CRF receptor type 1 (CRF₁) and CRF receptor type 2 (CRF₂), which are encoded by 2 distinct genes (26). CRF₁ and CRF₂ belong to the B1 class subfamily of 7-transmembrane-domain G protein-coupled receptors (26, 27) (Figure 1). CRF₁a is the main functional variant of CRF₁ and is widely expressed in the brain and some peripheral tissues in mammals (26). In addition, alternative splicing of the primary transcript encoding CRF₁ can lead to a number of other variants, named CRF₁b–n, all of which display impaired signaling (26). The expression of the CRF₁b–n variants is tissue specific, can vary with the functional activity of the tissues, and might be influenced by environmental factors — as reported so far in the skin of humans and rodents and in human myometrium and placenta (26). The functional significance of these other trancripts is still poorly characterized, but some splice variants, such as CRF₁d, have been reported to modulate CRF and urocortin 1 signaling in transfected cells by acting as a “decoy receptor” able to compete with CRF₁a for agonist binding (26). In addition, recent data in human myometrial smooth muscle cells indicate that steroids can change the ratio of expression of CRF₁a and CRF₁b with increased expression of the CRF₁a functional form of CRF₁ and decreased expression of the nonfunctional form CRF₁b, thereby enhancing tissue responsiveness to CRF (26). However, similar information regarding the expression of various CRF₁ splice variants in the brain and gut, and their regulation in these tissues under stress conditions, is still lacking.

In contrast to CRF₁, 3 functional CRF₂ variants, 2α, 2β, and 2γ (renamed 2a, 2b, and 2c), have been identified in mammals (24, 26). The CRF₂ variants have a common carboxy-terminal region and structurally distinct amino-terminal extracellular domains (the region involved in ligand binding) that contain 34 aas for CRF₂a, 61 aas for CRF₂b, and 20 aas for CRF₂c (24, 28). Recently, a novel soluble splice variant has been identified in the mouse brain and shown to encode only the first extracellular domain of CRF₂a and to function as a soluble binding protein for CRF and urocortin 1 (29).

Despite sharing 70% aa sequence similarity, CRF₁ and CRF₂ display distinct characteristic affinities for the CRF family of peptides (Figure 1) (24, 26). CRF₁ has a higher affinity (10- to 40-fold higher) for CRF₁ than for CRF₂, whereas all the urocortins signal preferentially through CRF₂. Urocortin 1 binds CRF₂ with 100-fold greater affinity than does CRF₁, and CRF₁γ has 6-fold greater affinity than does CRF₁γ (30–32). Urocortin 2 and urocortin 3 exhibit high selectivity only for CRF₂ (31, 32), with a slightly higher affinity for CRF₂b compared with CRF₂a, and a low affinity for the new soluble CRF₂b splice variant (29, 32) (Figure 1). CRF₂ variants display tissue- and species-specific expression. In nonprimate mammals, CRF₂b is expressed only by neurons and CRF₂a and CRF₂b are expressed in the periphery and by non-neuronal cells of the brain (33), whereas CRF₂b is found only in the amygdala of the human brain (34). It is well documented that stimulation of CRF₁a, CRF₂a, and CRF₂b activates adenylyl cyclase/cAMP signaling pathways through coupling and activation of Gαs proteins (26). However, several recent reports indicate that the nature of a trimeric complex, made of CRF agonist, CRF receptor, and G protein, influences the pattern of intracellular signaling in a tissue-specific manner (26).

CRF receptor antagonists. The development of competitive CRF receptor antagonists was an important early development in the endeavor to determine the functions of CRF receptors under basal and stress conditions (35). The first CRF antagonist was α-helical CRF₉₋₄₁, a CRF analog generated by deletion of 8 aas from the amidated carboxyl terminus of CRF (27, 36). A subsequent approach to enhance the potency of CRF antagonists was to design analogs in which the secondary structure of CRF was constrained, leading to the generation of [α-Phε₁₂, Nle²₁,³₆, CαMeLeu²⁷]CRF₁₂₋₄₁ (α-Phε₁₂CRF₁₂₋₄₁) and cyclo(30–33)[α-Phε₁₂, Nle²₁,³₆, Glu⁵₀, Lys⁵₃]Ac-CRF₉₋₄₁ (known as astressin) (37). Additional astressin-like analogs were later developed, of which cyclo(30–33)[α-Phε₁₂, Nle²₁,³₆, CαMeLeu²⁷]Glu⁵₀, Lys⁵₃, Nle⁵₆, CαMeLeu⁶₀[Ac-CRF₉₋₄₁ (known as astressin-B) is the most efficacious and long-acting (being still effective 24 hours after a single peripheral injection) (38). The use of these CRF antagonists has unraveled the many roles that CRF receptors have in orchestrating the behavioral (anxiety, decreased feeding, and drug-seeking), cognitive (anxiety and anxiety), and neuroendocrine (ACTH and β-endorphin release), autonomic (activation of the sym-
pathetic nervous system), immunological, and visceral (hypertension and alterations in gut motor function) responses to stress.

However, these CRF antagonists bind both CRF₁ and CRF₂ and, therefore, do not provide selectivity to assess the involvement of the 2 CRF receptor subtypes (27, 42) (Figure 1). An important goal was reached recently when competitive and selective peptide antagonists for CRF₂ were developed and shown to bind equally to the a, b, and c variants of CRF₂ while having little to no affinity for CRF₁ receptors (29, 43, 44) (Figure 1). Three of these peptides are [d-Phe¹,His¹²]sauvagine₁₁–₄₀ (known as antisauvagine-30), [d-Phe¹¹,His¹²,Nle¹⁷]sauvagine₁₁–₄₀ (known as K41498), and the long-acting analog with additional conformational constraints, cyclo(31–34)[d-Phe¹¹,His¹²,Nle¹²,CzαMeLeu¹³,35,Nle¹⁷,Glu¹⁹,Lys²³⁴]Ac-sauvagine₉–₄₀ (known as astressin-B) (Figure 1). So far, there are no peptide analogs that are selective CRF₁ antagonists; however, a flurry of patents for orally bioavailable, nonpeptidic selective CRF₁ antagonists have been recently disclosed (16, 35). These small–molecular weight compounds cross the blood-brain barrier with a penetrance largely influenced by their distinct physico-chemical properties, particularly their lipophilicity (35). Among the selective CRF₁ antagonists, CP-154,526, antalarmin, DPM696, NBI 30775 (also known as R121919), and NBI 35965 have been among the most commonly used and characterized (35, 45, 46) (Figure 1). With the availability of selective CRF₁ receptor antagonists, it has become clear that the constellation of physiological effects produced by endogenous CRF peptides might be attributed to actions on distinct CRF receptor subtypes. Compelling evidence indicates that activation of the brain CRF–CRF₁ signaling pathway has a leading role in coordinating many of the physiological responses to adaptive stress as it relates to the activation of the hypothalamic-pituitary-adrenal (HPA) axis, sympathetic nervous system, and changes in cardiovascular, colonic, and immune functions in rodents and primates (23, 39, 47–49). Preclinical and clinical studies also indicate that abnormally increased central CRF₁ signaling contributes to the pathogenesis of anxiety and depression and can have implications in the pathophysiology of IBS (18, 20, 49). With regard to CRF₁ receptors in the brain, emerging evidence supports a role for these receptors as mediators of ways to dampen and/or facilitate the proper recovery of the CRF₁-initiated behavioral, endocrine, and visceral responses to stress (50–52). However, in some systems — for instance, the suppression of feeding behavior — activation of CRF₁ has an additive effect with the CRF₁-mediated orexigenic effect (49).

Link between CRF receptors in the brain and stress-related alterations of gut motor function
Convergent experimental reports have shown that central injection of CRF and urocortins reproduces stress-related alterations of gut motor function in naive rodents, whereas central injection of CRF antagonists prevents the effects of various stressors, supporting a crucial role for CRF receptors in the brain in the regulation of stress-induced alterations in gastrointestinal motility (53).

**Stress, CRF receptors in the brain, and gastric transit.** CRF, urocortin 1, urocortin 2, and the nonmammalian CRF-related peptides sauavagine and urotensin I inhibit gastric emptying of noncaloric liquid, caloric liquid, and solid food when injected into the cerebrospinal fluid (CSF) of several nonprimate mammals (53). These peptides also inhibit basal and cholinergic-stimulated gastric motility in rodents and dogs (54, 55). CRF₁ is the CRF receptor subtype in the brain through which CRF and urocortins injected into the CSF primarily initiate their inhibitory effect on gastric transit and motility (56–58). Sites of CRF action in the brain are specific and localized in the paraventricular nucleus of the hypothalamus (PVN) and the dorsal vagal complex nuclei, both of which contain neurons bearing CRF₂ and are known to influence autonomic nervous outflow to the stomach (Figure 2) (53, 59, 60). Consistent with this, blocking of the transmission of impulses by the autonomic nervous system prevents CRF injected into the CSF or PVN from inhibiting gastric transit (61–62). Removal of the pituitary gland or adrenal glands had no effect on CRF inhibition of gastric emptying; this indicates that the gastric effect is not secondary to the activation of the HPA axis (61, 62). All reports, except 2 (61, 63), have identified the vagus nerve as the main pathway mediating the delayed gastric transit and inhibition of gastric motility induced by central injection of either CRF or urocortin 1 in rats and dogs (54, 55, 57, 59, 62, 64, 65). By contrast, the delayed gastric emptying induced by injection of urocortin 2 into the CSF is not altered by gastric vagotomy and instead requires the integrity of the sympathetic nervous system and peripheral α-adrenergic receptors (57). These data indicate that CRF and its related peptides differentially modulate vagal and sympathetic components of the autonomic nervous system to suppress gastric motor function.

The importance of CRF signaling in the brain was established using pharmacological blockade of CRF receptors. Injection of α-helical CRF₉₈–₄₁, d-Phe¹²CRF₁₂–₄₁, astressin, or astressin-B into the CSF or PVN completely prevented the delayed gastric emptying induced by various psychological, physical, visceral, immunological, or chemical stressors, including swim stress, restraint, abdominal or cranial surgery, peritoneal irritation with 0.6% acetic acid, systemic or brain injection of IL-1β, and exposure to ether anesthesia (5, 63, 66). Consistent with this, various stressors, including abdominal surgery and peripheral administration of IL-1β, activate neurons that express CRF and upregulate levels of mRNA encoding CRF in the PVN (67–70). Likewise, urocortin 1, urocortin 2, and urocortin 3 are present in the PVN, and expression of the urocortins is upregulated during stress (49, 71, 72). The CRF receptor subtypes and endogenous CRF ligands primarily involved in delaying gastric motor function under stress conditions have been characterized in only a few studies so far. The CRF₂ antagonist astressin₂-B injected into the CSF abolished the delayed gastric emptying in response to restraint in rats (63). By contrast, pharmacological blockade with a selective CRF₁ antagonist and the use of mice lacking CRF₁ suppressed the inhibition of gastric transit induced by surgical stress (caused by abdominal surgery or cecal palpation) (73). Collectively, these data provide new insights into the role of specific CRF receptors in the brain in the altered gastric digestive function that occurs in response to stress of surgical or immunological origin. As inhibition of gastric propulsive activity after surgical intervention represents a substantial medical problem for which effective treatments are still lacking (74), these experimental findings might open new therapeutic avenues.

**Stress, CRF receptors in the brain, and small-intestinal transit.** Alterations in small-intestinal motor function induced by stress and CRF ligands have been investigated in parallel with those occurring in the stomach (53). Acute psychological stress and central injection of CRF and urocortin 1 exert an inhibitory effect on duodenal and small-intestinal transit and propulsive motility, similar to their effects on gastric functions (6, 54, 65, 66, 75–77). Peptide-inhibitory action is mediated directly by vagal nerves and is independent of activation of the HPA axis (6, 61, 66, 78).
The inhibitory action of central CRF on small-intestinal transit is, however, less prominent than its inhibitory action on gastric transit; this most probably reflects the lesser density of vagal innervation of the small intestine as compared with the stomach (79). In addition, the role of CRF receptors in the brain in stress-related inhibition of small-intestinal transit is yet to be characterized. The reduction of small-intestinal transit induced by partial restraint was reported to be blocked in male, but not in female, rats injected with α-helical CRF9–41 into the CSF (6, 66). Whether these conflicting data relate to sex differences or other experimental components remains to be determined.

Stress, CRF1 in the brain, and colonic transit. In contrast to the inhibitory effects of CRF and urocortin 1 injected into the CSF on gastric and small-intestinal motor function, these peptides stimulate colonic transit and defecation and induce diarrhea through increased sacral parasympathetic outflow to the large intestine in female and male rats, mice, and gerbils (6, 7, 56, 61, 80–85). Convergent studies have shown that the activation of CRF1 receptors in the brain contributes to the stimulatory effects of central injection of CRF and urocortin 1, as well as the stimulatory effects of various stressors, on colonic motor function (23, 53). First, the colonic propulsive motor activity induced by stress is mimicked by central administration of urocortin 1 and the preferential CRF1 agonist ovine CRF (27), whereas the selective CRF2 agonists urocortin 2 and urocortin 3, injected into the CSF at a dose similar to that of CRF, are inactive (56). In addition, central administration of the pan–CRF peptide antagonists α-helical CRF9–41, D-Phe12-CRF12–41, and astressin blocked the colonic motor stimulation (motility, transit, and defecation) induced by central injection of CRF and urocortin 1, as well as by various stressors (wrap or partial restraint, water avoidance, conditioned fear, IL-1β injected into the CSF, and morphine withdrawal) (6, 7, 56, 66, 80, 82, 83, 86–89). Similarly, the selective CRF1 antagonists CP-154,526, CRA 1000, NBI 27914, NBI 35965, and antalarmin, injected either into the CSF or i.p., prevented the acceleration of colonic transit induced by restraint, dampened defecation in response to water avoidance, restraint, and social stress, and inhibited the diarrhea elicited by morphine withdrawal (23). Likewise, CRF1-deficient mice have lower defecation scores than wild-type littermates in an open-field test (90). Lastly, the CRF2-specific peptide antagonist astressin2-B, injected into the CSF at doses that block CRF2 effects on gastric emptying, did not inhibit the stimulatory effect of CRF on colon function in rodents (5, 23, 56).

The PVN, the locus coeruleus (LC), and the Barrington’s nucleus, which lies just ventromedial to the LC, are areas of the brain where CRF and stress stimulate colonic motor function and anxious behavior (16, 91) (Figure 2). These sites are activated by water-
avoidance stress, as is shown by their increased expression of FOS, a neuronal marker of cell activation (80). Water avoidance also induces rapid transcription of the gene encoding CRF in the PVN (92). Furthermore, α-helical CRF$_{9–41}$ injected into the PVN prevents the stimulation of colonic transit and defeation induced by partial restraint and water avoidance (64, 80, 87). Likewise, in inbred rats with a genetically impaired hypothalamic CRF response to stress (93), water avoidance results in a reduced activation of neurons in the PVN and sacral parasympathetic nucleus (as shown by decreased expression of FOS) and is associated with an attenuated colonic motor response (86). Moreover, expression of the gene encoding CRF$_1$ in the PVN (60) is markedly increased by different types of interoceptive or exteroceptive stressors (94). It has been shown that CRF-synthesizing neurons in the Barrington’s nucleus project to both the noradrenergic LC and the sacral parasympathetic nucleus of the spinal cord, which innervates the descending colon (Figure 2) (91, 95). In the LC, CRF increases the rate at which noradrenergic neurons fire and thereby increases the amount of noradrenaline released into the brain cortex, leading to arousal and anxiogenic behavior (Figure 2) (91, 96). Consequently, the activation of CRF-CRF$_1$ signaling in the PVN and LC (94, 97) is well positioned to participate in stress circuits that coordinate behavioral anxiogenic and autonomic responses that impact colonic motility (81, 91). It might be speculated that overactivity of these neurological circuits has relevance to the high incidence of anxiety disorders in patients with IBS and that these effects might be efficiently targeted by CRF$_1$ antagonists (16, 23, 98).

Peripheral CRF signaling and stress-related alterations of gut motor function

As established for a number of neuropeptides (such as somatostatin, opiates, and calcitonin gene-related peptides) that act in the brain to influence gut motility (99), the CRF ligands and receptors that were initially characterized in the brain (where they function to influence gut motor function) have recently been shown to be widely expressed in peripheral tissues, including the gastrointestinal tract of experimental animals and humans (19, 32, 100–103). The coincident expression of CRF ligands, mostly urocortins, with cognate receptors provided strong support for the idea that their local action could influence gut motor function (100–102, 104, 105).

CRF$_1$ receptors in the periphery and gut transit. Initial functional studies showed that injection of CRF$_1$ peripherally alters gut motility and transit in several mammalian species, including rodents, dogs, and humans (6, 62, 106–109). In particular, injection of CRF$_1$, either i.v. or i.p., inhibited gastric emptying, delayed small-intestinal transit, stimulated colonic transit and defeation, and induced diarrhea with a potency similar to that of CRF injected into the CSF (6, 61, 106). Although central administration and peripheral administration of CRF result in similar gut transit alterations, distinct sites and mechanisms of action are involved (54, 57, 61, 110, 111). For example, pharmacological blockade of autonomic outflow does not modify the inhibition of gastric emptying and acceleration of colonic transit induced by injection of CRF$_1$, whereas it abrogates the gastric and colonic responses induced by injection of CRF into the CSF (61). In addition, injection of α-helical CRF$_{9–41}$ into the CSF does not modify the stimulation of colonic transit induced by injection of CRF$_1$ i.v.; this indicates that the peripherally injected CRF did not activate CRF receptors in the brain (66).

Further studies in rodents have established that peripheral injection of CRF$_1$, urocortin 1, urocortin 2, or urocortin 3 delays gastric emptying by activating CRF$_2$, whereas peripheral injection of CRF$_1$ or urocortin 1 stimulates colonic motility through activation of CRF$_1$ expressed by colonic myenteric neurons (19). This was shown by the fact that injection of the selective CRF$_2$, agonists, urocortin 2, or, less potently, urocortin 3 either i.p. or i.v. inhibited gastric emptying of a solid or liquid meal but did not influence distal colonic transit in rodents (106, 112). By contrast, under the same conditions, CRF and urocortin 1 inhibited gastric motor function and stimulated colonic propulsion and defeation in rats and mice (54, 106, 112). Moreover, in rodents, peripheral injection of the CRF$_2$-specific antagonists astressin-B and antistauvine-30 prevented the inhibition of gastric emptying that is induced by CRF and urocortin 1 given i.v. or i.p. but did not modify their stimulation of distal colonic transit (106, 112). Conversely, peripheral injection of the CRF$_2$-specific antagonists CP-154,526 and NBI 27914 blocked the stimulation of colonic transit, defeation, and diarrhea induced by i.p. injection of CRF and urocortin 1 but did not prevent delayed gastric emptying (106, 112–114). The mechanisms by which peripherally administered CRF and urocortin 1 stimulate colonic motor activity might involve direct activation of colonic myenteric neurons that lie between the longitudinal and circular muscles. Indeed, in rats, high levels of FOS expression are induced in neurons of the colonic myenteric ganglia by CRF injected i.p., and this is blocked by peripheral injection of astressin and CP-154,526 (115). These data are consistent with the expression of CRF$_1$ by rat colonic myenteric neurons (101, 104).

CRF$_1$ receptors in the periphery and gut motility. Analysis of the motility changes underlying gut transit alterations showed that i.v. injection of urocortin 1 or CRF reduces the amplitude of postprandial gastric contractions, inhibits jejunal motility induced by i.v. injection of motilin, and increases propulsive colonic motility in experimental animals (54, 113, 116, 117). The motor alterations induced by CRF and urocortin 1 were reproduced in vitro in isolated stomach tissue and distal segments of the colon, which both have functional enteric neurons; this supports the idea of local peripheral action (102, 105, 113, 118, 119). Studies in healthy humans revealed that i.v. injection of CRF increases nonpropulsive postprandial duodenal motor activity and stimulates propulsive motor contractions in the descending colon (108, 109). Of interest is the report that patients with IBS show enhanced colonic motility in response to i.v. injection of CRF as compared with healthy volunteers, which indicates that they are hyperresponsive to CRF, and this might be linked by upregulation of colonic CRF$_1$ (108).

Stress, CRF$_1$ receptors in the periphery, and gut transit. Pharmacological studies support the notion that gut CRF signaling occurs under stress (6, 19, 112, 113). Several reports showed that the delayed gastric emptying induced by abdominal surgery can be blocked by peripheral injection of α-helical CRF$_{9–41}$, d-Phe$_{12–41}$ CRF$_{1}$, and astressin (111, 120, 121). CRF$_2$ antagonists injected i.v. also prevented the inhibition of gastric emptying induced by acute wrap-restraint stress, whereas the selective CRF$_1$ antagonist CP-154,526 did not (112). With respect to stress-related stimulation of colonic motor function, peripheral administration of α-helical CRF$_{9–41}$, astressin, and CP-154,526, but not of astressin-B, prevented or blunted the stimulation of distal colonic transit and defeation induced by acute wrap-restraint stress and water-avoidance stress (6, 83, 112, 113, 122). In patients with IBS, compared with healthy subjects, the administration of α-helical CRF$_{9–41}$ improves colonic motility, visceral perception, and the negative mood elicited by rectal transmural electrical stimulation, without affecting the HPA axis (20).
The cellular origins of the CRF and CRF-related peptides that activate peripheric CRF receptors present in the gut remain to be elucidated. CRF ligands have been detected in the gut myenteric nervous system, as well as in enteroeendocrine cells and lamina propria macrophages in rodents and humans (103, 123, 124). Because both central and peripheral administration of CRF receptor antagonists is able to counteract the impact of stress on gut motility, this supports the concept that stress influences the release of CRF ligands in the gut through autonomic pathways, where they can then function as local effectors of altered gastrointestinal motility.

Conclusions and future perspectives

CRF signaling in the brain, established as a leading mediator of the biochemical effect on the endocrine and axonergic and behavioral responses to stress, is also part of the underlying mechanisms through which stress inhibits gastric transit and stimulates colonic transit in experimental animals. In addition to the brain, the gut is endowed with a CRF-signaling system that also has a role as a key feature of symptoms in IBS diarrhea-predominant patients, such as stimulation of colonic motility, defecation/watery diarrhea, visceral hypersensitivity, and anxiogenic/hypervigilant behavior, that are alleviated by CRF₁ receptor antagonists (23). These data support the involvement of the CRF₁ system at central and/or peripheral sites as part of the mechanisms whereby stress triggers or enhances gut complaints in patients with IBS (9–11). The promising completion of the first open-label clinical trial with the CRF₁ antagonist R121919 in severely depressed patients (125), along with the improvement of colonic motility and visceral perception by peripheral injection of the CRF antagonist α-helical CRF₉₄, is also part of the underlying mechanisms that are alleviated by CRF₁ receptor antagonists to treat IBS, particularly given the high frequency of comorbid psychiatric disorders in IBS (22).

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