Key concepts in Digestion...
‘Raging Thirst’ module

The endocrine pancreas
...hormones and blood sugar homeostasis

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The endocrine system

Adapted from Martini - 'Fundamentals of Anatomy and Physiology.'

- ADH conserves body water
- GH increases body size
- T₃/₄ increase metabolism and growth
- Maturation of immune system
- Fight or flight response (medulla)
- Induces sleep
- Increases blood calcium
- Decreases blood pressure
- EPO Increases red blood cell formation
- Gastrin regulates acid secretion
- Blood sugar regulation
- Sexual characteristics

HYPOTHALAMUS
- Production of ADH, oxytocin, and regulatory hormones

PINEAL GLAND
- Melatonin

PITUITARY GLAND
- Anterior pituitary: ACTH, TSH, GH, PRL, FSH, LH, and MSH
- Posterior pituitary: Release of oxytocin and ADH

PARATHYROID GLANDS
- Parathyroid hormone (PTH)

HEART
- Atrial natriuretic peptide (ANP)

THYROID GLAND
- Thyroxine (T₄)
- Triiodothyronine (T₃)
- Calcitonin (CT)

THYMUS
- Undergoes atrophy during adulthood
- Thymosins

ADRENAL GLANDS
- (one at each kidney)
- Each gland contains two endocrine regions.
- Medulla: Epinephrine (E)
- Norepinephrine (NE)
- Cortex: Cortisol, corticosterone, aldosterone, androgens

PANCREATIC ISLETS
- Insulin, glucagon

GONADS
- Testes (male):
  - Androgens (especially testosterone), inhibin
- Ovaries:
  - Estrogens, progestins, inhibin
Ernest Henry Starling introduced the term 'hormone' in his Croonian Lectures to the Royal College of Physicians, delivered on the 20th, 22nd, 27th and 29th June 1905.

"Hormone" comes from the Greek word hormao - to spur or urge on/to arouse to activity.
Hormonal and local communication

**Endocrine**

- Classical **endocrine** hormones are: substances released from one tissue and transported via the bloodstream to a different tissue, resulting in changes to that tissue.
- Local hormones are not transported via blood.

**Paracrine**

- Paracrine cell
- Nearby target cell

**Autocrine**

- Autocrine cell
- Nearby target cell
Amino acid-derived hormones

Water soluble, cannot passively diffuse across membranes (except for thyroid hormones)
Lipid-derived hormones

Lipid soluble, can passively diffuse across membranes

Arachidonic acid is converted to leukotrienes by lipoxygenase enzymes; and to prostaglandins by cyclooxygenase enzymes (Aspirin is a cyclooxygenase inhibitor)

Cholesterol is converted to the various steroid hormones by sequential action of several different enzymes.

Androgens (eg. testosterone) are converted into estrogens (eg. estradiol) by enzymatic removal of a single methyl (CH₃) group
Peptide/protein hormones

Water soluble, cannot passively diffuse across membranes

Over 200 amino acids

Processing
Short polypeptide hormones are derived from larger prohormone precursors (e.g., ACTH and MSH are both derived from the same prohormone, proopiomelanocortin)
How do endocrine cells synthesise and release hormones?

**Lipid-derived hormones**
- not stored in cells, synthesised on demand from precursor lipids
- **Steroid hormones** are formed from cholesterol; first enzymatic modification in mitochondria, remaining modifications in smooth endoplasmic reticulum
  - transported in blood bound to serum proteins
- **Eicosanoids** are formed from arachidonic acid in plasma membrane
  - once formed, these hormones are released from cells via simple diffusion

**All other hormones (except thyroid)**
- stored, often at high concentrations, in secretory vesicles
- released by regulated exocytosis when required
The pancreas
The pancreas is a mixed gland…
98% exocrine, 2% endocrine

Exocrine cells secrete digestive enzymes and alkaline pancreatic juices into the small intestine

Endocrine cells secrete regulatory hormones.

1869: Paul Langerhans (Med student, Berlin) discovers a distinct collection of cells within the pancreas. Islets of Langerhans.
1901: Eugene Opie discovers that the Islets produce insulin and that the destruction of these cells resulted in diabetes.
Endocrine cells are located in the islets of Langerhans.

There are 4 cell types:
• Alpha (α) cells secrete glucagon
• Beta (β) cells secrete insulin
• Delta (δ) cells secrete somatostatin
  Inhibits insulin and glucagon – paracrine action
• F or D₁ cells secrete pancreatic polypeptide (PP)
  Regulates gastric motility and satiation

Adapted from...Nature Reviews Cancer 2002; 2, 897-909.
Insulin

- Insulin is an anabolic hormone, that is, it increases the storage of glucose, fatty acids and amino acids in cells and tissues.

- In mammals, insulin is expressed as a single chain prepro hormone, which is secreted through the plasma membrane.

*Prepro- hormone contains extra amino acids not present in the mature hormone*

- Kallikrein, an enzyme present in the islets, aids in the conversion of proinsulin to insulin. The C peptide chain is removed from the proinsulin molecule producing the disulfide-connected A and B chains that are insulin.

\[
\begin{align*}
\alpha & \text{ chain - 30 amino acids long} \\
\beta & \text{ chain - 21 amino acids long} \\
& \text{(If separated they only have partial activity)}
\end{align*}
\]
• After a meal, increased blood glucose enters β cells

• the glycolytic phosphorylation of glucose causes a rise in cellular ATP

• ATP inactivates potassium channels

• this depolarises the cell, opening calcium channels

• the consequent increase in cytoplasmic calcium causes secretory granule exocytosis
Effects of insulin

• acts to lower blood glucose levels

• liver, CNS, red blood cells and kidney are able to take up glucose unaided
• Skeletal and cardiac muscle and adipose tissue require insulin for glucose uptake

• Insulin triggers the insertion of GLUT4 glucose transporters into the plasma membrane enabling facilitated diffusion of glucose into fat and muscle cells

• also decreases glucose production in liver, stimulates glycogen synthesis in liver and muscle, promotes amino acid transport and protein synthesis, and inhibits glucagon secretion
Glucagon is a catabolic hormone, that is, it mobilizes glucose, fatty acids and amino acids from stores into the blood.

Secreted by $\alpha$ cells in response to a fall in blood glucose levels

**The primary effect of glucagon is to raise blood glucose levels by:**

1. Stimulating gluconeogenesis (formation of glucose from lactate)
2. Mobilising liver glycogen (glycogenolysis releases glucose from the liver)

Other effects:
1. Increases lipolysis (breakdown of fats in adipose tissue)
2. Stimulates insulin release (so allowing newly-formed glucose entry into the cells)
Hormonal regulation of blood glucose levels

**HOMEOSTASIS DISTURBED**
- Rising blood glucose levels

**HOMEOSTASIS**
- Normal glucose levels (70–110 mg/dl)

**HOMEOSTASIS RESTORED**
- Blood glucose concentration rises

**HOMEOSTASIS DISTURBED**
- Declining blood glucose levels

**HOMEOSTASIS**
- Normal glucose levels (70–110 mg/dl)

Beta cells secrete insulin

Increased rate of glucose transport into target cell

Increased rate of glucose utilization and ATP generation

Increased conversion of glucose to glycogen (liver, skeletal muscle)

Increased amino acid absorption and protein synthesis

Increased triglyceride synthesis (adipose tissue)

Alpha cells secrete glucagon

Increased breakdown of glycogen to glucose (liver, skeletal muscle)

Increased breakdown of fats to fatty acids (adipose tissue)

Increased synthesis and release of glucose (liver)
Diabetes Mellitus

**Symptoms:** polydipsia (increased thirst), polyuria (increased frequency and volume of urination), sweet tasting urine (hence *mellitus*).

**Reason:** Excessive blood glucose due to lack of insulin function. Normally glucose is reabsorbed by the kidney. If the glucose concentration exceeds that which can be reabsorbed (~11mmol/L), glucose is lost in the urine (sweet urine). Glucose takes water with it due to osmosis (polyuria). This induces dehydration (polydipsia).

**Pathophysiology:**
- **Type 1 (juvenile onset)** - insufficient production of insulin, often due to autoimmune destruction of pancreatic β cells
- **Type 2 (adult onset)** - characterised by insulin resistance – insulin is secreted normally, but neither stimulates glucose storage as glycogen by the liver nor activates glucose uptake into fat and muscle cells.
- In both, cells respond as if glucose levels are low, utilising proteins and lipids as alternative energy sources. Leads to protein depletion, wasting, ketosis, and acidosis. **If you have Type 2 diabetes in your family, you can prevent onset by eating right and exercising**
Hyperinsulinaemia

**Symptoms**: low blood glucose concentrations in neonates

**Reason**: Excessive insulin secretion reduces blood glucose to dangerously low levels

**Pathophysiology**: Genetic defects in ATP-sensitive potassium channels in β cells results in dysregulation of insulin secretion by glucose.

Consequent decrease in blood glucose levels causes brain damage if glucose is not maintained therapeutically.
Insulin production for treatment

1916 - Romanian Professor, Nicolae Paulescu, develops pancreatic extract that lowers blood sugar in diabetic dogs. WW I prevents studies continuing. Publishes in 1921.

1921 - Frederick G. Banting and Charles H. Best successfully purified insulin from a dog's pancreas

1936 - insulin with a slower release in the blood; added fish sperm protamine which the body breaks down slowly

1950 - a type of insulin that acted slightly faster

1970s - attempts to produce insulin that mimicked better how the body's natural insulin worked; releasing a small amount all day, with surges occurring at mealtimes

1977 - spliced a rat insulin gene into a bacterium that then produced insulin.

1980s - biotechnology revolution. Eli Lilly Corp. produced a human insulin … first approved genetically engineered pharmaceutical, contained no animal ‘contaminants’.

1990s - Analog insulin; change of a.a. sequence - clumps less and dispersed more readily into the blood - starts working in the body minutes after an injection.

By 2001 - 95% of insulin users in most parts of the world take some form of human insulin. All companies focus on synthesizing human insulin or insulin analogs