Opioid receptors are not involved in the increase of the nociceptive threshold induced by aerobic exercise

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ABSTRACT

Objective: To investigate the involvement of opioid receptors in antinociception induced by different aerobic exercise protocols in rats.

Methods: This experimental study, conducted in the Federal University of Minas Gerais, Belo Horizonte, Brazil from November 2011 to May 2012, included 60 female Wistar rats, divided into 10 groups of 6 animals per group. The rats were subjected to different aerobic exercise protocols: acute, cardiac stress, eccentric, and training. The nociceptive threshold was measured by the paw-withdrawal test. To investigate the involvement of the endogenous opioids system, the non-selective opioid receptor antagonist naloxone (5 mg/kg) was administered subcutaneously before the beginning of the exercise.

Results: All exercise protocols increased the nociceptive threshold for 15 minutes. The naloxone pre-treatment did not alter the antinociception induced by aerobic exercise protocols.

Conclusion: The endogenous opioids system did not participate in the antinociceptive effect produced by the aerobic exercise protocols.

Physical exercise has been demonstrated as an important non-pharmacological therapy for patients with chronic and acute pain. Exercise is effective treatment for different pain disorders, such as chronic low back pain, osteoarthritis, and fibromyalgia. Several registers concerning nociceptive threshold elevation following physical activity have been demonstrated in recent decades, and the main substance responsible for this effect has been the endogenous opioids. These peptides produce a variety of physiological and pharmacological effects, such as antinociception, after binding to opioids receptors. Opioid receptors are distributed widely throughout the central and peripheral nervous systems. Three opioid receptor subtypes (mu,
delta, and kappa) have been cloned and each shows structural features characteristic of G-protein coupled receptors. Additionally, previous studies have shown a role for endogenous opioids in controlling pain in that stimulation of specific brain sites produces a decrease in pain perception, an effect that is blocked by naloxone (an opioid receptor antagonist).3

The relation between exercise-induced analgesia and the endogenous opioids was found in different models of aerobic exercise, such as the bicycle ergometer and treadmill in humans, and swimming in both humans and rodents.2 Recently, our group demonstrated that naloxone blocked the antinociceptive effect induced by resistance exercise in rats, suggesting the involvement of the endogenous opioids in this effect.4 However, there is a lack of research comparing, in parallel, different aerobic exercise protocols with the opioid system. Therefore, the present study investigated the involvement of opioid receptors in exercise-induced antinociception by different aerobic exercise protocols.

Methods. This is experimental study was conducted in the Federal University of Minas Gerais, Belo Horizonte, Brazil from November 2011 to May 2012. The study was conducted in concordance with the International Association for the Study of Pain guidelines on use of laboratory animals, and the Ethics Committee on Animal Experimentation (CETEA) of the Federal University of Minas Gerais approved all the experiments and protocols.

Animals. All experiments were performed on 60, 230-250 g female Wistar rats (from CEBIO-UFMG, MG, Brazil). The rats were housed in a temperature-controlled room (23±1°C) on an automatic 12h light/dark cycle (06:00-18:00 h). All tests were conducted during the light phase (08:00-16:00 h). Food and water were freely available until the onset of the experiments.

Drugs. Naloxone (Nx) (Sigma, MO, USA; 5 mg/kg) was dissolved in saline. Rats in the control group were injected with saline. Naloxone and saline were injected subcutaneously (1 ml/kg) into the dorsal nuchal area, 10 minutes before the onset of exercise. The control groups received the same volume of physiological saline solution in the same area as the experimental groups.

Exercise. The exercise was performed in a rodent treadmill following the exercise protocols previously described.5 The animals were randomly divided into the following groups: control (Co, N = 6): rats that did not run; acute exercise (Ac, N = 6): rats that ran until fatigue at 20 m/min and 0% grade; cardiac stress (Cs, N = 6): animals that ran to exercise protocol that started at 10 m/
The rats ran approximately 39.25 (±4.3) minutes in the Ac protocol, 15.75 (±3.2) minutes in the Cs protocol, 90 minutes in the Ec protocol, and 45 minutes in the Tr protocol. Naloxone was tested alone and did not alter the nociceptive threshold of exercised and non-exercise rats, or change the performance of the rats on the treadmill.

**Discussion.** The results of the present study demonstrated that the different exercise protocols increased the nociceptive threshold in the paw-withdrawal test. Although each protocol evaluated produced antinociception through different mechanisms, the duration and intensity of the effect were similar in all.

The eccentric exercise protocol (Ec) is similar to downhill running, where the contracting quadriceps muscle controls the rate of knee flexion against the force of gravity, and in this process the muscle undergoes an eccentric contraction with each step. Eccentric contractions involve forced lengthening of active muscle, causing release of muscle enzymes to plasma, ultrastructural muscle damage, and performance deterioration. In addition, muscle injury produced by eccentric exercise also results in an increased muscle concentration of bradykinin, serotonin, potassium, and histamine that might activate or sensitize nociceptive afferent fibers. Thus, the Ec protocol might cause an increase in peripheral sensory nerve terminal activation and axonal transport that activates the inhibitory pain descendent control, thereby producing antinociception. Even in Ec protocols producing an increase in nociceptive threshold and a possible tissue injury, naloxone did not reverse the antinociceptive effect, suggesting that opioid receptors are not involved. Although, other authors reported an increase in opioid receptors in the inflamed tissue, such as the muscle and skin of rats. However, other receptors described as being involved in antinociception, such as cannabinoid receptors, have also been found in inflamed muscle and can participate in this effect.

In the present study, we showed that exercise until fatigue (Ac) also produced antinociception. This effect may be found in athletes after prolonged exercise, such as a marathon running, cycling, and swimming. An early study described a case of a woman, who continued to run with one complete fracture of the tibia, without experiencing pain. Another study also found similar results after acute running or cycling until fatigue, in which the participants were submitted to mechanical or electrical nociceptive stimulus applied to the finger or dental pulp. Unlike our results, most of these studies found that naloxone reversed analgesia after acute aerobic exercise. Furthermore, other substances
may be involved in the antinociceptive effect produced by the Ac protocol, such as the nitric oxide/cGMP/KATP pathway. The involvement of this pathway was demonstrated in a recent study conducted by our group.11

In our experiments, the Cs protocol also produced antinociception. Similar to running up hill, the Cs protocol challenges the muscles, heart, and lungs, burns more calories and provides additional toning, and is clinically similar to a stress test used in humans, which can evaluate cardiac problems, such as coronary artery disease. Thus, the Cs protocol may induce a greater overload on the heart with an acute consequent increase of blood pressure.12 Corroborating this, many studies have demonstrated that arterial hypertension can reduce pain sensibility, and some suggested mechanisms underlying this effect have included the increased activation of baroreceptors, and consequently a coordinated response between the descendental control of pain and the cardiovascular regulatory center.13 Although studies have shown the involvement of endogenous opioids in the hypoalgesia induced by hypertension and exercise,13 in our study the participation of this system was not observed. However, other mechanisms have also been described as involved in this effect (hypertension induced analgesia), such as the renin-angiotensin system, which may be involved in the antinociception induced by the Cs protocol.14

Similar to results obtained in the acute exercise protocols (Ec, Ac, and Cs), the training protocol (Tr) also increased the nociceptive threshold. Previous studies have demonstrated that regular athletes presented with similar thresholds to non-athletes after exercise.15 These authors suggest that during competition there is a greater incidence of injuries, mainly in the muscle and joints, that may activate the descendent pain modulatory pathway as a protective mechanism for the athletes and to prevent the exercise from stopping. The analgesia induced by exercise during training may be due to a form of short-term adaptation to pain, that can also occur as a result of systematic exposure to periods of intense, but limited pain. The characteristics of this adaptation indicate a possible role of the hypothalamic-pituitary-adrenocortical axis.2 Additionally, a study demonstrated that both naloxone pre-treatment and bilateral adrenalectomy attenuated the antinociception produced by swimming in mice, suggesting the participation of the adrenal glands in this effect.16 However, the naloxone pre-injection did not alter the antinociception induced by the Tr protocol. This result is consistent with other studies that used different doses of naloxone (1, 5, 10, 20 mg/kg), in both rodents and in trained humans, and also did not find reversion of the antinociceptive effect. Although, our group demonstrated that the antinociception induced by acute resistance exercise in rats was reversed by naloxone.9 However, the resistance exercise used in our previous study had a lower duration and intensity, which can activate endogenous opioid that has not been seen in the Tr protocol. In addition, previous work suggests that the differences in exercise protocols can explain opposite results.16

One factor that could interfere with the effect of naloxone would be the dose used. The dose of naloxone used in the present study was the same as that which reversed the antinociception induced by morphine and Danae racemosa in different nociception models in rats.17 These results support the hypothesis that other endogenous systems may be involved in exercise-induced analgesia. In addition, studies demonstrated that some endogenous substances, such as serotonin, N-Methyl-D-aspartic acid (NMDA), adrenergic system, the nitric oxide/cGMP/KATP pathway and the endocannabinoid system also are involved with antinociception induced by aerobic exercise.2,6,11,18

The majority of studies that evaluated the involvement of opioids in exercise-induced analgesia were performed in males. Furthermore, this analgesic effect may be different between genders. One study demonstrated that males display greater analgesic effects after morphine systemic administration than in female humans. This difference may be due to greater immunoreactive density of the endogenous opioid peptides and their proteolytic enzymes, and greater opioid receptor sensitivity in males.19 Another factor may be the influence of gonadal steroid hormones. For example, gonadectomy in adult female rats has been shown to increase opioid antinociception.19 Furthermore, a study found that females reported a decrease in pain after isometric contractions, when compared with males.20 Thus, exercise-induced antinociception found in females and not in males may be due to activation of other analgesic pathways.

Based on the evidence provided by the present study, we can conclude that all exercise protocols were effective in producing antinociception, and this effect occurs without the participation of opioid receptors. Future studies are needed to investigate other mechanisms involved.

References


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