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CaV2.3 calcium channels control second-phase insulin release

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Concerted activation of different voltage-gated Ca2+ channel isoforms may determine the kinetics of insulin release from pancreatic islets. Here we have elucidated the role of R-type CaV2.3 channels in that process. A 20% reduction in glucose-evoked insulin secretion was observed in CaV2.3-knockout (CaV2.3–/–) islets, close to the 17% inhibition by the R-type blocker SNX482 but much less than the 77% inhibition produced by the L-type Ca2+ channel antagonist isradipine. Dynamic insulin-release measurements revealed that genetic or pharmacological CaV2.3 ablation strongly suppressed second-phase secretion, whereas first-phase secretion was unaffected, a result also observed in vivo. Suppression of the second phase coincided with an 18% reduction in oscillatory Ca2+ signaling and a 25% reduction in granule recruitment after completion of the initial exocytotic burst in single CaV2.3–/– β cells. CaV2.3 ablation also impaired glucose-mediated suppression of glucagon secretion in isolated islets (27% versus 58% in WT), an effect associated with coexpression of insulin and glucagon in a fraction of the islet cells in the CaV2.3–/– mouse. We propose a specific role for CaV2.3 Ca2+ channels in second-phase insulin release, that of mediating the Ca2+ entry needed for replenishment of the releasable pool of granules as well as islet cell differentiation.

Introduction
Systemic glucose tolerance is orchestrated by the regulated release of insulin and glucagon from the β and α cells of the pancreatic islets of Langerhans. The α and β cells are electrically excitable and use electrical signals to couple changes in blood glucose concentration to stimulation or inhibition of hormone release. In both cell types, influx of extracellular Ca2+ through voltage-gated Ca2+ channels with resultant elevation of intracellular Ca2+ concentration (Ca2+i) triggers exocytosis of the hormone-containing secretory granules. Like other electrically excitable cells, both α and β cells contain several types of voltage-gated Ca2+ channel (1, 2). Assigning physiological functions to the respective Ca2+ channels is central to the understanding of electrical and secretory activities in these cells.

Voltage-gated Ca2+ channels are divided into 3 subfamilies: (a) L-type high voltage–activated (HVA) Ca2+ channel family that comprises the CaV1.1, 1.2, 1.3, and 1.4 channels and is inhibited by dihydropyridines (DHPs) (1, 3, 4); (b) non–L-type HVA channels CaV2.1 (P/Q-type), 2.2 (N-type), and 2.3 (R-type) that are sensitive to ω-agatoxin IVA and ω-conotoxin GVIA and SNX482, respectively (1, 4, 5); and (c) the low voltage–activated (LVA) T-type Ca2+ channel family (CaV3.1, 3.2, and 3.3). The latter subtype differs electrophysiologically from the HVA Ca2+ channels in opening transiently already upon modest depolarization (6, 7) and fulfilling important roles in pacemaker cells (8).

Nonstandard abbreviations used: [Ca2+]i, intracellular Ca2+ concentration; CaV2.3–/–, CaV2.3-knockout; DHP, dihydropyridine; P/!F, P/Q-conotoxins; HVA, high voltage–activated; KATP, ATP-sensitive K+ channel; LVA, low voltage–activated; RRP, readily releasable pool.

Conflict of interest: The authors have declared that no conflict of interest exists.

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By contrast, recent evidence in neurons suggests that R-type channels are physically detached from the exocytotic machinery (20) and are not involved in rapid neurotransmission in mossy fibers (21).

About one-quarter of the β cell whole-cell Ca\(^{2+}\) current is sensitive to the R-type Ca\(^{2+}\) channel blocker SNX482, but the role of R-type Ca\(^{2+}\) channels in insulin secretion remains elusive. A general Ca\(_{\alpha 2.3}\) knockout (Ca\(_{\alpha 2.3}^{-/-}\)) mouse has been established. It exhibits a relatively modest neurological phenotype, including altered pain responses (22), impaired spatial memory (23), and enhanced fear reaction (24). Pancreatic islets express the endocrine splice variant of Ca\(_{\alpha 2.3}\) (22), impaired spatial memory (23), and enhanced fear reaction (24).

Whole cell Ca\(^{2+}\) currents in WT and Ca\(_{\alpha 2.3}^{-/-}\) mice. (A) Whole-cell Ca\(^{2+}\) currents (i) evoked by a 300-ms voltage-clamp depolarization (V) in WT Ca\(_{\alpha 2.3}^{+/+}\) (black) and Ca\(_{\alpha 2.3}^{-/-}\) (gray) β cells. β cells were identified by exhibiting half-maximal Na\(^{+}\) channel inactivation at membrane potentials (V) lower than −100 mV (half-maximal inactivation at −102 mV; inset). (B) Average integrated current-voltage (Q-V) relationships. Data are mean values ± SEM in 10 WT (filled circles) and 10 Ca\(_{\alpha 2.3}^{-/-}\) (shaded circles) β cells. *P < 0.05. (C) Whole-cell Ca\(^{2+}\) currents were recorded as in A, but using Ca\(_{\alpha 2.3}^{-/-}\) β cells. The recordings were made under control conditions (lower gray line) in the presence of R-type Ca\(^{2+}\) channel blocker SNX482 (100 nM; black line) and after addition of L-type Ca\(^{2+}\) channel inhibitor isradipine (isr) (2 μM; upper gray line). (D) Average Q-V relationships representing mean values ± SEM in 4 Ca\(_{\alpha 2.3}^{+/+}\) β cells under control conditions (shaded circles), in the presence of SNX482 (filled circles), and after addition of isradipine (open circles). *P < 0.05. **P < 0.01, control versus SNX482 plus isradipine. (E) Whole-cell Ca\(^{2+}\) currents were recorded as in A, but in α cells identified by Na\(^{+}\) channel inactivation at membrane potentials greater than −100 mV (half-maximal inactivation at −49 mV; inset). (F) Q-V relationships in α cells. Data represent average values ± SEM in 8 WT (filled circles) and 4 Ca\(_{\alpha 2.3}^{-/-}\) (shaded circles) α cells. pC, picocoulombs.

**Results**

**Whole cell Ca\(^{2+}\) currents in α and β cells from Ca\(_{\alpha 2.3}^{+/+}\) and Ca\(_{\alpha 2.3}^{-/-}\) mice.** Integrated Ca\(^{2+}\) current versus voltage (Q-V) relations were measured in dissociated single pancreatic islet cells using the perforated-patch whole cell configuration. Insulin-releasing β cells were identified by the absence of voltage-gated Na\(^{+}\) currents at membrane potentials relevant for β cell electrical activity, that is, between the β cell resting membrane potential (~70 mV) and the peak of the β cell action potential (~10 mV; Figure 1A, inset). In β cells from Ca\(_{\alpha 2.3}^{-/-}\) mice, the integrated Ca\(^{2+}\) currents observed at membrane potentials less than or equal to ~10 mV were reduced compared with WT cells. At ~10 mV, the reduction averaged approximately 23% (P < 0.05; Figure 1B). The Ca\(_{\alpha 2.3}^{-/-}\) mice exhibited a selective loss of a high-voltage Ca\(^{2+}\) current component, and current amplitudes at voltages below ~10 mV were not affected. The R-type Ca\(^{2+}\) channel blocker SNX482 (100 nM) had no effect on voltage-gated Ca\(^{2+}\) currents in Ca\(_{\alpha 2.3}^{-/-}\) mice, whereas the L-type inhibitor isradipine (2 μM) significantly reduced Ca\(^{2+}\) influx approximately 60% at potentials greater than or equal to ~30 mV (P < 0.05; Figure 1, C and D).

Cells exhibiting Na\(^{+}\) currents when holding at ~70 mV (Figure 1E, inset) were classified as non-β cells and likely represent glucagon-releasing α cells (27). The frequency of α cells was much lower in dispersed islet cells from Ca\(_{\alpha 2.3}^{-/-}\) mice than cells made from WT islets. Counting all cells that could be functionally defined as belonging to either group, only approximately 7% of the Ca\(_{\alpha 2.3}^{-/-}\) cells could be classified as α cells versus approximately 27% of the WT cells. In 4 cells from Ca\(_{\alpha 2.3}^{-/-}\) mice with the electrophysiological properties expected for α cells, the Ca\(^{2+}\) current amplitude was not different from that observed in WT cells (Figure 1, E and F).

**Single cell exocytosis in Ca\(_{\alpha 2.3}^{+/+}\) and Ca\(_{\alpha 2.3}^{-/-}\) mice.** Ca\(^{2+}\)-elicited exocytosis in β cells was monitored as increases in whole-cell membrane capacitance and was elicited by trains of 10 500-ms voltage...
clamp depolarizations from the holding potential −70 mV to 0 applied at 1 Hz (Figure 2, A and B). In β cells from Caβ3−/− mice, the increase in cell capacitance during the train averaged 392 ± 47 femtofarads (fF) (n = 7). The latter value is 21% less than the exocytotic response evoked by the same stimulus in WT mice (P < 0.05; 496 ± 42 fF; n = 6). Interestingly, the early component of exocytosis (in response to the first depolarization) was not affected and averaged 55 ± 19 fF and 57 ± 22 fF in WT and Caβ3−/− β cells, respectively. Instead, selective suppression of the late component of exocytosis was observed. The 23% reduction of the whole cell α cell capacitance is determined by β cell electrical activity. We therefore monitored [Ca2+]i, under basal conditions as well as after the addition of glucose, the KATP channel blocker tolbutamide, or following depolarization with high extracellular K+ (Figure 3). Resting [Ca2+]i, measured at 5 mM glucose was identical in islets from Caβ3−/− and WT mice and averaged approximately 90 nM. In WT islets, elevation of extracellular glucose from 5 to 15 mM evoked an initial robust elevation in [Ca2+]i, after 204 ± 33 seconds (n = 7). This initial peak decayed slowly (over 4–10 minutes) toward baseline and was eventually followed by a pattern of repetitive [Ca2+]i oscillations. Subsequent depolarization by the nonmetabolizable stimuli tolbutamide and high K+ in the continued presence of glucose elicited a rapid elevation of [Ca2+]i, but did not result in oscillatory activity. In Caβ3−/− islets, the glucose-evoked initial peak in [Ca2+]i, occurred 227 ± 15 seconds (n = 9) after elevating the glucose concentration. This initial amplitude was almost unaffected (7% decrease), but the time-averaged [Ca2+]i during the subsequent oscillatory phase was 17% lower than in WT islets (P < 0.01). In addition, the oscillatory activity was 29% slower

**Figure 3**

Ca2+ homeostasis in WT and Caβ3−/− islets. (A) [Ca2+]i in an intact WT Caβ3−/− islet assayed by ratiometric fura-2 measurements. The islets were stimulated at the time points indicated by the arrows in the continued presence of previously added stimuli. (B) [Ca2+]i was determined as in A, but the experiment was performed in an intact Caβ3−/− islet. Recordings selected for display are representative of 7 and 9 separate experiments in WT and Caβ3−/− islets, respectively. Statistical significances are provided in the text.
in the Ca\textsubscript{V2.3–/–} islets (1.8 ± 0.1 versus 2.5 ± 0.2 bursts/minute in Ca\textsubscript{V2.3+/+} and WT islets, respectively; \(P < 0.01\)). By contrast, the peaks in \([Ca^{2+}]\) induced by depolarization with tolbutamide or high K+ were, if anything, slightly augmented in the Ca\textsubscript{V2.3–/–} islets (NS versus control). The finding that no \([Ca^{2+}]\), oscillations were observed at 5 mM glucose and that elevating the glucose concentration to 15 mM increased \([Ca^{2+}]\) signaling suggests that the signal principally reflects the behavior of the pancreatic β cells (see ref. 30).

**In vivo glucose tolerance and pancreatic hormone release in Ca\textsubscript{V2.3–/–} mice.** In vivo glucose homeostasis was investigated by intraperitoneal glucose challenges (2 g/kg body weight; Table 1). Basal (nonfasted) plasma glucose levels averaged 9.8 ± 0.6 mmol/l (\(n = 8\)) in WT Ca\textsubscript{V2.3+/+} mice and increased 67% and 135% 3 and 8 minutes after the glucose load, respectively. In Ca\textsubscript{V2.3–/–} mice, basal glucose levels were elevated by 17% compared with WT (\(P < 0.05\) versus WT; \(n = 9\)), and the plasma glucose concentrations measured 3 and 8 minutes after challenge were also elevated approximately 15% (\(P < 0.05\) for values at 8 minutes versus WT). Basal plasma insulin levels did not differ between the Ca\textsubscript{V2.3+/+} and Ca\textsubscript{V2.3–/–} strains, although the plasma glucose concentration was somewhat higher in the former mice. In WT mice, glucose increased plasma insulin concentrations 43% and 52% 3 and 8 minutes after the challenge, respectively. In Ca\textsubscript{V2.3–/–} mice, the glucose-induced increase in circulating insulin was similar to that in WT mice 3 minutes after challenge, but after 8 minutes it was limited to less than 10% (\(P < 0.05\) versus WT). These findings reinforce previous observations indicating an impaired glucose tolerance of the Ca\textsubscript{V2.3–/–} mice (26).

We also monitored plasma glucagon concentrations during the glucose challenge. Basal glucagon levels in Ca\textsubscript{V2.3+/+} mice were modestly decreased (approximately 10%) compared with Ca\textsubscript{V2.3+/+} littermates. In WT mice, the glucose load reduced circulating glucagon 15% already at 3 minutes after challenge, and an additional 8% decrease was observed at 8 minutes. In Ca\textsubscript{V2.3–/–} mice, the inhibition of glucagon release was sluggish. At 3 minutes after challenge, plasma glucagon concentrations actually increased 18% (\(P < 0.05\) versus basal; \(n = 9\)).

**Insulin and glucagon release in vitro in pancreatic islets.** Pancreatic islets in situ receive extensive neuronal input from parasympathetic nerve endings (31). Since Ca\textsubscript{V2.3} Ca\textsuperscript{2+} channels are also expressed in neuronal tissue, their ablation might affect pancreatic hormone release in vivo by indirect mechanisms and not by directly affecting α and β cell function. Insulin and glucagon secretion was therefore also investigated in isolated islets. The first set of experiments investigated the effects of L-type and R-type channel blockers isradipine and SNX482, respectively, in WT Ca\textsubscript{V2.3–/–} islets (Table 2). Basal insulin release (1 mM glucose) was low and was unaffected by either channel blocker. Elevation of extracellular glucose to 20 mM stimulated insulin release more than 15-fold. Isradipine (2 μM) suppressed glucose-stimulated insulin release 77%, whereas SNX482 (100 nM) reduced insulin secretion 17% (Table 2). The latter value agrees favorably with the inhibition observed in capacitance measurements (see Figure 2, A and B). Glucagon release was measured under the same conditions. At 1 mM glucose glucagon release was high and remained unchanged by either isradipine or SNX482. Elevating the glucose concentration (20 mM) reduced glucagon secretion 70% (\(P < 0.001\); low versus high glucose). At high glucose, blockade of R-type channels by SNX482 failed to affect glucagon release, whereas isradipine stimulated glucagon secretion under the same condition.

We next compared the effects of the Ca\textsuperscript{2+} channel blockers with the consequences of Ca\textsubscript{V2.3} gene ablation on pancreatic hormone release (Table 3). In WT Ca\textsubscript{V2.3+/+} islets, elevating glucose from 1 to 20 mM again stimulated insulin release more than 15-fold. In Ca\textsubscript{V2.3–/–} islets, glucose-stimulated insulin release was reduced approximately 25% compared with WT. The effects of isradipine on glucose-stimulated insulin release were comparable in WT (66% reduction) and in Ca\textsubscript{V2.3–/–} islets (68% suppression). Insulin secretion elicited by stimulation with high extracellular K+ (50 mM) resulted in a 75% enhancement of release relative to that observed in the presence of glucose alone in WT islets. A similar relative stimulation was observed in Ca\textsubscript{V2.3–/–} islets (96%), but in absolute terms, the response in the latter type of islets was reduced 13% compared with WT islets. Surprisingly, whereas elevating glucose from 1 to 20 mM suppressed glucagon release 58% in WT Ca\textsubscript{V2.3+/+} islets (\(P < 0.001\); low versus high glucose), the inhibitory action of the sugar was severely impaired in the Ca\textsubscript{V2.3–/–} islets and amounted to a mere 27% (\(P < 0.01\) versus WT). Isradipine exerted divergent actions in WT and Ca\textsubscript{V2.3–/–} islets. As discussed above, in WT islets the

<table>
<thead>
<tr>
<th>Time after i.p. glucose challenge (min)</th>
<th>WT</th>
<th>Ca\textsubscript{V2.3–/–}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plasma glucose (mmol/l)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>9.8 ± 0.6</td>
<td>11.5 ± 0.8*</td>
</tr>
<tr>
<td>3</td>
<td>16.4 ± 2.1</td>
<td>18.9 ± 1.7</td>
</tr>
<tr>
<td>8</td>
<td>23.0 ± 2.1</td>
<td>26.5 ± 2.1*</td>
</tr>
<tr>
<td>Plasma insulin (pmol/l)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>163.0 ± 15.5</td>
<td>170.1 ± 14.8</td>
</tr>
<tr>
<td>3</td>
<td>229.4 ± 29.6</td>
<td>207.5 ± 11.1</td>
</tr>
<tr>
<td>8</td>
<td>244.4 ± 17.8</td>
<td>185.2 ± 18.5*</td>
</tr>
<tr>
<td>Plasma glucagon (ng/l)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>194.0 ± 15.1</td>
<td>175.7 ± 6.1</td>
</tr>
<tr>
<td>3</td>
<td>196.9 ± 13.2</td>
<td>197.0 ± 7.7</td>
</tr>
<tr>
<td>8</td>
<td>148.5 ± 13.5</td>
<td>130.3 ± 4.9</td>
</tr>
</tbody>
</table>

Average values for plasma glucose, insulin, and glucagon concentrations ± SEM immediately before and 3 and 8 minutes after an i.p. glucose challenge (2 g/kg body weight) in 8 WT and 9 Ca\textsubscript{V2.3–/–} mice. Levels of statistical significance are shown only for comparisons between WT and Ca\textsubscript{V2.3–/–} data. \* \(P < 0.05\).

<table>
<thead>
<tr>
<th>Condition</th>
<th>Insulin secretion (ng/islet/h)</th>
<th>Glucagon secretion (pg/islet/h)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 mM glucose</td>
<td>0.2 ± 0.03</td>
<td>38.4 ± 3.0</td>
</tr>
<tr>
<td>1 mM glucose + 2 μM isradipine</td>
<td>0.2 ± 0.05</td>
<td>36.7 ± 6.1</td>
</tr>
<tr>
<td>1 mM glucose + 100 nM SNX482</td>
<td>0.3 ± 0.03</td>
<td>38.5 ± 4.5</td>
</tr>
<tr>
<td>20 mM glucose</td>
<td>2.6 ± 0.2*</td>
<td>12.8 ± 4.7</td>
</tr>
<tr>
<td>20 mM glucose + 100 nM SNX482</td>
<td>0.7 ± 0.08*</td>
<td>22.8 ± 2.1*</td>
</tr>
<tr>
<td>2 μM isradipine</td>
<td>2.3 ± 0.2*</td>
<td>16.2 ± 4.1</td>
</tr>
</tbody>
</table>

Average values for insulin and glucagon release ± SEM measured in 60-minute batch incubations of 10 islets from WT Ca\textsubscript{V2.3–/–} mice under conditions as indicated. Data are from 10 independent experiments. \* \(P < 0.001\), \*\* \(P < 0.05\) versus the same condition in 1 mM glucose; \* \(P < 0.001\), \*\* \(P < 0.05\) versus 20 mM glucose alone.
L-type Ca\textsuperscript{2+} channel antagonist stimulated glucagon release 52\% when applied in the presence of 20 mM glucose. By contrast, isradipine reduced glucagon secretion in Ca\textsubscript{V2.3–/–} islets 32\% under high-glucose conditions. Increasing extracellular K\textsuperscript{+} enhanced glucagon secretion massively, approximately 320\% in WT and 220\% in Ca\textsubscript{V2.3–/–} islets.

Phasic insulin release measured by in situ pancreatic perfusion. To assess the role of Ca\textsubscript{V2.3} in dynamic insulin release, we performed in situ pancreatic perfusions with fractionated sampling. When WT Ca\textsubscript{V2.3+/+} pancreata were perfused (Figure 4A) with a low-glucose solution (3.3 mM), insulin release was barely detectable. After increasing the glucose concentration to 16.7 mM (at t = 11 minutes), first-phase insulin release was initiated with a 2-minute delay. The peak in first-phase insulin secretion was attained 2 minutes after onset of release (t = 15 minutes) and measured 8.8 ± 1.7 ng/ml (n = 4). Insulin release then exhibited a transient nadir phase (t = 18–21 minutes) during which release rates averaged 4–5 ng/ml, before accelerating again during second-phase insulin secretion to approximately 18 ng/ml at t = 36 minutes and later. When the same experiment was repeated in Ca\textsubscript{V2.3–/–} pancreata (Figure 4B), the peak in first-phase insulin secretion was only slightly reduced (19\%) and measured 7.1 ± 2.1 ng/ml (NS; n = 4). More importantly, second-phase insulin release was markedly suppressed and averaged 9.4 ± 2.7 ng/ml at t = 40 minutes, representing a 46\% reduction compared with WT (P < 0.05).

Genetic ablation of Cav2.3 may result in compensatory mechanisms resulting in rearrangements of the Ca\textsuperscript{2+} channels in the β cell itself or neighboring α and δ cells. In addition, we wanted to verify that the observed effects of Ca\textsubscript{V2.3} on insulin secretion are not limited to the background C57B mouse strain. Similar experiments were therefore made in pancreata from standard inbred NMRI mice, but instead Ca\textsubscript{V2.3} channel function was inhibited by SNX482. In the absence of the channel inhibitor, first-phase insulin secretion was initiated with a 2-minute delay and peaked 1 minute, 30 seconds later when it measured 15.3 ± 2.5 ng/ml (n = 6).

Table 3

<table>
<thead>
<tr>
<th>Glucagon release (pg/islet/h)</th>
<th>Insulin release (ng/islet/h)</th>
<th>WT</th>
<th>Ca\textsubscript{V2.3–/–}</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 mM glucose</td>
<td>0.2 ± 0.02</td>
<td>0.4 ± 0.05</td>
<td></td>
</tr>
<tr>
<td>20 mM glucose</td>
<td>3.1 ± 0.3</td>
<td>2.4 ± 0.14</td>
<td></td>
</tr>
<tr>
<td>20 mM glucose +</td>
<td>0.8 ± 0.09\textsuperscript{B}</td>
<td>1.1 ± 0.18</td>
<td></td>
</tr>
<tr>
<td>2 μM isradipine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 mM glucose + 50 mM K\textsuperscript{+}</td>
<td>5.4 ± 0.28</td>
<td>4.7 ± 0.38\textsuperscript{D}</td>
<td></td>
</tr>
</tbody>
</table>

Average values for insulin and glucagon release measured in 60-minute batch incubations of 10 WT Ca\textsubscript{V2.3+/+} and Ca\textsubscript{V2.3–/–} islets under conditions as indicated. Data represent means ± SEM of 18 experiments in each group. \textsuperscript{A}P < 0.01, \textsuperscript{B}P < 0.05 for comparisons between WT and Ca\textsubscript{V2.3–/–}; \textsuperscript{C}P < 0.001, \textsuperscript{D}P < 0.01, \textsuperscript{E}P < 0.05 versus results obtained in 20 mM glucose alone.

<table>
<thead>
<tr>
<th>Glucagon release (pg/islet/h)</th>
<th>Insulin release (ng/islet/h)</th>
<th>WT</th>
<th>Ca\textsubscript{V2.3–/–}</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 mM glucose</td>
<td>39.8 ± 1.3</td>
<td>40.9 ± 1.8</td>
<td></td>
</tr>
<tr>
<td>20 mM glucose + 50 mM K\textsuperscript{+}</td>
<td>71.7 ± 6.5\textsuperscript{D}</td>
<td>94.8 ± 10.6\textsuperscript{B,E}</td>
<td></td>
</tr>
</tbody>
</table>

Data in Table 3 represent means ± SEM of 18 experiments in each group. \textsuperscript{A}P < 0.01, \textsuperscript{B}P < 0.001, \textsuperscript{C}P < 0.01, \textsuperscript{D}P < 0.05 versus results obtained in 20 mM glucose alone.

Figure 4

Dynamics of insulin release. (A) Insulin release measured in WT Ca\textsubscript{V2.3+/+} pancreata before and after increasing the glucose concentration in the perfusate from 3.3 mM to 16.7 mM at t = 11 minutes. Samples were taken at 60-second intervals, except during the first 10 minutes after increasing the glucose concentration (t = 11 to 21 minutes, as indicated by the gray bar) when the sample interval was 30 seconds. (B) Insulin release was measured as in A, but the experiments were performed in Ca\textsubscript{V2.3–/–} mice. To facilitate comparison with WT, mean values measured under that condition are indicated by the dotted line. Data in A and B represent means ± SEM from 4 and 5 experiments in WT and Ca\textsubscript{V2.3–/–} mice, respectively. (C) Insulin release was measured as in A, but the experiments were performed in NMRI mice. (D) Insulin release was measured as in C, but SNX482 (100 nM) was included in the high-glucose solution. To facilitate comparison with mean values measured in the absence of SNX482, these values are denoted by the dotted line. Data in C and D represent means ± SEM from 6 experiments performed with and without SNX482, respectively. Statistical significance is provided in Results.
Insulin release then decayed toward a lower plateau level of approximately 8 ng/ml and increased slightly to approximately 10 ng/ml during the second phase (Figure 4C). When SNX482 (100 nM) was included in the perfusate (Figure 4D), first-phase insulin release was largely unaffected, and peak values averaged 13.0 ± 3.7 ng/ml (n = 6). By contrast, second-phase insulin secretion was reduced more than 80% (e.g., 1.8 ± 0.6 ng/ml versus 10.0 ± 0.6 ng/ml at t = 40 minutes in the presence or absence of SNX482, respectively; P < 0.01). It was verified that the glucose concentration in the effluent medium was identical in all experiments.

In insulin and glucagon immunoreactivity in WT and \( \text{Ca}_{2.3}^- \) islet cells. Islet cells were finally dispersed and investigated by confocal immunocytochemistry (Figure 5). In WT islet cells, 80% of the dispersed cells revealed immunoreactivity for insulin and approximately 20% stained positive for glucagons in double-labeling experiments. The relative frequency of \( \beta \) and \( \alpha \) cells suggested by this analysis compares favorably with the electrophysiological data. Only 1 out of 230 cells investigated revealed immunoreactivity for both insulin and glucagons. A rather different picture emerged in the \( \text{Ca}_{2.3}^- \) islet cell preparation. Whereas 75% and 9% of the cells could readily be characterized as \( \beta \) and \( \alpha \) cells, respectively, 16% of the 210 cells coexpressed insulin and glucagons.

Discussion

Insulin-producing \( \beta \) cells contain multiple types of \( \text{Ca}^{2+} \) channel. Whereas the role of L-type \( \text{Ca}^{2+} \) channels in insulin secretion is amply documented, that of the non-L-type \( \text{Ca}^{2+} \) channels is less well understood. The advent of subtype-specific \( \text{Ca}^{2+} \) channel blockers in combination with the generation of transgenic knockout mice provides a unique opportunity for an in-depth analysis of the function(s) fulfilled by the different \( \text{Ca}^{2+} \) channel subtypes. Here we have used SNX482 and \( \text{Ca}_{2.3}^- \)-null mice to study the significance of R-type \( \text{Ca}_{2.3} \) \( \text{Ca}^{2+} \) channels in islet insulin and glucagon secretion in vivo and in vitro.

The role of \( \text{Ca}_{2.3} \) channels for \( \beta \) cell [\( \text{Ca}^{2+} \)], homeostasis and insulin secretion. Here we demonstrate that pharmacological inhibition of R-type \( \text{Ca}_{2.3} \) \( \text{Ca}^{2+} \) channels using SNX482 does not affect first-phase insulin secretion, but reduces second-phase release by a dramatic 80%. A similar preferential effect on late-phase insulin secretion is observed in \( \text{Ca}_{2.3}^- \) mice (Figure 4). At the single cell level, close inspection of the capacitance recordings (Figure 2, A and B) reveals that the initial component of exocytosis is not much affected in \( \text{Ca}_{2.3}^- \) cells. In fact, the overall reduction results exclusively from suppression of the late component of exocytosis (elicited by the third and subsequent depolarizations). We have previously demonstrated that opening of L-type \( \text{Ca}_{1.2} \) \( \text{Ca}^{2+} \) channels is tightly associated with rapid exocytosis and first-phase secretion. Thus, it appears that \( \text{Ca}^{2+} \) entry via L-type \( \text{Ca}_{1.2} \) and R-type \( \text{Ca}_{2.3} \) channels have distinct intracellular effects.

\( \text{Ca}_{2.3} \) ablation is associated with a 23% decrease in \( \beta \) cell \( \text{Ca}^{2+} \) current in \( \text{Ca}_{2.3}^- \) mice (Figure 1). This is in good agreement with the response to acute application of SNX482 in WT mice (13), suggesting that there is little compensatory upregulation of other \( \text{Ca}^{2+} \) channels in the knockout mice. We acknowledge that \( \text{Ca}_{2.3} \) channel activity may represent only part of the R-type current component (24, 32). In addition, other reports suggest that all R-type current components are not blocked by SNX482 with the same efficacy (33). The observation that SNX482 fails to affect whole cell \( \text{Ca}^{2+} \) currents in \( \text{Ca}_{2.3}^- \) cells (Figure 1, C and D), however, indicates at least that SNX482, at the concentration used here (100 nM), does not affect any \( \text{Ca}^{2+} \) channels other than \( \text{Ca}_{2.3} \), but we cannot exclude the contribution of an SNX482-insensitive R-type \( \text{Ca}^{2+} \) current component. Indeed, approximately 40% of the whole cell \( \text{Ca}^{2+} \) current is unaffected by either SNX482 or the L-type blocker isradipine in \( \text{Ca}_{2.3}^- \) cells. Although most of this current probably represents P/Q-type \( \text{Ca}^{2+} \) currents as previously shown for WT \( \beta \) cells (13), it is possible that part of it reflects a SNX482-resistant portion of the R-type \( \text{Ca}^{2+} \) current.

**How do \( \text{Ca}_{2.3} \) \( \text{Ca}^{2+} \) channels regulate second-phase insulin secretion?** Secretoory granules in pancreatic \( \beta \) cells can be classified according to their release competence (34). A limited (1–5%) pool is immediately available for rapid exocytosis upon stimulation (readily releasable pool, RRP). Once this pool of granules has been...
V2.3 channels were disrupted in vivo by deleting a region containing V2.3 ablated mice appears to be due to the systemic level. In the in vivo glucose challenge test, 3-minute exposure to glucose islets, it has the opposite effect in WT islets. This observation demonstrates linkage with elevated blood glucose levels in the Framingham Heart Study (45). It is also pertinent that the above region around 1q25 reveals linkage to type 2 diabetes in several research articles. A surprising finding in the present study is that the majority of the glucagon immunoreactive cells in CaV2.3−/− islets coexpress insulin, indicating that CaV2.3 channels play a role in the development of mature α cells. A transient peak in CaV2.3 channel expression in glial cells along specific CNS pathways has been demonstrated to coincide with postnatal myelination of the white matter in the rat (41). It can be speculated that CaV2.3 channel expression exerts a similar action in defining the differentiated mature islet cell lineages, but the exact underlying mechanism remains to be established.

Pathophysiological implications. Although R-type CaV2.3 channels appear to be of little importance for first-phase insulin secretion and their contribution becomes apparent only during late exocytosis/second-phase insulin secretion, this does not mean that they are unimportant for systemic glucose homeostasis. Indeed, the CaV2.3−/− mice exhibited basal hyperglycemia (Table 1). In humans, CaV2.3 is encoded by the CACNA1E gene, which is located on chromosome 1q25–31. Interestingly, a chromosomal region around 1q25 reveals linkage to type 2 diabetes in several independent studies in different populations. These include early onset type 2 diabetes in Pima Indians (42), Utah Caucasians (43), and English sib pairs (44). In addition, the 1q25–32 region demonstrates linkage with elevated blood glucose levels in the Framingham Heart Study (45). It is also pertinent that the above region contains a CACNA1E gene alone are not sufficient to confer protective insulin secretion in type 2 diabetes in Pima Indians (46). Type 2 diabetes is a multifactorial polygenic disorder. Clearly, polymorphisms in the CACNA1E gene alone are not sufficient to trigger disease. Given the present functional data, however, it is tempting to speculate that dysfunctional CaV2.3 Ca2+ channels may frequently be involved in creating the disturbed β cell phenotype in type 2 diabetes.

Methods

Experimental animals. As previously reported (26), the CACNA1E gene encoding CaV2.3 was disrupted in vivo by deleting a region containing exon 2 on mating CaV2.3+/− and deleter mice on a C57Bl/6 background.
that expresses Cre recombinase constitutively under the control of the CMV promoter. Ca2,3−/− mice containing 1 cre transgene were inbred, and pups with the Ca2,3−/− genotype were selected and transferred by embryo transfer into a SPF facility. The transfer included breeding with C57Bl/6 mice and resulted in heterozygous Ca2,3−/− mice. Only cre-negative pups were selected and inbred, yielding either Ca2,3+/− or Ca2,3−/− mice. Thus, the Ca2,3+/− and Ca2,3−/− mice used in this study have an identical genetic background. In Figure 4, inbred NMRI mice purchased from Charles River Wiga GmbH were used.

The mice were housed at a constant temperature (22–23°C) and 12-hour light cycles (6:00 a.m.–6:00 p.m.), with access to standard pellet food and water ad libitum. All experiments were evaluated and approved by the local ethical committee Malmö/Lund djurförsöksetiska nämnd, Lund District Court, Sweden.

Islet isolation and islet cell preparation. The mice were sacrificed by cervical dislocation, and collagenase was administered into the pancreas by retrograde injection via the pancreatic duct. After 15–20 minutes' incubation at 37°C, the islet suspension was washed 4 times with HBSS (4°C) before being manually collected. The islets were cultured in RPMI-1640 medium (Invitrogen Corp.) supplemented with 10% FCS, penicillin, and streptomycin. For the preparation of single cells, islets obtained by collagenase digestion were dissociated by incubation and gentle trituration in Ca2+/free medium. The resulting cell suspension was centrifuged, the supernatant discarded, and the pellet (containing the cells) was resuspended in RPMI-1640 medium, plated on plastic Nunc 35-mm Petri dishes, and maintained in tissue culture for up to 2 days.

Electrophysiology. The measurements were conducted using an EPC-10 patch-clamp amplifier in conjunction with the PULSE software suite (version 8.53; HEKA Elektronik). Whole-cell Ca2+ currents were measured in intact cells using the perforated-patch whole-cell approach (Figure 1) using a pipette solution consisting of 76 mM Cs2SO4, 10 mM NaCl, 10 mM CsCl, 1 mM MgCl2, 5 mM HEPES (pH 7.35 with KOH), and 0.24 mg/ml amphotericin B (47). Exocytosis was monitored as increases in cell capacitance using the sine + DC mode of the lock-in amplifier included in the PULSE software and the standard whole cell configuration. When eliciting exocytosis by trains of ten 500-ms voltage clamp depolarizations (Figure 2, A and E), the pipette solution consisted of 125 mM Cs-glutamate, 10 mM CsCl, 10 mM NaCl, 1 mM MgCl2, 5 mM HEPES, 3 mM Mg-ATP, 0.1 mM cAMP, and 0.05 mM EGTA (pH 7.2 with CsOH). In Figure 2, C and G, this pipette solution was slightly modified to include 10 mM EGTA and 9 mM CaCl2, and all Cs+ salts were replaced by corresponding K+ salts. The resulting free intracellular Ca2+ concentration of this Ca2+/EGTA buffer was estimated to 1.5 μM using the binding constants of Martell and Smith (48, 49). The extracellular bath solution consisted of 138 mM NaCl, 5.6 mM KCl, 2.6 mM CaCl2, 1.2 mM MgCl2, 5 mM glucose, and 5 mM HEPES (pH 7.4 with NaOH). In the recordings of whole-cell Ca2+ currents and depolarization-evoked exocytosis (Figure 2, A and E), 20 mM of NaCl was equimolarly replaced by the K+ channel blocker TEA-Cl to facilitate the separation of the small voltage-gated Ca2+ currents from the large outward K+ current. The DHP isradipine (Pfizer Inc.) was prepared as stock solution in DMSO (final concentration less than or equal to 0.1%). The R-type Ca2+ channel blocker SNX482, tolbutamide, or high K+ as specified in the text and figures. Immediately after incubation, a 25-μl aliquot of the medium was removed for assay of insulin and glucagon radioimmunoassay as described previously (50).

Immunocytochemistry. Insulin and glucagon immunoreactivities were visualized in dissociated islet cells by indirect immunocytochemistry using a Carl Zeiss AG 510 LSM confocal microscope and a x100 Plan-Apochromat 100/1.4 oil objective. After fixation with 3% paraformaldehyde and permeabilization by 0.1% Triton-X, the cells were incubated with normal donkey serum to reduce unspecific staining. The primary insulin and glucagon Abs, raised in guinea pigs and sheep, respectively, were incubated at 1:1,000. To prevent cross-talk between the channels, the secondary Cy3-conjugated anti–guinea pig, and the Cy5-conjugated anti-sheep Abs (1:600) were excited in the multitrack mode using the 543-nm and 633-nm lines of the HeNe lasers, and emitted light was collected using greater than 560-nm and greater than 650-nm long-pass filters, respectively.

Microfluorimetry. Ca2+ in intact pancreatic islets was measured by dual-wavelength microfluorimetry using fura-2 and a D104 PTI microfluorimetry system. The temperature of the experimental chamber was +32°C to allow comparison with the electrophysiological data. Procedures for loading and calibration of the fluorescence signal were as described previously (52).

Statistical analysis. All data are given as means ± SEM. Statistical significance was evaluated using absolute values only. A paired Student’s t test was used when comparing responses in the same cell. For comparisons between groups with independent observations we used independent Student’s t tests or, when comparisons involved more than 2 groups, ANOVA.

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