Hope and fear for new classes of type 2 diabetes drugs: is there preclinical evidence that incretin-based therapies alter pancreatic morphology?

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Abstract
Incretin-based therapies appear to offer many advantages over other approaches for treating type 2 diabetes. Some preclinical studies have suggested that chronic activation of glucagon-like peptide 1 receptor (GLP1R) signalling in the pancreas may result in the proliferation of islet β-cells and an increase in β-cell mass. This provided hope that enhancing GLP1 action could potentially alter the natural progression of type 2 diabetes. However, to date, there has been no evidence from clinical trials suggesting that GLP1R agonists or dipeptidyl peptidase-4 (DPP4) inhibitors can increase β-cell mass. Nevertheless, while the proliferative capacity of these agents remains controversial, some studies have raised concerns that they could potentially contribute to the development of pancreatitis and hence increase the risk of pancreatic cancer. Currently, there are very limited clinical data to directly assess these potential benefits and risks of incretin-based therapies. However, a review of the preclinical studies indicates that incretin-based therapies probably have only a limited capacity to regenerate pancreatic β-cells, but may be useful for preserving any remaining β-cells in type 2 diabetes. In addition, the majority of preclinical evidence does not support the notion that GLP1R agonists or DPP4 inhibitors cause pancreatitis.

Key Words
- GLP1
- DPP4
- islets
- β-cells
- pancreatitis
- mice
- rats

Introduction
The incretins glucagon-like peptide 1 (GLP1) and glucose-dependent insulino tropic polypeptide (GIP) act via specific G-protein-coupled receptors to potentiate insulin secretion from pancreatic β-cells in a glucose-dependent manner. However, the native forms of GLP1 and GIP are rapidly inactivated in vivo by the enzyme dipeptidyl peptidase-4 (DPP4). Therefore, pharmacological approaches aimed at enhancing incretin action have focused on either utilising incretin analogues that are resistant to DPP4 cleavage or inhibiting the DPP4 enzyme. There are several GLP1 receptor (GLP1R) agonists (exenatide, liraglutide and lixisenatide) and multiple DPP4 inhibitors (sitagliptin, vildagliptin, saxagliptin, linagliptin and alogliptin) that are approved in many countries for use in patients with type 2 diabetes. A number of others are in late-stage clinical development. All these drugs act...
to enhance incretin signalling not only in pancreatic β-cells, but also in other pancreatic cells and tissues expressing the relevant incretin receptors. However, due to limitations in some commonly used detection methods, the precise locations of functional incretin receptors in the pancreas outside of β-cells still remain to be fully elucidated (Drucker 2013). To date, clinical trial data have indicated that currently available incretin-based therapies have multiple beneficial effects contributing to their efficacy, but recently their safety has been questioned.

The potential benefits of enhancing GLP1 action are not limited to potentiating insulin secretion (Lovshin & Drucker 2009). When glucose levels are elevated, GLP1 also inhibits glucagon secretion from pancreatic α-cells, and thus the glucagon-lowering effects of GLP1R agonists and DPP4 inhibitors probably contribute to their ability to improve glycaemic control. Moreover, the effects of GLP1 are not confined to the pancreas, and the activation of GLP1R signalling in extra-pancreatic tissues such as the intestine and CNS is thought to contribute to the overall improvement in metabolic homeostasis observed with incretin-based therapies. However, DPP4 inhibitors and GLP1R agonists modulate incretin action via different mechanisms, and the relative levels of active GLP1 (or GLP1R agonist) appear to be an important determinant of their actions. For example, pharmacological levels of GLP1R agonists reduce the rate of intestinal nutrient absorption by inhibiting the rate of gastric emptying and promote weight loss via the suppression of appetite. By contrast, DPP4 inhibitors, which result in more physiological elevations in GLP1 levels, are weight neutral and do not affect gastric emptying. Additionally, GLP1 may also have direct protective effects on the heart and cardiovascular system, and preclinical studies suggest that there may be benefits such as reduced blood pressure and reduced atherosclerotic severity associated with the use of either GLP1R agonists or DPP4 inhibitors (Ussher & Drucker 2012).

The various actions of incretin-based therapies provide clear advantages over other available diabetes medications. For example, in contrast to the potential weight loss observed with GLP1R agonists, drugs such as insulin, sulphonylureas (SUs) and thiazolidinediones promote weight gain. In addition, while the effects of GLP1 on pancreatic hormone secretion are glucose dependent, which virtually eliminates the risk of hypoglycaemia, the actions of insulin and SUs are not dependent on elevated glucose levels, and thus therapies with these agents lead to much higher rates of hypoglycaemia. Furthermore, while non-glucose-dependent insulin secretagogues, such as SUs, may place excessive stress on pancreatic β-cells and potentially promote β-cell apoptosis (Maedler et al. 2005, Takahashi et al. 2007, Aston-Mourney et al. 2008), incretins activate signalling pathways that provide protection against apoptosis (Trumper et al. 2002, Hui et al. 2003, Wang et al. 2004). Preclinical studies in rodents have provided hope that enhancing GLP1R signalling may be able to halt the progressive decline in β-cell mass and perhaps even promote the growth of new β-cells in vivo (Xu et al. 1999, Stoffers et al. 2003). However, current techniques do not allow for the accurate assessment of β-cell mass in clinical trials, and to date, data relating incretin action to sustained improvement in β-cell function or mass in older diabetic human subjects have not been as encouraging as the initial data from rodents (Drucker 2011). So, it is worth re-examining the published preclinical studies to determine the strength of the evidence supporting the regenerative capacity of incretin-based therapies.

While the potential benefits of enhanced GLP1R signalling for β-cell mass are apparent, the putative proliferative effects of GLP1R agonists and DPP4 inhibitors raise theoretical concerns that in type 2 diabetes therapies with these agents could potentially contribute to the development of precancerous lesions. In addition, excessive proliferation of ductal cells could block the passage of digestive enzymes secreted from the exocrine pancreas. Indeed, concerns about pancreatic inflammation were revealed following several case reports of pancreatitis in patients treated with exenatide (Ahmad & Swann 2008). Based on very limited clinical data (Elashoff et al. 2011, Singh et al. 2013) and a few preclinical studies (Matveyenko et al. 2009, Nachmani et al. 2010, Gier et al. 2012), some researchers have suggested that GLP1-based therapies increase the risk of pancreatitis (Gale 2013, Gier & Butler 2013). Moreover, the associated publicity surrounding these issues may have contributed to an increase in the reporting of pancreatitis in US Food and Drug Administration (FDA) adverse event databases for exenatide and sitagliptin (Raschi et al. 2013). However, such self-reporting databases are prone to bias and are thus not useful for establishing the incidence of adverse events. Therefore, to determine whether there is a true effect of incretin-based therapies, it is critically important that data from well-controlled long-term studies be carefully analysed. Unfortunately, it will be some time before we have the data available from such clinical trials designed to examine the cardiovascular safety of these drugs. Currently, the only way to assess pancreatic
histology following incretin-based therapies in humans is to examine cadaver samples. However, this technique is severely limited by the lack of available donors and it is difficult to obtain appropriately matched control subjects. Indeed, a recent publication (Butler et al. 2013) that described the expansion of both the endocrine and exocrine pancreas in patients who had been treated with either sitagliptin or exenatide has been widely criticised (Drucker 2013, Engel et al. 2013, Harja et al. 2013, Heine et al. 2013, Kahn 2013, Nauck 2013, Bonner-Weir et al. 2014) for the obvious differences in age, diabetes duration and other potential confounding factors of the control group and is thus difficult to interpret. So at this stage, it appears worthwhile to carefully examine all the available preclinical studies that provide data on the effects of incretin-based therapies on the exocrine pancreas.

In summary, currently controversy and uncertainty exist as to whether incretin-based therapies alter pancreatic morphology in diabetic human subjects. Given the difficulty in obtaining useful data and material from human patients, we sought to review the available data from in vivo preclinical studies utilising GLP1R agonists or DPP4 inhibitors.

**GLP1R agonists and β-cell mass**

**Can GLP1R agonists affect β-cell mass in normal rodents?**

**Normal rats** One of the earliest studies to examine the effect of GLP1R agonists on pancreatic morphology demonstrated that 10-day exenatide administration (1 nmol/kg once daily i.p.) to 4–5-week-old male Sprague Dawley rats increased β-cell proliferation and β-cell mass (by ~40%) (Xu et al. 1999). Another study in older (22-month-old) Wistar rats used a s.c. infusion of native GLP1 for 5 days and also reported an increase in β-cell mass immediately after the treatment period (Perfetti et al. 2000). While the administration of the GLP1R agonist lixivtaglutide (200 µg/kg twice daily s.c.) was found to be associated with increased β-cell mass in Sprague Dawley rats after 1 week of treatment, when pancreatic sections were analysed after 6 weeks of continued treatment, differences in β-cell mass were no longer detected (Bock et al. 2003). Similarly, while an increase in the number of proliferating β-cells was observed soon after the initiation of exenatide treatment (at 2 days), several studies were unable to detect any changes in β-cell proliferation at later time points (Xu et al. 1999, Perfetti et al. 2000, Stoffers et al. 2003). Therefore, in normal rats, the effect of GLP1R agonists on β-cell proliferation appears to be transient, and any effect on β-cell mass may not be durable, particularly once treatment has ceased.

**Normal mice** The majority of studies that have described the effects of GLP1R agonists in normal mice have been carried out using the C57BL/6 laboratory strain. This inbred mouse strain is known to expand β-cell mass in response to diet-induced obesity (Stamateris et al. 2013), so it is a good candidate for testing the effects of other potential stimuli of β-cell proliferation. Several studies in young C57BL/6 mice (<12 weeks of age) demonstrated that exenatide (administered by daily injections or a constant s.c. infusion over a period of up to 3 weeks) increased the proportion of proliferating β-cells, as identified by markers such as bromodeoxyuridine (BrdU) incorporation and Ki67 immunopositivity (Li et al. 2003, 2005, Park et al. 2006, Rankin & Kushner 2009, Tschen et al. 2009). Moreover, a short duration of GLP1R agonist treatment was also found to be associated with increases in islet size and β-cell mass (Stoffers et al. 2000, Park et al. 2006, Tschen et al. 2009). Similar short-term effects of exenatide treatment on β-cell proliferation were also observed in 8-week-old mice that were of mixed background (C57BL/6×Sv129 or C57BL/6×FVB; Buteau et al. 2006, Rankin & Kushner 2009). However, changes in β-cell mass with GLP1R agonists in normal mice may not be maintained with continued treatment. An abstract presented at the annual scientific meeting of the American Diabetes Association (ADA) in 2012 revealed that treating 9-week-old B6129SF1/J (hybrid B6×Sv129) mice for 4 months with exenatide (1 nmol/kg per day s.c. infusion) did not affect β-cell mass (Rankin et al. 2012). Moreover, while this study observed a modest increase in the number of proliferating β-cells in mice treated with exenatide, it was less than one-third of that observed in the mice fed a high-fat diet alone. Thus, while GLP1R agonists may enhance β-cell proliferation in young mice, in comparison with other physiological stimuli, their effect may be quite small and therefore difficult to detect.

**High fat-fed mice** Whether GLP1R agonists can enhance β-cell mass in a situation that also requires elevated insulin secretary capacity has been examined in high fat-fed (HFF) C57BL/6 mice. In this model, starting at ~8 weeks of age, high doses of either exenatide (24 nmol/kg twice daily i.p. for 2 or 4 weeks) or an exenatide–albumin conjugate (CJC-1134-PC; 100 nmol/kg once daily i.p. for 4 weeks) was not able to increase β-cell mass above that of the vehicle-treated mice (Baggio et al. 2008, Lamont et al. 2012). A longer period of exenatide
treatment (24 nmol/kg twice daily for 8 weeks) was also unable to increase β-cell mass in 16-week-old HFF mice (Lamont & Drucker 2008). A recently published study has even observed that treatment with the longer-acting GLP1R agonist liraglutide (0.1 mg/kg twice daily) for 6 weeks actually reduced β-cell mass in both HFF and normal chow-fed C57BL/6 mice (Ellenbroek et al. 2013). Likewise, a similar reduction in β-cell mass was accompanied by reduced rates of β-cell proliferation in HFF B6129SF1/J mice that were infused with exenatide (1 nmol/kg per day s.c.) for 4 months (Rankin et al. 2012). Therefore, it seems that when there is a demand for increased β-cell mass and function associated with high-fat feeding, GLP1R agonist treatment is not able to further enhance the rate of β-cell proliferation. Moreover, the effect of GLP1 on the reduction of food intake and body weight may actually reduce the demand for β-cell expansion in this model of insulin resistance, leading to reduced rather than increased β-cell mass.

**Young vs old mice**  The age of the animals is another factor that influences the ability of GLP1R agonists to modulate β-cell mass. Young rodents’ β-cells have the capacity to proliferate in response to stressors such as peripheral insulin resistance induced by diet-induced obesity or loss of β-cell mass via chemicals (streptozotocin (STZ)) or surgical methods. However, the regenerative capacity of pancreatic β-cells in mice declines significantly with increasing age (Rankin & Kushner 2009). Hence, studies carried out by several independent research groups have shown that treatment with exenatide increases β-cell proliferation in young (C57BL/6 or B6129SF1/J) mice, but has no effect on the endocrine pancreas in mice that are older than 6 months (Rankin & Kushner 2009, Tschen et al. 2009, Lamont et al. 2012). Moreover, this lack of an effect on β-cell proliferation was found to be associated with an inability of exenatide to increase β-cell mass in studies using mice older than 6 months (Tschen et al. 2009, Lamont et al. 2012). Although one study did observe an increase in β-cell mass in 22-month-old Wistar rats that were infused with GLP1 for 5 days, there was no increase in islet cell proliferation, and as the body weights of these animals were not reported, it is not possible to assess how well the vehicle control and treatment groups were matched (Perfetti et al. 2000). Nevertheless, further evidence that GLP1R agonists can only transiently affect the morphology of the pancreatic islets in younger animals comes from preclinical safety studies. When Sprague Dawley rats or CD1 mice were administered high doses of liraglutide for 2 years, GLP1R activation did not lead to islet cell hyperplasia (Nyborg et al. 2012). Therefore, the weight of preclinical evidence suggests that GLP1R may have a very limited capacity to enhance β-cell mass in older animals.

**Can GLP1R agonists affect β-cell mass in diabetic rodents?**

**Pancreatectomised rats**  While the effects of GLP1R agonists on β-cell mass in normal rodents are modest, a number of studies have examined whether these agents can affect β-cell morphology in commonly used rodent models of diabetes and obesity. One method of inducing diabetes through a loss of β-cell mass in rodents is to remove a significant amount of the pancreas through surgery. A partial pancreatectomy in young rodents results in a robust proliferative response in both the endocrine and exocrine pancreas. However, despite the apparent regenerative capacity of the pancreas in these animals, when a sufficient proportion (95%) of the pancreas is removed, the remaining β-cells cannot cope with the required excess insulin secretory capacity and hyperglycaemia ensues (Bonner-Weir et al. 1983). Therefore, a few studies have examined whether GLP1R agonists could increase β-cell mass in this situation. In one study, exenatide was administered to 4–5-week-old Sprague Dawley rats that were hyperglycaemic due to 95% pancreatectomy, and this resulted in a significantly greater β-cell mass compared with that in vehicle-treated rats (Xu et al. 1999). However, the rates of β-cell proliferation were already increased 2.5-fold as a result of the pancreatectomy and were not further enhanced by the administration of a GLP1R agonist (Xu et al. 1999). By contrast, a more recent study showing a similar effect of exenatide on β-cell mass in pancreatectomised rats did report significant increases in the number of proliferating (BrdU-positive) β-cells, as well as a reduction in apoptosis (Kwon et al. 2009). Interestingly, the effect of GLP1R agonists in this model may be dependent on the level of hyperglycaemia or severity of β-cell loss. For example, in 60% pancreatectomised rats, which were glucose intolerant but not hyperglycaemic, liraglutide administration for 4 days did not have any effect on β-cell proliferation or β-cell mass (Sturis et al. 2003). Overall, the data from these studies also suggest that the proliferative effect of GLP1R agonists is at best modest. Therefore, rather than promoting the regeneration of new β-cells, perhaps the protection of the remaining β-cells against apoptosis has a major role in the ability of GLP1R agonist treatment to result in an enhanced β-cell mass in this model.

**Other non-obese diabetic rat models**  The effects of GLP1R agonists on β-cell mass have also been studied in
β-cell insufficiency models caused by non-surgical methods. The Goto-Kakizaki (GK) rat model of diabetes was generated via selective breeding of glucose-intolerant rats originally from a non-diabetic Wistar rat colony. The GK rat develops hyperglycaemia in adulthood that is associated with a 50% reduction in β-cell mass (Movassat et al. 1995). When female GK rats were administered either GLP1 (400 µg/kg once daily s.c.) or exenatide (3 µg/kg once daily s.c.) from days 2 to 6 after birth, β-cell mass was significantly greater compared with that in non-treated GK rats at 7 days and up to 2 months of age (Tourrel et al. 2002). This improvement in β-cell mass with postnatal GLP1R agonist treatment was associated with an increased number of proliferating (BrdU-positive) β-cells 1 day after the final injection. However, it should be noted that glycaemia and β-cell mass were not completely normalised when compared with control Wistar rats (Tourrel et al. 2002). These investigators used the same protocol to treat Wistar rats that had been administered STZ at birth (Tourrel et al. 2001). In this model, the number of BrdU-positive β-cells was significantly increased 7 days after STZ administration, but was not further enhanced by either GLP1 or exenatide treatment (administered from days 2 to 6). Nevertheless, there was a partial restoration of β-cell mass at 7 days and 2 months of age in these rats following the 5-day neonatal GLP1R agonist treatment. Therefore, similar to the results obtained in the partially pancreaticectomised rats, these studies in STZ and GK rats support a role for GLP1R agonists in the protection of β-cells. However, while it was reported that TUNEL-positive apoptotic cells could be detected in pancreatic islets in these two studies, the authors chose not to quantify differences in apoptotic β-cells between treatment and control groups. Another study carried out in STZ-treated Sprague Dawley rats did find that a longer course of exenatide treatment (150 pmol/kg twice daily for 4 weeks) increased the number of (BrdU-positive) proliferating β-cells and also reduced the number of apoptotic cells within islets (Kwon et al. 2009). However, even this length of treatment only led to a partial restoration of β-cell mass, suggesting only a limited capacity of GLP1R agonists to regenerate β-cell mass.

**STZ diabetic mice** The ability of GLP1R agonists to protect β-cells against apoptosis has also been investigated in STZ-treated mice. Two studies have used an approach involving multiple low-dose STZ injections (50 mg/kg once daily i.p. for 5 days) in 8–9-week-old C57BL/6 mice, which results in a significant reduction in β-cell mass, associated with increased β-cell apoptosis and compensatory increases in β-cell proliferation, as identified by BrdU incorporation (Li et al. 2003, Maida et al. 2009). When exenatide treatment (24 nmol/kg twice daily) was initiated before the beginning of STZ administration and then continued until 1 or 2 days after the final STZ injection, the rates of β-cell apoptosis (assessed by TUNEL or cleaved caspase 3 immunoreactivity) were significantly reduced (Li et al. 2003, Maida et al. 2009). This resulted in the maintenance of a greater β-cell mass compared with that in non-treated STZ-mice (Maida et al. 2009). However, when mice were assessed 1 month later, the β-cell mass of the exenatide-treated STZ-mice was still less than half of that of the normal control mice, and this resulted in only a mild improvement in glycaemic control (Maida et al. 2009). Moreover, even when exenatide injections were continued for up to 2 months, β-cell mass and glycaemic control in this model were improved but not normalised. Hence, these studies further illustrate the limited capacity of GLP1R agonists to regenerate β-cells and suggest that the anti-apoptotic effects of these agents may be more important for protecting the remaining β-cells, leading to the preservation of a greater β-cell mass in hyperglycaemic animals.

**db/db mice** The anti-apoptotic effects of GLP1R agonists have been observed in several models of diabetes precipitated by genetically determined obesity. When exenatide injections (1 nmol/kg once daily for 2 weeks) were initiated in female db/db mice at 6 weeks of age, before the onset of overt hyperglycaemia, a greater β-cell mass was preserved, and the expected rise in blood glucose levels in this model at 8 weeks of age was prevented (Wang & Brubaker 2002). In this study, exenatide treatment was found to lead to both increased β-cell proliferation (BrdU) and reduced apoptosis (TUNEL) in islets. Exenatide or liraglutide treatment in slightly older (10–11 weeks) female db/db mice also exhibited similar positive effects on β-cell mass and proliferation (BrdU); however, blood glucose levels were not normalised (Rolin et al. 2002). Similarly, the administration of a long-acting albumin–exenatide conjugate (CJC-1131, 25 µg twice daily for 4 weeks) to 7–10-week-old male db/db mice was able to enhance β-cell proliferation, but did not completely normalise blood glucose levels (Kim et al. 2003). Therefore, to maintain good glycaemic control in db/db mice, it appears that GLP1R agonist administration needs to be started early, before there is a significant loss of β-cell mass and function. This is consistent with a predominant protective effect of GLP1R agonists on pancreatic β-cells rather than an ability to generate significant numbers of new β-cells.
**Zucker diabetic fatty rats** Studies in diabetic rats have reported results similar to those reported by studies examining the effects of GLP1R agonists in mouse models. The Zucker diabetic fatty (ZDF) rat was generated by inbreeding a hyperglycaemic substrain of the Zucker fatty rat, a model of obesity resulting from the genetic disruption of leptin signalling. Consistent with their impaired glycaemic control, ZDF rats also display a disruption of leptin signalling. Consistent with their rat, a model of obesity resulting from the genetic inbreeding a hyperglycaemic substrain of the Zucker fatty rat, a model of obesity resulting from the genetic inbreeding a hyperglycaemic substrain of the Zucker fatty rat, a model of obesity resulting from the genetic inbreeding a hyperglycaemic substrain of the Zucker fatty rat, a model of obesity resulting from the genetic inbreeding a hyperglycaemic substrain of the Zucker fatty rat, a model of obesity resulting from the genetic.

In agreement with mouse data discussed above, several studies in ZDF rats have shown that the administration of GLP1 (30 pmol/kg per min s.c. infusion for 2 days), exenatide (0.25 mg/kg per day s.c. infusion for 13 weeks) or liraglutide (150 µg/kg twice daily s.c. for 6 weeks) can result in the maintenance of a greater β-cell mass (Farilla et al. 2002, Sturis et al. 2003, Vrang et al. 2012). In two of the three studies, this was found to be associated with an increased number of proliferating (Ki67-positive) β-cells (Farilla et al. 2002, Vrang et al. 2012). Only one of these studies reported measuring β-cell apoptosis, but did find that GLP1 also had a protective effect (Farilla et al. 2002).

Interestingly, the effect of GLP1R agonists on β-cell mass in obese rodents appears to depend on the relative degree of β-cell insufficiency. At 7 weeks of age, ZDF rats have a greater β-cell mass and higher rates of β-cell proliferation compared with older non-diabetic control animals; however, between 7 and 20 weeks of age, β-cell mass declines, and at 20 weeks of age, β-cell mass and the number of proliferating β-cells are no longer elevated (Vrang et al. 2012). In untreated rats, this decline in β-cell mass is associated with a progressive loss of glycaemic control; however, treatment with either GLP1 or liraglutide is able to reduce blood glucose levels in association with its effect on the preservation of a greater β-cell mass and a higher proliferation rate (Vrang et al. 2012).

**Can GLP1R agonists affect β-cell mass in obese (normoglycaemic) rodents?**

In addition to studies in normal rodents demonstrating that GLP1R agonists do not expand β-cell mass, studies in ZDF rats that had not yet developed hyperglycaemia showed that short-term iraglutide treatment (200 µg/kg twice daily s.c. for 2 weeks) resulted in a reduced β-cell mass (Sturis et al. 2003). Similarly, when the effects of GLP1R agonist therapy were studied in Zucker fatty rats that were not on a diabetes-prone genetic background, exenatide administration (3 µg/kg twice daily s.c. for 6 weeks) was also found to be associated with reduced β-cell mass (Gedulin et al. 2005). Another model of genetic obesity that does not progress to diabetes is the ab/ob mouse (Coleman 1978), and in this mouse model, liraglutide administration (100 µg/kg twice daily s.c. for 2 weeks) did not affect β-cell mass or proliferation (Rolin et al. 2002). Thus, in several obese models, in which there are already compensatory increases in β-cell mass, GLP1R agonists probably reduce the need for β-cell proliferation via extra-pancreatic effects on body weight and gastric emptying that improve the metabolic milieu in these animals.

**Is there potential for GLP1R agonists to regenerate or preserve β-cell mass in type 2 diabetes?**

The effects of GLP1R agonists on β-cell mass in rats and mice have been discussed above and are summarised in Fig. 1. While evidence in younger rodents suggests that GLP1R agonists can increase β-cell mass and proliferation, these effects are modest and may only be transient. Moreover, with advanced age and insulin resistance, the ability of GLP1R agonists to stimulate the expansion of β-cell mass is blunted. Given that the majority of clinical trials recruit obese and insulin-resistant patients with type 2 diabetes over the age of 40 years, it is perhaps not surprising that we have not seen any indirect evidence of β-cell regeneration with exenatide (Bunck et al. 2011) or liraglutide (Garber et al. 2011). However, it is possible that such agents could still be very useful for preventing further loss of β-cell mass and/or function, particularly if treatments with these agents are initiated early in the disease progression when perhaps there are still a significant number of functioning β-cells.

**DPP4 inhibitors and β-cell mass**

**Can DPP4 inhibitors affect β-cell mass in normal rodents?**

The majority of published data indicate that DPP4 inhibitors do not affect islet morphology in normal rodents. A single study in (2-day-old) neonatal Wistar rats did record a transient increase in the number of proliferating β-cells and a decrease in apoptosis associated with an increase in β-cell mass following vildagliptin administration (60 mg/kg once daily for 3 weeks) (Duttaroy et al. 2011). Two other studies demonstrated that if vildagliptin treatment was initiated just a few weeks later (between 4 and 6 weeks of age) in this strain of rats, then no effect on β-cell mass or proliferation was detected (Maiztegui et al. 2011, Inaba et al. 2012). Similarly, treatment with other DPP4 inhibitors
Effects of incretin-based therapies on β-cell mass in mice. In young mice (<6 months), GLP1R agonists initially increase β-cell mass; however, with prolonged treatment, this effect is not sustained. In old mice (>6 months), the capacity for β-cell proliferation is significantly diminished, and GLP1R agonists generally do not alter β-cell mass. To compensate for an increased demand for insulin secretion, β-cell mass is increased in high fat-fed (HFF) mice. In HFF mice, GLP1R agonists and DPP4 inhibitors improve insulin sensitivity, and this effect is often associated with a relative reduction in β-cell mass compared with that in non-treated HFF mice. In streptozotocin (STZ)-treated diabetic mice and other models of β-cell insufficiency, early administration of either a GLP1R agonist or a DPP4 inhibitor is able to preserve a greater β-cell mass.

Figure 1

Effects of incretin-based therapies on β-cell mass in mice. In young mice (<6 months), GLP1R agonists initially increase β-cell mass; however, with prolonged treatment, this effect is not sustained. In old mice (>6 months), the capacity for β-cell proliferation is significantly diminished, and GLP1R agonists generally do not alter β-cell mass. To compensate for an increased demand for insulin secretion, β-cell mass is increased in high fat-fed (HFF) mice. In HFF mice, GLP1R agonists and DPP4 inhibitors improve insulin sensitivity, and this effect is often associated with a relative reduction in β-cell mass compared with that in non-treated HFF mice. In streptozotocin (STZ)-treated diabetic mice and other models of β-cell insufficiency, early administration of either a GLP1R agonist or a DPP4 inhibitor is able to preserve a greater β-cell mass.
(vildagliptin, des-fluoro-sitagliptin and NVP-DPP728) for 2–5 months in young chow-fed C57BL/6 mice did not increase β-cell mass (Reimer et al. 2002, Rankin et al. 2012, Shimizu et al. 2012). Only one of these studies reported a slight increase in β-cell proliferation with des-fluoro-sitagliptin treatment, but it was only a fraction of the increase observed with high-fat feeding alone (Rankin et al. 2012). As the proliferative effects of various stimuli in mice are reduced with advanced age, it is perhaps not surprising that even 11 months of vildagliptin treatment (dose in drinking water) did not affect islet morphology in either chow-fed or HFF female C57BL/6J mice when treatment was initiated in much older (10 months) mice (Omar et al. 2013).

Can DPP4 inhibitors affect β-cell mass in HFF mice?

Multiple studies in HFF mice also indicate that DPP4 inhibitors do not promote β-cell mass expansion (Fig. 1). Short-term studies in HFF C57BL/6 mice treated with either des-fluoro-sitagliptin (11 g/kg of food for 8 weeks) or vildagliptin (0.3 mg/ml of drinking water for 20 weeks) resulted in no change in β-cell mass (Lamont & Drucker 2008, Sato et al. 2012). Similar results were obtained when mice of the same strain were fed a sucrose+linoleic acid diet (Shirakawa et al. 2011a). Two studies reported that treatment with either NVP-DPP728 or des-fluoro-sitagliptin decreased β-cell mass, which was associated with reduced numbers of proliferating β-cells (Reimer et al. 2002, Rankin et al. 2012). In agreement with these observations in short-term studies, a much longer treatment regimen (1 year) with sitagliptin (3.1 g/kg of food) in HFF C57/DBA mice was also found to be associated with reduced β-cell mass at the end of the study, compared with that in non-treated HFF mice (Aston-Mourney et al. 2013). Although DPP4 inhibitors do not reduce body weight and gastric emptying, they have been reported to be associated with improvements in insulin sensitivity (Duez et al. 2009, Shirakawa et al. 2011b), which may contribute to a reduced need for β-cell mass in the face of insulin resistance caused by a high-fat diet.

Can DPP4 inhibitors affect β-cell mass in diabetic mice?

Several groups have injected a moderate dose of STZ into HFF 1CR mice in an attempt to generate a rodent model that mimics some features of type 2 diabetes. HFF–STZ mice become hyperglycaemic due to a reduction in β-cell mass in the setting of diet-induced peripheral insulin resistance (Mu et al. 2006). In this model, 20-week administration of a DPP4 inhibitor (des-fluoro-sitagliptin, sitagliptin or alogliptin) resulted in the preservation of β-cell mass at levels similar to those observed in non-diabetic control mice (Mu et al. 2006, 2009, Zhang et al. 2011). While the number of proliferating islet cells increased in an attempt to compensate for the STZ-induced destruction of β-cells, sitagliptin did not further enhance the number of Ki67-positive cells detected after 20 weeks of treatment (Mu et al. 2009). However, both proliferation and apoptosis probably need to be examined at earlier time points.

A reduction in β-cell mass leading to sustained hyperglycaemia in C57BL/6 mice can also be achieved with the administration of a low dose of STZ (50 mg/kg once daily) for 5 consecutive days. In this STZ mouse model, the administration of sitagliptin (or the des-fluoro-sitagliptin analogue) before, during and immediately after the course of STZ injections led to reduced rates of β-cell apoptosis and the preservation of a greater β-cell mass, although it was not completely normalised (Maida et al. 2009, Takeda et al. 2012). There was no significant effect on the number of proliferating β-cells, but the rate of apoptosis was reduced (Takeda et al. 2012), perhaps highlighting the relative importance of the protective effects of DPP4 inhibitors for maintaining β-cell mass. Further evidence for a predominant anti-apoptotic effect of DPP4 inhibition also arises from another model of β-cell insufficiency. In young fructose-fed Wistar rats, a reduction in β-cell mass was also prevented by sitagliptin treatment (6 g/kg of food for 3 weeks), and this was accompanied by a reduction in β-cell apoptosis, but there was no effect on proliferation (Maiztegui et al. 2011).

Can DPP4 inhibitors affect β-cell mass in obese, hyperglycaemic rodents?

The β-cell protective effects of DPP4 inhibitors have also been observed in several genetically determined models of hyperglycaemia. Whereas incretin-based therapies have only a minimal impact on β-cell morphology in animals that are able to expand their β-cell mass in response to an obesogenic diet, in obese mice that also display β-cell deficiency associated with hyperglycaemia, it appears that DPP4 inhibitors can preserve a greater β-cell mass. In both db/db mice and ZDF rats, the administration of des-fluoro-sitagliptin (6–11 g/kg of food for 5–6 weeks) reduced β-cell apoptosis, although this only led to the preservation of a greater β-cell mass in the ZDF rats (Han et al. 2011, Yeom et al. 2011). By contrast, sitagliptin treatment beginning at 6 weeks of age in the Akita mouse, a non-obese model of hyperglycaemia, had no effect on β-cell mass or on the
rates of apoptosis (Yeom et al. 2011). However, the β-cell mass in these mice was less than half of that reported for the db/db mice used in the same study, and the rates of apoptosis in Akita mouse islets at this age were also very low compared with those in the db/db mouse islets. So perhaps, β-cell apoptosis and loss of β-cell mass occur earlier in the Akita mice and therefore DPP4 inhibitor treatment probably needs to be initiated at a younger age. Vildagliptin administration starting at 4 weeks of age (15 mg/kg twice daily for 18 weeks) in GK rats, which also display hyperglycaemia and β-cell insufficiency but in the absence of obesity, results in β-cell mass being maintained at levels similar to those in the control Wistar rats (Inaba et al. 2012). There was a small increase in the number of proliferating β-cells with vildagliptin treatment; however, at the end of the study, no apoptotic cells were detected in any islets, suggesting that a protective effect on β-cells may have been exerted at an earlier time point.

Can DPP4 inhibitors affect β-cell mass in transgenic or knockout rodent models of β-cell deficiency?

Studies carried out in other transgenic and knockout mice with reduced β-cell mass have reported that β-cell mass can be maintained with the administration of DPP4 inhibitors. In rats that overexpress the islet amyloid-forming human islet amyloid polypeptide (hIAPP), sitagliptin treatment for 12 weeks (200 mg/kg per day) improved, but did not completely normalise β-cell mass (Matveyenko et al. 2009). In these relatively young transgenic rats, the rates of β-cell apoptosis are very high (≈2.5 vs <0.05% in control animals), and sitagliptin treatment reduced this significantly. Sitagliptin treatment also led to an increase in β-cell proliferation. In a mouse model that expresses hIAPP at levels roughly equal to those of the endogenous mouse protein, sitagliptin treatment for 1 year was able to maintain β-cell mass at levels that were very similar to those in the non-transgenic control mice (Aston-Mourney et al. 2013). In other genetically modified animals, such as the Irs2 knockout and Cebpb transgenic mice, vildagliptin treatment (0.3 mg/ml in drinking water) for 20 weeks in both these strains was able to increase β-cell mass to levels approaching those observed in normal mice, and this was associated with either a reduction in apoptosis or an increase in β-cell proliferation (Sato et al. 2012, Shimizu et al. 2012). In Gck-deficient mice, sitagliptin treatment for 20 weeks was able to maintain almost normal β-cell mass, which was accompanied by a reduction in the rates of β-cell apoptosis and a small increase in proliferation (Shirakawa et al. 2011a). Therefore, the protective effects of DPP4 inhibitors are seen across multiple mouse models with reduced β-cell mass.

Is there potential for DPP4 inhibitors to preserve β-cell mass in type 2 diabetes?

Overall, the preclinical studies utilising several different agents indicate that similar to GLP1R agonists, DPP4 inhibitors have protective effects on β-cells in rodent models that display reduced β-cell mass and hyperglycaemia (Fig. 1). In studies that have compared these two therapies, it appears that both DPP4 inhibitors and GLP1R agonists have equivalent effects on the reduction of β-cell apoptosis in mice exposed to STZ (Maida et al. 2009, Takeda et al. 2012). However, there is currently a lack of studies directly comparing the effects of these two therapeutic approaches on β-cell mass.

GLP1R agonists and the exocrine pancreas

Assessment of pancreatitis following incretin-based therapies

Pancreatitis occurs as a result of the release of activated pancreatic enzymes within the pancreas. The tissue damage caused by these digestive enzymes results in pancreatic inflammation as well as oedema and, in some cases, necrosis. Pancreatitis can be caused by alterations in exocrine function or a blockage of the pancreatic ducts. In addition to the presence of abdominal pain, increased serum levels of pancreatic enzymes lipase and amylase are considered during diagnosis. As incretins could potentially affect exocrine function through either direct or indirect mechanisms and there have been case reports of pancreatitis in patients treated with all incretin-based therapies, a number of preclinical studies have examined whether incretin-based therapies affect lipase and amylase levels or alter the morphology of the exocrine pancreas. As pancreatitis is strongly correlated with the development of pancreatic cancer, the presence of such changes may also have important implications for assessing the risk of cancer with incretin-based therapies.

Can GLP1R agonists affect the exocrine pancreas in normal rodents?

Histological findings in Sprague Dawley rats Two studies examined the effect of daily administration of exenatide in normal Sprague Dawley rats (Nachnani et al. 2010, Gier et al. 2012; Table 1).
Both treated ten rats each (10 μg/kg per day for 11–12
weeks), and no instances of actual pancreatitis were
observed in histological sections, and the typical five-to
tenfold increases in serum lipase levels associated with
pancreatitis were also not observed. In one study, exenatide
treatment was found to result in slightly increased scores
for inflammation and pyknotic nuclei in the exocrine
pancreas; however, these scores were at the lower end of
the reported scoring scale (mean <10 on a scale of 5–40;
Nachnani et al. 2010). In this cohort, serum amylase levels
were not affected by exenatide treatment, but lipase levels
were slightly increased (0.46 ± 0.12 vs 0.28 ± 0.07 U/l). The
other study reported that exenatide-treated rats did not
display an increase in lipase levels, but that they did exhibit
pancreatic ductal gland (PDG) hyperplasia proximal to the
main pancreatic duct (Gier et al. 2012). These PDG
structures can be seen in normal pancreatic sections; however, they have been shown to be increased in response
to injury, and it is thought that they could give rise to
pancreatic intraepithelial neoplasia (PanIN) lesions, which
can be precursors to cancer (Strobel et al. 2010). This is
the only study to show an effect of a GLP1R agonist on
PDG proliferation, so it is not known whether it is related to
this particular strain of rats. In both these Sprague Dawley
rat studies, the exenatide-treated animals exhibited ~30%
reductions in body weight. It is not clear what effect such
a substantial body weight difference may have on the
function and morphology of the exocrine pancreas. It is
also important to highlight that even under normal
conditions the Sprague Dawley rat commonly displays
histological findings in the exocrine pancreas such as focal
acinar cell hypertrophy and atrophy, as well as gland-like
structures in pancreatic duct sections (Chadwick et al.
2013). In addition, data from 2-year toxicity studies with
liraglutide in this strain of rats revealed no significant
increase in adverse pancreatic findings (Nyborg et al. 2012).
Moreover, there were also no PanIN lesions identified in
ten non-human primates that were treated with liraglutide
(5 mg/kg per day) for 87 weeks (Nyborg et al. 2012).

### Effects of GLP1R agonists on pancreas weight in C57BL/6 mice

Several studies in C57BL/6 mice have shown that the administration of a GLP1R agonist can result in an increase in absolute pancreas weight (Table 1). Exenatide treatment (10 nmol/kg twice daily for 1 week) in this mouse strain resulted in a 20% increase in pancreas weight, but this was not associated with changes in susceptibility to pancreatitis, pancreatic oedema or serum amylase levels (Koehler et al. 2009). Importantly, examination of pancreatic mRNA levels in this study revealed that the expression of proinflammatory genes (Ccl2, Icam1, Stat3, Ndrg1 and Ifitm3) was not increased. However, there was a significant induction of anti-
inflammatory genes (Reg3a and Reg3b), suggesting that
GLP1R agonists may actually have an anti-inflammatory
effect in the exocrine pancreas. Similarly, liraglutide admi-
nistration to 8–9-week-old male C57BL/6 mice for a longer
period of time (0.1 mg/kg twice daily s.c. for 6 weeks)

### Table 1

<table>
<thead>
<tr>
<th>Species</th>
<th>Strain</th>
<th>n</th>
<th>Diet</th>
<th>Treatment</th>
<th>Body weight</th>
<th>Pancreas weight</th>
<th>Lipase</th>
<th>Amylase</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rat</td>
<td>SD</td>
<td>10</td>
<td>Normal chow</td>
<td>Ex, 10 μg/kg QD for 11 weeks</td>
<td>↓↓↓</td>
<td>–</td>
<td>↑</td>
<td>↔</td>
<td>Nachnani et al. (2010)</td>
</tr>
<tr>
<td>Rat</td>
<td>SD</td>
<td>10</td>
<td>Normal chow</td>
<td>Ex, 10 μg/kg QD for 12 weeks</td>
<td>↓↓↓</td>
<td>↔</td>
<td>↔</td>
<td>–</td>
<td>Gier et al. (2012)</td>
</tr>
<tr>
<td>Mouse</td>
<td>C57BL/6J</td>
<td>5</td>
<td>Normal chow</td>
<td>Ex, 1 nmol/kg BID for 1 week</td>
<td>–</td>
<td>↑</td>
<td>–</td>
<td>↔</td>
<td>Koehler et al. (2009)</td>
</tr>
<tr>
<td>Mouse</td>
<td>C57BL/6J</td>
<td>3</td>
<td>Normal chow</td>
<td>Lira, 75 μg/kg BID for 1 week</td>
<td>–</td>
<td>↑</td>
<td>–</td>
<td>–</td>
<td>Koehler et al. (2009)</td>
</tr>
<tr>
<td>Mouse</td>
<td>C57BL/6J</td>
<td>13–14</td>
<td>Normal chow</td>
<td>Lira, 100 μg/kg BID for 6 weeks</td>
<td>↓</td>
<td>↑</td>
<td>–</td>
<td>–</td>
<td>Ellenbroek et al. (2013)</td>
</tr>
<tr>
<td>Mouse</td>
<td>C57BL/6J</td>
<td>7</td>
<td>High fat</td>
<td>Ex, 24 nmol/kg BID for 4 weeks</td>
<td>↓</td>
<td>↑</td>
<td>–</td>
<td>↔</td>
<td>Koehler et al. (2009)</td>
</tr>
<tr>
<td>Mouse</td>
<td>C57BL/6J</td>
<td>4–8</td>
<td>High fat</td>
<td>Ex, 24 nmol/kg BID for 4 weeks</td>
<td>↓</td>
<td>↑</td>
<td>–</td>
<td>–</td>
<td>Baggio et al. (2008)</td>
</tr>
<tr>
<td>Mouse</td>
<td>C57BL/6J</td>
<td>13–14</td>
<td>High fat</td>
<td>Lira, 100 μg/kg BID for 6 weeks</td>
<td>↓</td>
<td>↑</td>
<td>–</td>
<td>–</td>
<td>Ellenbroek et al. (2013)</td>
</tr>
</tbody>
</table>

SD, Sprague Dawley; Ex, exenatide; Lira, liraglutide; ↓↓↓, large reduction (30%); ↓↓, reduction (10%); ↑, increase; ↔, no difference; and –, not reported.
also resulted in a 10% increase in pancreas weight, but this was not associated with any increase in the expression of proinflammatory markers (IL1β, IL6 or CCL2) in the plasma (Ellenbroek et al. 2013). Several studies have also observed increases in pancreas weight following either exenatide or liraglutide treatment for 4–8 weeks in C57BL/6 mice that were fed a high-fat diet (Baggio et al. 2008, Lamont & Drucker 2008, Ellenbroek et al. 2013).

In chow-fed mice, the increase in pancreas weight with liraglutide treatment was found to be associated with a small increase in the proliferation of acinar cells (Ellenbroek et al. 2013). However, as there was no significant difference in the number of BrdU-positive acinar cells with liraglutide treatment in HFF animals, the mechanisms for increased pancreas weight following GLP1R agonist administration in the C57BL/6 mouse strain remain incompletely understood.

**Effects of GLP1R agonists on pancreas weight in rats**

In a study involving 22-month-old Wistar rats, a 20% increase in pancreas weight was observed after a 5-day GLP1 infusion (1.5 pmol/kg per min), and this was associated with increased markers of proliferation in the exocrine pancreas (Perfetti et al. 2000). However, increases in the number of proliferating cell nuclear antigen (PCNA)-positive ductal and exocrine cells were only observed after 2 days of GLP1 infusion, and these changes were no longer evident at 5 days. While another study in 10-week-old Sprague Dawley rats has also detected an increase in ductal cell proliferation following 12 weeks of exenatide administration, this was not actually associated with an increase in absolute pancreas weight (Gier et al. 2012). Moreover, other rodent models that have been used to assess the effect of GLP1R agonists on the pancreas have not observed an expansion in exocrine tissue (Vrang et al. 2012, Tatarkiewicz et al. 2013).

**Results of preclinical safety studies with GLP1R agonists**

It is important to note that as part of the drug development process, substantial toxicological and carcinogenicity studies are required. As such, several studies in normal animals have been conducted to assess the safety of various GLP1R agonists including exenatide and liraglutide (Nyborg et al. 2012, Parkes et al. 2013). In these studies in which mice, rats and rabbits have been treated for up to 2 years with high doses of GLP1R agonists, there have not been any reported effects of drug treatment on the development of pancreatitis or pancreatic tumour formation. However, as these experiments were mainly carried out as part of the regulatory approval process, much of the data are not publicly available. If more of these studies were to be published in the scientific literature, it would probably improve our understanding of whether there are any potential risks of such therapies.

**Can GLP1R agonists affect the exocrine pancreas in obese and/or hyperglycaemic rodents?**

Although preclinical safety studies are usually carried out in normal animals, GLP1R agonists are used in patients with diabetes who may be insulin resistant and are often overweight/obese, so it seems pertinent to review the effects of such agents in animals that display similar metabolic characteristics (summarised in Table 2). When ZDF rats are administered a GLP1R agonist (either exenatide or liraglutide), glycaemic control is significantly improved (Farilla et al. 2002, Vrang et al. 2012, Tatarkiewicz et al. 2013). However, even though food intake is also reduced by these drugs, treated ZDF rats actually tend to exhibit increased body weight compared with animals in the vehicle control group (Farilla et al. 2002, Vrang et al. 2012, Tatarkiewicz et al. 2013). This may be due to the improved diabetic state following GLP1R activation. It has been observed that ZDF rats display higher rates of ductal proliferation compared with lean control animals (Vrang et al. 2012). However, the rates of proliferation in this model (<0.1%) are still quite low and do not appear to be affected by either exenatide or liraglutide administration (Vrang et al. 2012, Tatarkiewicz et al. 2013). In these animals, the proliferation of acinar cells was shown to decrease in the ZDF rats as their glycaemic control worsens with increasing age. Exenatide treatment of ZDF rats tends to maintain the initial higher rates of acinar cell proliferation (Farilla et al. 2002, Vrang et al. 2012), perhaps as a result of the effects of improving the diabetic state. Nevertheless, despite these findings that may be suggestive of a proliferative effect in the exocrine pancreas, administration of GLP1R agonists to this diabetic rat strain did not result in increased pancreas weight (Farilla et al. 2002, Vrang et al. 2012), which is consistent with the findings of studies in normal Sprague Dawley rats.

The effects of GLP1R agonists have also been assessed in the ob/ob mouse. In this obese and mildly hyperglycaemic (but non-diabetic) model, exenatide is able to lower blood glucose levels (−0.8% HbA1c) and also reduce body weight by about 10% (Tatarkiewicz et al. 2010). Interestingly, even though the genetic background of ob/ob mice is very close to that of the C57BL/6 mice discussed above, exenatide administration in these mice for 4 weeks did not result in any changes in pancreas weight (Tatarkiewicz et al. 2010).
In this case, histological findings were not reported; however, there were no changes in serum lipase or amylase levels associated with exenatide treatment.

Several studies have also examined the effects of GLP1R agonists in mice that have been rendered diabetic by STZ administration. Although these agents have beneficial effects on the levels of glycaemia (Li et al. 2003, Kwon et al. 2009, Maida et al. 2009, Tatarkiewicz et al. 2010), only one study reported data on pancreas weight and enzyme levels. In this particular study, exenatide treatment was not found to be associated with any differences in pancreas weight or levels of pancreatic enzymes lipase and amylase (Tatarkiewicz et al. 2010).

Can GLP1R agonists affect the severity of pancreatitis in rodents?

Experimental pancreatitis Animal models have also been used to determine whether GLP1R agonists alter the severity of experimentally induced pancreatitis (Table 3). The injection of caerulein (CRN; a cholecystokinin mimetic) in rodents produces a mild form of secretagogue-induced pancreatitis that results in transient increases in plasma amylase and lipase levels as well as increased pancreas weight and inflammation (Lerch & Gorelick 2013). In addition, a more severe form of pancreatitis can be induced by the infusion of sodium taurocholate (ST; a bile salt) into the biliopancreatic duct (Aho et al. 1980). In C57BL/6J male mice, exenatide treatment that was started 1 week before the multiple CRN injections (5×3 μg/kg) appeared to have a somewhat protective effect, resulting in reduced levels of plasma amylase levels (Koehler et al. 2009). However, when CRN was administered at a higher dose (5×6 μg/kg), exenatide administration started either 1 week before or immediately after the induction of pancreatitis did not have an effect on pancreatic enzyme levels (Koehler et al. 2009). Therefore, even though exenatide treatment does have an effect on pancreas weight in the C57BL/6 strain, in this setting of experimental pancreatitis, it is not due to increased oedema and does not appear to affect the severity of pancreatitis (Koehler et al. 2009). In Sprague Dawley rats, GLP1R agonists may also have a mild protective effect, as it was found that the administration of exenatide before a single dose of CRN also reduced the resulting levels of serum lipase and amylase (Tatarkiewicz et al. 2009). However, in Wistar rats in which a more severe form of pancreatitis was induced by ST, exenatide treatment for 48 h was unable to affect the circulating levels of these pancreatic enzymes (Tatarkiewicz et al. 2010). Therefore, while there were no histology data available for the direct assessment of pancreatitis, together the lipase and amylase levels reported in these experiments suggest that the administration of a GLP1R agonist does not worsen the severity of experimental pancreatitis and could even have some beneficial effects when the disease is mild.

Pancreatitis in obese and/or diabetic rodents Patients with type 2 diabetes have been shown to have an increased risk of developing pancreatitis (Noel et al. 2009, Girman et al. 2010). Therefore, the effects...
Incretins and pancreatic morphology

**Table 3**  
Studies in rodent models of pancreatitis reporting pancreas weight and lipase or amylase levels following GLP1R agonist treatment

<table>
<thead>
<tr>
<th>Species</th>
<th>Strain</th>
<th>n</th>
<th>Model</th>
<th>Treatment</th>
<th>Body weight</th>
<th>Pancreas weight</th>
<th>Lipase</th>
<th>Amylase</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mouse</td>
<td>C57BL/6J</td>
<td>4</td>
<td>CRN (3 µg/kg, five times hourly)</td>
<td>Ex, 10 nmol/kg BID for 1 week before CRN injection</td>
<td>–</td>
<td>↑</td>
<td>–</td>
<td>↓</td>
<td>Koehler et al. (2009)</td>
</tr>
<tr>
<td>Rat</td>
<td>SD</td>
<td>6–7</td>
<td>CRN (10 µg/kg, single injection)</td>
<td>Ex, 0.72 nmol/kg single injection 15 min before CRN injection</td>
<td>–</td>
<td>↔</td>
<td>↓</td>
<td>↓</td>
<td>Tatarkiewicz et al. (2010)</td>
</tr>
<tr>
<td>Rat</td>
<td>Wistar</td>
<td>6–7</td>
<td>ST (ductal infusion)</td>
<td>Ex, 0.72 nmol/kg BID for 48 h</td>
<td>–</td>
<td>↔</td>
<td>↔</td>
<td>↔</td>
<td>Tatarkiewicz et al. (2010)</td>
</tr>
<tr>
<td>Rat</td>
<td>ZDF</td>
<td>6–7</td>
<td>CRN (10 µg/kg, single injection)</td>
<td>Ex, 0.72 nmol/kg single injection 15 min before CRN injection</td>
<td>–</td>
<td>↔</td>
<td>↔</td>
<td>↔</td>
<td>Tatarkiewicz et al. (2010)</td>
</tr>
<tr>
<td>Mouse</td>
<td>C57BL/6j</td>
<td>8–10</td>
<td>CRN (10 µg/kg five times hourly i.p. injections)</td>
<td>Ex, 7.2 nmol/kg per day for 4 weeks</td>
<td>↓</td>
<td>↔</td>
<td>↓</td>
<td>↓</td>
<td>Tatarkiewicz et al. (2010)</td>
</tr>
<tr>
<td>Mouse</td>
<td>C57BL/6, Pdx1–Kras</td>
<td>5–7</td>
<td>Activating Kras mutation</td>
<td>Ex, 5 nmol/kg QD for 12 weeks</td>
<td>↔</td>
<td>↑</td>
<td>↑</td>
<td>–</td>
<td>Gier et al. (2012)</td>
</tr>
</tbody>
</table>

SD, Sprague Dawley; CRN, caerulein; ST, sodium taurocholate; Ex, exenatide; Lira, liraglutide; ↓, reduction; ↑, increase; ↔, no difference; and –, not reported.

of GLP1R agonists on experimental pancreatitis have also been investigated in rodent models of diabetes and obesity. Similar to studies in normal rats, CRN has been used to induce pancreatitis in the ZDF model. In this diabetic rat model, the prior injection of exenatide did not have any significant effects on lipase or amylase levels (Tatarkiewicz et al. 2010). Ob/ob mice appear to be more susceptible to pancreatitis, and it has been shown that the administration of CRN to these mice results in greater increases in amylase and lipase levels (Tatarkiewicz et al. 2010). Associated with this increased susceptibility to experimentally induced pancreatitis is a lower level of Reg3b gene expression in the pancreas. When exenatide was infused for 4 weeks before the induction of pancreatitis in this model, the increases in lipase and amylase levels in ob/ob mice were significantly reduced and were similar to those observed in CRN-treated control (C57BL/6) mice (Tatarkiewicz et al. 2010). Interestingly, exenatide pretreatment also enhanced the levels of pancreatic Reg3b mRNA, so that the ob/ob mice in this study exhibited increases in the expression of this anti-inflammatory gene similar to those observed in lean C57BL/6 mice. However, as GLP1R agonists potentially have several beneficial effects in this obese model, it is difficult to ascertain whether the improvements in measures of pancreatitis severity are due to the reduction in body weight and improved glucose homeostasis or whether they could be due to a direct protective effect on the exocrine pancreas.

**Pdx1–Kras transgenic mice** 
An additional model of pancreatitis can be induced in rodents with an activating mutation of the *Kras* gene: *Pdx1–Kras* mice (Gier et al. 2012). This gene mutation is activated by another transgene (*Cre*) that is expressed in pancreatic cells under the control of the promoter sequence of the *Pdx1* gene. These mutant mice do not display hyperglycaemia or obesity, and exenatide administered for 12 weeks at a dose of 5 nmol/kg per day did not have any effect on body weight, food intake or blood glucose levels in this model. However, these mice are on the C57BL/6 genetic background, and this treatment regimen did result in an increase in pancreas weight. In addition, markers of acinar-to-ductal metaplasia and ductal cell proliferation were reportedly increased, although there were no reports of cancerous lesions in the pancreata of these mice. In addition, slightly higher histopathology scores for pancreatitis were observed in exenatide-treated *Pdx1–Kras* mice than in the vehicle-treated *Pdx1–Kras* mice. Moreover, in contrast to the beneficial effects on enzyme levels in other models of pancreatitis, exenatide administration was found to be associated with increased plasma lipase levels. However, the effects of using a GLP1R agonist in these mice should be interpreted with some caution. The activation of
GLP1R signalling in rodent β-cells has clearly been shown to induce increased transcription of the Pdx1 gene (Wang et al. 1999, Stoffers et al. 2000), and as a Pdx1-driven Cre transgene was used to mediate the induction of the Kras mutation in these mice, there could be unintended effects of GLP1R agonists through this mechanism.

Can GLP1R agonists cause or worsen pancreatitis in preclinical models?

In summary, the majority of studies in laboratory animals demonstrate that GLPR agonists do not cause pancreatitis or worsen pancreatitis induced by other stimuli. In fact, there are some data suggesting that when pancreatitis is mild, exenatide may even have a beneficial effect, at least in terms of the relative levels of serum lipase and amylase. Although some conflicting results were obtained in a transgenic model of pancreatitis, overall GLP1R agonists appear to have little or no impact on lipase or amylase levels when the induction of pancreatitis is more severe.

DPP4 inhibitors and the exocrine pancreas

IAPP transgenic rats

There are only a small number of published studies examining the effects of DPP4 inhibition on the exocrine pancreas, with disparate findings even in similar transgenic animal models expressing the hIAPP gene. Transgenic rats and mice expressing a hIAPP transgene under the control of the rat insulin promoter have been generated by two independent research groups to model changes that can occur in islets in type 2 diabetes. Unlike the normal rodent peptide, hIAPP forms amyloid in the pancreatic islets of transgenic animals, and this results in associated defects in islet β-cell function and survival (Hull et al. 2003, Butler et al. 2004). The HIP rat model overexpresses the hIAPP transgene at high levels in islet β-cells (Huang et al. 2007, Costes et al. 2011) and displays hyperglycaemia along with a significant loss of β-cell mass between 5 and 10 months of age (Matveyenko & Butler 2006). At 5 months of age, pancreatic sections from HIP rats were also found to display a threefold higher rate of Ki67 immunopositivity in pancreatic ductal cells compared with control Sprague Dawley rats (Matveyenko et al. 2009). When sitagliptin was administered to these animals in the food for 12 weeks, improved glycaemia and reduced body weight were observed; however, it also resulted in a further increase in ductal cell proliferation, as assessed by the number of Ki67-immunopositive cells (Matveyenko et al. 2009). It was also reported that one of eight rats treated with sitagliptin developed severe pancreatitis. However, a recent study has demonstrated that even under normal conditions, these transgenic rats can spontaneously exhibit multiple abnormalities in the exocrine pancreas, and so it is difficult to clearly ascertain the effects of DPP4 inhibition in studies using such small numbers of animals (Chadwick et al. 2013).

IAPP transgenic mice

To further investigate the impact of long-term DPP4 inhibition on pancreatic morphology, another study treated hIAPP transgenic mice with sitagliptin for a period of 1 year (Aston-Mourne et al. 2013). This model expresses the hIAPP transgene in β-cells at levels similar to those of the endogenous mouse iapp gene, and so it has been described as a more physiologically relevant model of islet amyloid deposition (Hull et al. 2009). In this model, the formation of islet amyloid is increased by dietary fat and is associated with the development of hyperglycaemia (Verchere et al. 1996, Hull et al. 2003). While sitagliptin treatment improved glycaemic control, there was no effect of the drug on food intake or body weight (Aston-Mourne et al. 2013). There was also no effect of sitagliptin on pancreas weight. In the hIAPP transgenic mice, the number of proliferating (Ki67-positive) ductal cells was found to be quite low (<3%) and was not different from that in the control mice or affected by sitagliptin treatment. As such, there was no pancreatitis or abnormal duct morphology associated with chronic DPP4 inhibitor treatment in either the hIAPP transgenic or the control (non-transgenic, C57/DBA2 mixed background) mice. While periductal fibrosis, inflammatory infiltration and a few instances of focal necrosis were detected, there were no differences between the experimental groups, suggesting that these findings in the exocrine pancreas may be related to either the age of the animals or the high-fat diet used in this study.

Results of preclinical safety studies with DPP4 inhibitors

There have also been extensive preclinical toxicological and carcinogenicity safety studies carried out as a requirement for regulatory approval for the various DPP4 inhibitors that are currently available to treat type 2 diabetes patients. As a requirement for regulatory approval, these types of studies use relatively large numbers of mice and rats (50–60 animals per treatment group) and so they are quite powerful for detecting adverse effects. Most of these studies have not been published in the scientific literature, so specific details...
are not readily available. However, it is important to note that there has been no increased risk of pancreatic cancer reported during the approval process for any of the currently available DPP4 inhibitors (Nauck 2013). Recently, the pancreatic histology data from the 104-week mouse and rat carcinogenicity studies for vildagliptin have been published and revealed that there is no pancreatitis or other significant histological findings in the exocrine pancreas (Busch et al. 2013). Therefore, even though pancreatitis was reported in one sitagliptin-treated transgenic HIP rat, overall the data from the majority of preclinical studies do not support the notion that DPP4 inhibition is associated with the induction of exocrine pancreatic abnormalities.

Conclusions

The current absence of available techniques to assess pancreatic morphology in clinical trial subjects means that the putative proliferative effects of incretin-based therapies are controversial. Therefore, we reviewed the published preclinical studies and found that GLP1R agonists or DPP4 inhibitors appear to have only modest and transient effects on β-cell proliferation. There is also little evidence from animal studies to suggest that incretin-based therapies contribute to the development of pancreatitis and other abnormalities in the exocrine pancreas.

β-cell mass

In contrast to some initial findings, a majority of studies now indicate that GLP1R agonists and DPP4 inhibitors have either very little or no effect on β-cell mass in normal rodents. Moreover, the effects of these incretin-based therapies on the improvement of insulin sensitivity may even lead to reduced β-cell mass in rodent models of obesity that are normally associated with β-cell expansion. The predominant action of GLP1R agonists and DPP4 inhibitors potentially affecting pancreatic morphology appears to be the preservation of β-cell mass in models of diabetes. In mice or rats that display a reduction in β-cell mass associated with hyperglycaemia, incretin-based therapies have been shown on multiple occasions to reduce β-cell apoptosis and in some cases to also preserve the normal proliferative response of β-cells to high glucose levels or other stresses. Overall, these findings suggest that for incretin-based therapies to have a beneficial effect on β-cell mass, they probably need to be used early in the progression of diabetes, when there are likely to be more functional β-cells remaining. However, the overall lack of evidence for strong in vivo proliferative actions of GLP1R agonists and DPP4 inhibitors may not only reduce the hope that therapies with these agents may be able to regenerate islet β-cells, but also dampen the fear that they could contribute to the development of pancreatitis or cancer.

Pancreatitis

Animal studies conducted in several species largely indicate that GLP1R agonists and DPP4 inhibitors do not contribute to the development of pancreatitis. Several studies have also shown that they do not worsen experimentally induced pancreatitis in rodents. While GLP1R agonists have been found to increase pancreas weight in one strain (C57BL/6) of mice, this does not appear to be associated with any clear pathology. Pancreatitis was reported in one of eight hIAPP-overexpressing transgenic rats that had been treated with sitagliptin, findings not yet reproduced by others. Even if such findings do not represent a generalisable effect of incretin-based therapies, they will probably continue to be raised in the debate on the safety of these agents. In any case, it would be unwise to either ignore or put too much emphasis on effects that are only observed in a particular strain or model. However, investigators do need to ensure that such findings are real, by using reliable experimental techniques for analysing changes in pancreatic morphology and by studying sufficient numbers of animals. We must also understand the limitations of any particular animal model that might be used and whether it is relevant to normal or diseased biology. Most importantly, the underlying genetic or phenotypic causes of atypical effects of potential or current therapeutic agents need to be properly investigated. Indeed, if we can precisely understand why some strains of mice, but not others, display adverse effects in response to drug exposure, this may help us understand which subgroups of patients are best positioned to benefit from a particular therapy and in which groups it may pose an unacceptable risk.

Declaration of interest

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