Glucagon-like peptide-2 acutely increases proximal small intestinal blood flow in TPN-fed neonatal piglets

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Am J Physiol Regul Integr Comp Physiol 290: R283–R289, 2006. First published September 15, 2005; doi:10.1152/ajpregu.00588.2005.—Glucagon-like peptide-2 (GLP-2) acutely increases proximal small intestinal blood flow in TPN-fed neonatal piglets. Am J Physiol Regul Integr Comp Physiol 290: R283–R289, 2006. First published September 15, 2005; doi:10.1152/ajpregu.00588.2005.—Glucagon-like peptide-2 (GLP-2) is a gut hormone that is secreted in response to enteral feeding and stimulates small intestinal mucosal growth. We have previously shown that GLP-2 infusion acutely increases portal venous blood flow in TPN-fed pigs. The aim of this study was to localize the vasoactive effect of GLP-2 within the gastrointestinal tissues and other visceral organs in TPN-fed piglets. Tissue blood flow rates were quantified using fluorescent microsphere deposition in anesthetized TPN-fed piglets given intravenous infusion of GLP-2 at either 500 pmol kg−1 h−1 (low GLP-2, n = 7 pigs) or 2,000 pmol kg−1 h−1 (high GLP-2, n = 8 pigs) for 2 h. Compared with baseline, the low and the high GLP-2 treatment significantly increased the blood flow rate in the duodenum (+77%) and jejunum (+40% and +80%), respectively, but blood flow to the distal small intestine and colon (−15%) was unchanged or slightly decreased. Baseline mucosal blood flow was five-fold higher than serosal blood flow; however, high GLP-2 treatment increased serosal (+140%) to a larger degree than mucosal blood flow (+73%). The high GLP-2 dose increased pancreatic flow (+34%) but decreased blood flow in the kidneys (−14%) and stomach (−12%), whereas the spleen and brain were unaffected. These findings suggest that the acute GLP-2-mediated stimulation of portal blood flow in TPN-fed piglets occurs principally via increased blood flow through the superior mesenteric artery to the proximal small intestine, a tissue region where the GLP-2R mRNA abundance and trophic GLP-2 effects are greatest.

glucagon-like peptide-2 receptor; mucosal growth; premature infants; enteral feeding; intestinal ischemia

GLUCAGON-LIKE PEPTIDE-2 (GLP-2), a 33-amino acid peptide, is produced by intestinal endocrine L-cells in response to enteral nutrients (4, 10). GLP-2 has multiple actions on gastrointestinal (GI) growth and function, including increased crypt cell proliferation, epithelial cell survival, gut blood flow, nutrient uptake, and mucosal barrier function (3, 5, 6). GLP-2 is also being tested clinically as a therapy mainly for treatment of short bowel syndrome, but also other GI diseases, such as inflammatory bowel disease and chemotherapy-induced enteritis (1, 17, 31, 35). GLP-2 also prevents the intestinal mucosal atrophy associated with total parenteral nutrition (TPN), a nutritional therapy that is critical in patients with impaired gut function (6, 7, 29).

GLP-2 actions are mediated by the GLP-2 receptor (GLP-2R), which is a G protein-coupled, transmembrane receptor that is expressed mainly in the gut and brain (20). Within the GI tract, the level of GLP-2R mRNA expression is most abundant in the proximal small intestine and in the colon but is also expressed in the stomach and distal small intestine (24, 36). Moreover, the precise cellular localization within the intestine remains controversial, but reports have indicated that the GLP-2R is expressed in enteric neurons, enteroendocrine cells, and subepithelial myofibroblasts (2, 22, 36). However, the GLP-2R mRNA has not been detected in other visceral organs, including the pancreas, liver, kidney, or spleen (24, 36).

Enteral feeding is a well-established stimulus of small intestinal blood flow (12, 13). Likewise, several GI hormones secreted in response to feeding have been implicated in the regulation of small intestinal blood flow (12, 16). Several gut hormones that are members of the glucagon superfamily have been shown to increase the blood flow to the GI tract (e.g., glucagon, vasoactive intestinal peptide, and secretin), whereas others decrease blood flow (e.g., neuropeptide Y and peptide YY) (28). We recently demonstrated that acute GLP-2 infusion rapidly increases portal blood flow in TPN-fed piglets (14). However, portal blood flow is derived from several visceral organs, namely the stomach, small intestine, large intestine, spleen, and pancreas. Thus, although we showed that GLP-2 increases portal blood flow, it remains uncertain whether this reflects an increase in blood flow within the small intestine, large intestine, and stomach, which are the key target tissues of GLP-2’s actions, and most abundantly express the GLP-2R mRNA.

In previous studies, radioactive and fluorescent microsphere deposition has been used to quantitate the effects of hormones and other agents on blood flow to GI tissues or organs (8, 9, 11, 26, 30). Therefore, the aim of the current study was to determine the effect of acute GLP-2 infusion on the distribution of blood flow in GI and other visceral organs in TPN-fed neonatal piglets using the fluorescent microsphere deposition method. We hypothesized that the GLP-2-induced stimulation of blood flow would be localized only to those tissues with abundant GLP-2R mRNA expression, namely, the small and large intestine, and that other visceral organs would be unaffected.
GLP-2 INCREASES JEJUNUM BLOOD FLOW

MATERIALS AND METHODS

Animals and surgical protocol. The study protocol was approved by the Animal Care and Use Committee of Baylor College of Medicine and was conducted in accordance with the Guide for the Care and Use of Laboratory Animals [DHHS publication no. (NIH) 85–23, revised 1985, Office of Science and Health Reports, DRR/NIH, Bethesda, MD 20205], Neonatal, 2-day-old, sow-fed, female crossbred (Large White × Hampshire × Duroc, the Texas Department of Criminal Justice, Huntsville, TX) piglets were transported to the Children’s Nutrition Research Center’s animal facility and fasted until surgery within 6–8 h of arrival. Piglets were housed at a temperature of 32–34°C with a 12:12-h light-dark cycle. At 2 days of age, piglets began receiving total parenteral nutrition (TPN) via the jugular vein at half-rate intake during the first day after surgery and thereafter were maintained at full-rate daily intake of 240 ml fluid, 13 g protein, and 900 kJ energy per kg body wt for 3 days before the microsphere infusion protocol. TPN solution consisted of glucose (104 g/l), lipid (21 g/l), Intralipid, Baxter Healthcare, Deerfield, IL), a complete amino acid mixture (55 g/l; Ajinomoto, Tokyo, Japan), electrolytes, trace minerals, and vitamins to meet the requirements for neonatal pigs (6); piglets were not given any enteral feeds during this study.

Piglets were fasted on the morning before surgery and surgically implanted with catheters in the right external jugular vein (silicone tubing, 1.65 mm outside diameter) and umbilical artery [3.5-Fr single-lumen catheter (Sherwood Medical, St. Louis, MO)] under general anesthesia with isoflurane. The jugular catheter was externalized between the scapulas, and both catheters were filled with heparinized (0.1 mg/kg butorphenol tartrate, Fort Dodge Labs, Fort Dodge, IA) saline and placed in a protective animal jacket. Preoperatively, piglets received an intramuscular antibiotic (20 mg/kg enrofloxacin, Bayer, Shawnee Mission, KS) and intramuscular analgesic (20 U/ml) saline and placed in a protective animal jacket. Preoperatively, piglets received an intramuscular antibiotic (20 mg/kg enrofloxacin, Bayer, Shawnee Mission, KS) and intramuscular analgesic (0.1 mg/kg butorphenol tartrate, Fort Dodge Labs, Fort Dodge, IA) immediately after surgery.

Microsphere infusion protocol. Four days after initial surgery (piglets ~4–5 days old), piglets were placed under general anesthesia with isoflurane anesthesia (2–3%), and TPN was continuously administered, while vitals (heart rate, blood pressure, oxygen saturation, and temperature) were continuously monitored every 15 min throughout the entire experiment using LW-6000 Life Window vitals monitor (Digicare Biomedical Technology, Boynton Beach, FL). A right common carotid catheter [3.5-Fr single-lumen catheter (Sherwood Medical)] was inserted, and the tip was advanced into the left ventricle; placement was verified by fluoroscopy. After piglets received their ventricular catheter, TPN was continued for another 20 min before the microsphere infusion and GLP-2 treatment was begun.

After the 20-min TPN baseline period, fluorescent microspheres (FMS; 15–μm mean diameter) were infused at the following time points in minutes: 0 (baseline), 15, 30, 45, and 120. The color, time of infusion, excitation, and emission wavelengths (nm) for each FMS were as follows: crimson (0 min, 610/652), scarlet (15 min, 654/690), orange (30 min, 532/563), blue green (45 min, 436/494), and red (120 min, 572/610). Immediately after infusion of FMS at time 0, piglets began receiving a continuous, intravenous infusion of GLP-2 at either 500 pmol·kg⁻¹·h⁻¹ (low GLP-2; n = 7 pigs) or 2,000 pmol·kg⁻¹·h⁻¹ (high GLP-2; n = 8 pigs) for 120 min. Synthetic human GLP-2 (1–33) (California Peptide Research, Napa, CA) was infused continuously in a solution containing 0.1% human serum albumin and 4.5 g NaCl. After the last FMS infusion at 120 min, the GLP-2 infusions were stopped, and the piglet was euthanized with a venous injection of pentobarbital sodium (50 mg/kg body wt) and sodium phenytoin (5 mg/kg body wt) (Beuthanasia-D, Schering-Plough Animal Health, Kenilworth, NJ), and the intestine and other organs were weighed and processed.

Tissue sampling. The small intestine was removed immediately distal to the ligament of treitz to the ileocecal junction. It was then divided equally into four sections named from proximal to distal end: proximal jejunum (PJ), distal jejunum (DJ), proximal ileum (PI), and distal ileum (DI). Of these individual sections, up to five 1-g pieces were used for whole gut analysis, and two separate pieces of the section were divided into mucosa and serosa by blunt dissection using a microscope slide. The duodenum is defined as the distal to the pylorus to ligament of treitz and is not analyzed as part of the small intestine for this study but as its own GI segment. One-gram samples of tissue were collected from each of the following organs: brain, left and right kidneys, liver, spleen, pancreas, proximal colon (PC) (the spiral portion of the colon), distal colon (DC), stomach, and duodenum. All tissues were placed into individual preweighed 15-ml polystyrene tubes and stored at room temperature.

Microsphere analysis. The use and technical aspects of the FMS [FluoSpheres Blood Flow Determination Kits #2 (F-8891), Molecular Probes, Eugene, OR] have been previously described (25, 27, 30). In short, FMS were injected directly into the heart via the carotid catheter to ensure adequate mixing. Blood flow was determined on the basis of the ratio between the measured fluorescence of the tissue sample and the arterial reference blood sample obtained via the umbilical catheter at a constant withdrawal rate of 2 ml/min using a Harvard PHD 4400 pump (Harvard Apparatus, Holliston, MA).

GLP-2 radioimmunoassay. At the end of the 120-min infusion period, blood samples were collected in EDTA tubes, centrifuged at 3,000 g at 4°C, and plasma was frozen immediately in liquid nitrogen. Plasma GLP-2 (1–33) concentrations were quantified by radioimmunoassay as described previously (5, 6). This assay recognizes the biologically active forms of the human and porcine GLP-2 (1–33) peptides.

Calculations. The regional blood perfusion (Qi) rate of a piece of tissue (g−1) was calculated by dividing the reference blood sample fluorescence (fref) by the fluorescence of the tissue sample (fi), multiplied by the rate of withdrawal of the reference blood sample (R): Qi, ml/min = (fi/fref)·R (ml/min).

The Qi flow was corrected for the amount of tissue used to extract the beads. The absolute blood flow rate to the organ or tissue bed of interest was calculated as the product of the tissue perfusion rate (Qi) per gram of tissue and the organ weight (g). Using these values, we estimated the superior mesenteric artery (SMA) blood flow as the sum of blood flows to the PJ, DJ, PI, DI, and PC, whereas the celiac blood flow was calculated by summing the flows to the stomach, duodenum, pancreas, spleen, and liver. For each piglet, we also calculated the mean organ blood flow rates across the four time points (15, 30, 45, and 120 min); this value was expressed as an absolute rate (ml/min) and relative to the time 0 baseline flow (%baseline).

Statistical analyses. All data were tested for significance using a general linear model ANOVA (Minitab 13, Minitab, PA). The effect of GLP-2 on small intestinal blood flow was analyzed using several different statistical models. The differences in absolute blood flow rates were first tested using a three-way ANOVA with treatment (low vs. high GLP-2), time (0, 15, 30, 45, and 120 min) and intestinal segment (PJ, DJ, PI, DI) as main effects (Fig. 1). Differences among segments were tested using a post hoc Tukey’s test. We then tested for differences in the absolute and relative blood flow rates between the baseline and the mean GLP-2-treated value estimated from all four time points (15, 30, 45, and 120 min) (Table 1, Fig. 2). In this model, we tested for differences in the absolute and relative intestinal blood flow rates using three-way ANOVA with treatment (low and high GLP-2), segment (PJ, DJ, PI, DI) and subsection (mucosal and...
serosal) as main effects. Differences between the saline baseline and the respective low and high GLP-2 treatment were determined using a paired t-test. Finally, we tested for differences in absolute and relative blood flow rates of the remaining organs (Table 2, Fig. 3) and for the celiac and SMA totals (Fig. 4) using ANOVA with treatment as a main effect. Data are expressed as means ± SE, and means were considered significantly different at P < 0.05.

RESULTS

Body weight, vital statistics, and plasma GLP-2. There was no significant difference in the mean body between either the low or high GLP-2 groups (1.95 ± 0.17 kg). Animals had their vital statistics measured during the experiment under general anesthesia. There was no significant difference (P > 0.05) in the mean values between the two treatment groups in heart rate (167 ± 23 beats/min), mean arterial blood pressure (41 ± 5

Table 1. Mean absolute blood flow in mucosal and serosal intestinal subsections estimated at baseline and during low and high GLP-2 infusion rates

<table>
<thead>
<tr>
<th>Segment</th>
<th>Baseline Low</th>
<th>Low GLP-2</th>
<th>Baseline High</th>
<th>High GLP-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proximal jejunum</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mucosa</td>
<td>22.3 ± 3.2</td>
<td>26.5 ± 4.1</td>
<td>20.9 ± 2.9</td>
<td>35.5 ± 5.0</td>
</tr>
<tr>
<td>Serosa</td>
<td>3.45 ± 0.59</td>
<td>6.65 ± 1.56</td>
<td>4.05 ± 0.69</td>
<td>8.94 ± 0.96</td>
</tr>
<tr>
<td>Distal jejunum</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mucosa</td>
<td>19.2 ± 3.5</td>
<td>18.5 ± 4.1</td>
<td>22.0 ± 3.1</td>
<td>31.1 ± 5.5</td>
</tr>
<tr>
<td>Serosa</td>
<td>3.67 ± 0.73</td>
<td>5.79 ± 1.49</td>
<td>3.42 ± 0.35</td>
<td>7.18 ± 0.65</td>
</tr>
<tr>
<td>Proximal ileum</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mucosa</td>
<td>13.8 ± 1.5</td>
<td>12.5 ± 2.3</td>
<td>18.4 ± 3.4</td>
<td>22.5 ± 4.1</td>
</tr>
<tr>
<td>Serosa</td>
<td>3.49 ± 0.68</td>
<td>5.24 ± 1.30</td>
<td>2.90 ± 0.35</td>
<td>5.24 ± 0.43</td>
</tr>
<tr>
<td>Distal ileum</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mucosa</td>
<td>13.7 ± 3.0</td>
<td>10.6 ± 2.2</td>
<td>13.4 ± 2.2</td>
<td>15.7 ± 3.0</td>
</tr>
<tr>
<td>Serosa</td>
<td>2.69 ± 0.43</td>
<td>3.23 ± 0.53</td>
<td>2.57 ± 0.44</td>
<td>3.61 ± 0.45</td>
</tr>
</tbody>
</table>

Values are presented as means ± SE. GLP-2 infusion rates are low (500 pmol·kg⁻¹·h⁻¹, n = 7) and high (2,000 pmol·kg⁻¹·h⁻¹, n = 8). All values for mean absolute blood flow are given in milliliters per minute. Significantly different from baseline based on paired t-test (*P < 0.05). Significant effect of treatment (P < 0.05; high > low GLP-2), segment (P < 0.05; jejunum > ileum), section (P < 0.05; serosa > mucosa) and treatment × segment interaction (P < 0.05), and treatment × section interaction (P < 0.05) were observed and are described in detail in the results section. Values are presented as means ± SE.
Table 2. Mean absolute blood flow of gastrointestinal tissues, visceral organs, and brain measured at baseline and during low and high GLP-2 infusion rates

<table>
<thead>
<tr>
<th>Tissue</th>
<th>Baseline Low</th>
<th>Baseline High</th>
<th>Low GLP-2</th>
<th>High GLP-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stomach</td>
<td>6.09±0.98</td>
<td>7.05±1.41</td>
<td>5.84±1.02</td>
<td>5.84±1.02</td>
</tr>
<tr>
<td>Duodenum</td>
<td>3.78±1.11</td>
<td>12.2±3.18</td>
<td>3.56±0.71</td>
<td>3.56±0.71</td>
</tr>
<tr>
<td>Proximal colon</td>
<td>15.6±3.31</td>
<td>18.2±5.7</td>
<td>14.3±4.18</td>
<td>14.3±4.18</td>
</tr>
<tr>
<td>Distal colon</td>
<td>2.72±0.62</td>
<td>2.86±0.95</td>
<td>2.61±0.73</td>
<td>2.61±0.73</td>
</tr>
<tr>
<td>Spleen</td>
<td>29.1±6.6</td>
<td>24.2±4.30</td>
<td>18.4±1.8</td>
<td>18.4±1.8</td>
</tr>
<tr>
<td>Pancreas</td>
<td>1.37±0.31</td>
<td>1.07±0.16</td>
<td>1.38±0.19</td>
<td>1.38±0.19</td>
</tr>
<tr>
<td>Left kidney</td>
<td>18.3±3.0</td>
<td>18.4±1.9</td>
<td>15.9±2.0</td>
<td>15.9±2.0</td>
</tr>
<tr>
<td>Right kidney</td>
<td>17.5±2.3</td>
<td>17.9±2.1</td>
<td>15.4±2.0</td>
<td>15.4±2.0</td>
</tr>
<tr>
<td>Brain</td>
<td>23.9±2.3</td>
<td>25.0±3.9</td>
<td>30.3±6.7</td>
<td>30.3±6.7</td>
</tr>
</tbody>
</table>

Values are presented as means ± SE. All values for mean absolute blood flow are given in milliliters per minute. GLP-2 infusion rates are low (500 pmol·kg⁻¹·h⁻¹, n = 7) and high (2,000 pmol·kg⁻¹·h⁻¹, n = 8).

mmHg), oxygen saturation (96.1 ± 3.0%), or core body temperature (37.9 ± 1.3°C). The plasma concentrations of the biologically active GLP-2 (1–33) peptide were 400 ± 24 pmol/l and 1,834 ± 88 pmol/l in the low and high GLP-2 infusion groups, respectively.

Small intestinal blood flow. The changes in absolute blood flow rates to each small intestinal segment in the two GLP-2 groups are shown in Fig. 1. The changes in proximal and distal jejenum (PJ, DJ) and ileum (PI, DI) absolute blood flow rates after low and high GLP-2 infusions are shown in Fig. 1. There was a significant main effect of time in the high GLP-2 but not the low GLP-2 infusion group, indicating that the absolute flow rates in response to low GLP-2 were not statistically different from the saline baseline. Moreover, the absolute blood flow in the high GLP-2 infusion group was greater than the low GLP-2 infusion (treatment × time, P < 0.05). In both the high and low GLP-2 infusion groups, there was a main effect of segment, indicating that blood flow was higher in the PJ and DJ than in the DI. In addition, the effect of high GLP-2 was higher in the PJ and DJ, than in the PI and DI segments (treatment × segment, P < 0.05).

We also quantified the absolute (ml/min) and relative (%baseline) (Figs. 2B and 3) blood flow rates in the whole intestine for the baseline and the mean GLP-2-treated value estimated from all four time-points (15, 30, 45, and 120 min). The absolute blood flow was increased by the high GLP-2 infusion rate but not the low GLP-2 infusion (treatment, P < 0.05) and only in the PJ and DJ but not the PI and DI segments (segment, P < 0.05) (data not shown). However, the relative blood flow in the low GLP-2 group in the PI (149%) was significantly (P < 0.05) higher than the baseline values. Similarly, the relative blood flow rates in the high GLP-2 group in the PJ (189%) and DJ (170%) were higher (P < 0.05) than baseline.

Mucosal vs. serosal small intestinal blood flow. In addition to analysis of whole tissue blood flow in the four small intestinal segments, we estimated the absolute (ml/min) (Table 1) and relative (%baseline) (Fig. 2) blood flow rates to the mucosa vs. serosa sections. As expected, the absolute blood flow to the mucosa was 5- to 6-fold higher (section, P < 0.05) than the serosal section throughout all of the small intestinal segments. Moreover, the high GLP-2 infusion increased blood flow to both mucosa and serosa above the value seen in either the baseline or low GLP-2 group (treatment, P < 0.05). However, the high GLP-2-mediated increase in blood flow was proportionally greater in the serosa than the mucosal fraction (treatment × section, P < 0.05). We observed higher absolute rates of mucosal and serosal blood flow in the high GLP-2 group in the PJ and DJ compared with the PI and DI (treatment × segment, P < 0.05). The mean relative estimates in the PJ and DI segments indicated that the serosa blood flow was
240% and 155%, whereas the mucosa blood flow was 173% and 114%, respectively. In both the low and high GLP-2 groups, the mucosal flow rates in the PJ segment were higher than in any of the other segments. However, the serosal flow rates in both GLP-2 groups were similar in all four small intestinal segments.

**Nonsmall intestinal tissues.** We quantified the absolute (Table 2) and relative (Fig. 3) blood flow rates of the remaining GI tract tissues, other abdominal organs, and brain. There were no significant changes in blood flow in any tissue or organ in the low GLP-2 group compared with the baseline. However, the duodenal blood flow was significantly higher (177%) in the high GLP-2 group than saline baseline (100%). Interestingly, blood flow in both the stomach and the proximal colon decreased ($P < 0.05$) from baseline by $-12\%$ and $-15\%$, respectively. The distal colon was the only section of the GI tract that was unchanged from baseline in response to GLP-2 treatment.

The only nonintestinal organ in which the blood flow was increased by GLP-2 was the pancreas. The relative pancreatic blood flow tended to be higher ($P > 0.05$) (121%) at the low GLP-2 rate but was significantly increased 134% with the high GLP-2 rate compared with baseline (100%). The renal blood flow rate was similar in the right and left kidney and was decreased ($P < 0.05$) by $\sim 15\%$ at the high, but not low, GLP-2 rate. Similarly, the splenic blood flow tended to be reduced (15%) by GLP-2 infusion, but this was not statistically significant. Blood flow to the brain was not affected by GLP-2 treatment.

**Calculated SMA and celiac artery flows.** On the basis of the known anatomy of the organs perfused by the celiac artery and the SMA, the actual flows for each artery were calculated. Figure 4 shows the calculated blood flow of the celiac and superior mesenteric artery in the low and high GLP-2 groups expressed relative to baseline. For the celiac artery, both GLP-2 infusion rates tended to decrease the blood flow to 81–87% of the baseline value, but neither was statistically significant. In contrast, the SMA flow tended to be higher (121%) ($P > 0.05$) in the low GLP-2 group but was statistically higher (141%) in the high GLP-2 group than in the baseline group (100%).

**DISCUSSION**

The primary aim of this study was to ascertain whether the stimulatory effect of GLP-2 on portal blood flow that we previously observed in TPN-fed piglets is localized to the small intestine. Two main aspects of GLP-2 function form the basis for this aim. First, the trophic actions of GLP-2 are localized to the mucosal epithelium of the small intestine, and secondly, the GLP-2R mRNA is localized mainly in the stomach, small and large intestine, and not other organs drained by the portal vein. We examined the brain as well, given the report that the GLP-2R mRNA is expressed in this tissue, which might not be directly stimulated by GLP-2. The finding that GLP-2 increased pancreatic blood flow warrants further study as to whether the GLP-2R mRNA is expressed in this tissue, which might not be surprising given that this is a key tissue that expresses the GLP-1 receptor.

We observed a stimulation of relative proximal small intestinal blood flow at the low and high GLP-2 infusion rates compared with baseline. However, it is notable that we did not detect significant changes in either the absolute flow rates (Fig. 1) or the calculated SMA flow rate (Fig. 4) at the low GLP-2 infusion rate. We should note that the low GLP-2 infusion rate...
was identical to that found previously to increase portal blood flow in TPN-fed piglets. However, the GLP-2 infusion rates used in this study were pharmacological, producing circulating concentrations of the biologically active GLP-2 (1–33) peptide ranging from 5- to 25-fold higher than normal physiological levels observed in enterally fed piglets (5). The low GLP-2 infusion dose is comparable to that being used in recent clinical trials for treatment of short-bowel syndrome in adult humans (17). We suggest that two factors may explain the lack of response to the low GLP-2 infusion rate. First, and most likely, is the fact that the piglets were studied under general isoflurane anesthesia, whereas the piglets were conscious in our previous report on portal blood flow (14). Isoflurane has been shown to decrease GI blood flow in the stomach, small intestine, colon, and pancreas in studies using a similar microsphere deposition technique (15, 18, 19). Interestingly, although isoflurane has been shown to decrease mean arterial pressure and increase heart rate, especially at higher exposure rates, we observed no significant change in either MAP or heart rate across the 120-min period in either GLP-2 group. A second factor contributing to the lack of response to the low GLP-2 infusion rate is the inherently higher variance associated with single time-point blood flow estimates using the microsphere deposition method compared with continuous blood flow measurements with implanted ultrasonic flow probes. Given this fact, it is notable that in the current study, the relative increases in proximal intestinal blood flow at the low GLP-2 infusion rate were ~30–50% higher than baseline, a response that is consistent with the relative changes in portal blood flow observed previously in conscious piglets (14).

The decrease in the blood flow to the stomach, spleen, and kidneys was also of interest. Despite the fact that the GLP-2R is expressed in the stomach, the finding of GLP-2-induced suppression of stomach blood flow is consistent with our previous report that GLP-2 suppresses the stomach tissue protein synthesis rate (5). Taken together, these observations coupled with previous evidence of GLP-2-mediated reduced secretory and motor function (33, 34) are congruent with the idea that GLP-2 generally suppresses metabolism and function of the stomach. The GLP-2-associated reductions in splenic and kidney blood flow were unexpected, as expression of the GLP-2R was not detected previously in the kidney (24) and has not been reported in the spleen. The close proximities of the arteries that supply these organs, namely, the celiac and renal, are cranial or caudal to the SMA, and this raises the possibility that increased flow to the SMA indirectly decreased flow to the celiac artery and kidneys. Whether these changes in blood flow alter function and metabolism of the spleen or kidney is unknown, although we found no changes in spleen protein synthesis or growth after GLP-2 treatment in a previous study (5). Furthermore, we did not observe any change in brain blood flow, even though the GLP-2R has been reported to be localized in the hypothalamus. The finding of no effect on brain-blood flow is also an important finding, particularly, if GLP-2 is used clinically in human neonates or infants.

In summary, the current study extends our previous finding that GLP-2 stimulates gastrointestinal or portal blood flow and demonstrates a specific effect on the SMA-derived tissues, namely, the jejunum, but also the duodenum and pancreas. In other gastrointestinal tissues, we found that GLP-2 either had no effect or a modest suppression of blood flow in the stomach and colon but also slightly decreased spleen and kidney blood flow at the highest infusion rate. These findings may be clinically relevant for the prevention and treatment of intestinal dysfunction in infants, especially those supported by TPN, to maintain mucosal growth and function. These results also may be clinically relevant by serving to augment blood flow and minimize tissue ischemia in chronic rejection in small bowel-transplanted patients and during pancreatitis (21, 23).

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