Chronic betahistine co-treatment reverses olanzapine's effects on dopamine D2 but not 5-HT2A/2C bindings in rat brains

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Abstract
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Keywords
Betahistine, Dopamine receptor, Olanzapine, Receptor binding, Serotonin receptor

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Running title: Chronic betahistine and olanzapine co-treatment affects serotonin and dopamine receptor binding

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Abstract

Olanzapine is widely prescribed for treating schizophrenia and other mental disorders although it leads to severe body weight gain/obesity. Chronic co-treatment with betahistine has been found to significantly decrease olanzapine-induced weight gain; however it is not clear whether this co-treatment affects the therapeutic effects of olanzapine. This study investigated the effects of chronic treatment of olanzapine and/or betahistine on the binding density of the serotonergic 5-HT\textsubscript{2A} (5-HT\textsubscript{2A}R) and 5-HT\textsubscript{2C} (5-HT\textsubscript{2C}R) receptors, 5-HT transporter (5-HTT), and dopaminergic D\textsubscript{2} receptors (D\textsubscript{2}R) in the brain regions involved in antipsychotic efficacy, including the prefrontal cortex (PFC), cingulate cortex (Cg), nucleus accumbens (NAc), and caudate putamen (CPu). Rats were treated with olanzapine (1 mg/kg, t.i.d.) or vehicle for 3.5 weeks, and then olanzapine treatment was withdrawn for 19 days. From week 6, the two groups were divided into 4 groups (n=6) for 5 weeks’ treatment: (1) olanzapine-only (1 mg/kg, t.i.d.), (2) betahistine-only (9.6 mg/kg, t.i.d.), (3) olanzapine and betahistine co-treatment (O+B), and (4) vehicle. Compared to the control, the olanzapine-only treatment significantly decreased the bindings of 5-HT\textsubscript{2A}R, 5-HT\textsubscript{2C}R, and 5-HTT in the PFC, Cg and NAc. Similar changes were observed in the rats receiving the O+B co-treatment. The olanzapine-only treatment significantly increased the D\textsubscript{2}R binding in the Cg, NAc, and CPu, while the betahistine-only treatment reduced D\textsubscript{2}R binding. The co-treatment of betahistine reversed the D\textsubscript{2}R bindings in the NAc and CPu that were increased by olanzapine. Therefore, the chronic O+B co-treatment has similar effects on serotonin transmission as the olanzapine-only treatment, but reverses the D\textsubscript{2}R that is up-regulated by chronic olanzapine treatment. The co-treatment maintains the therapeutic effects of olanzapine but decreases / prevents the excess weight gain.

Key Words: olanzapine; betahistine; dopamine receptor; serotonin receptor; receptor binding
LIST OF ABBREVIATIONS

5-HT$_{2A}$R, serotonin 5-HT$_{2A}$ receptor
5-HT$_{2C}$R, serotonin 5-HT$_{2C}$ receptor
5-HTT, serotonin 5-HT transporter
ANOVA, analysis of variance
CAFE, comparison of atypical anti-psychotics for first episode
CATIE, the clinical anti-psychotic trials of intervention effectiveness
Cg, cingulate cortex
CPu, caudate putamen
D$_2$R, dopamine D$_2$ receptor
EPS, extrapyramidal symptoms
FGAs, first generation antipsychotic drugs
HIP, hippocampus
H$_1$R, histamine H$_1$ receptor
NAc, nucleus accumbens
NAcC, nucleus accumbens core
NAcS, nucleus accumbens shell
PFC, prefrontal cortex
SGAs, second generation antipsychotic drugs
SN, substantia nigra
VTA, ventral tegmental area
1. Introduction

Second generation antipsychotic drugs (SGAs) such as olanzapine have improved tolerability compared with first generation antipsychotic drugs (FGAs) as they produce fewer extrapyramidal symptoms (EPS) (Leucht et al., 2009). However, SGAs, such as olanzapine, can induce severe body weight gain and obesity side-effects (Lambert, 2011, Deng, 2013). For example, the CATIE (The Clinical Anti-psychotic Trials of Intervention Effectiveness) study reported that olanzapine caused significant weight gain (>7% from baseline) in highest proportion of chronic schizophrenia patients (30%) and amount of weight gain (average 0.9kg/month) over an 18 months period, compared with quetiapine (16% and 0.23kg/month respectively), risperidone (14% and 0.18kg/month respectively) and ziprasidone (7% and 0.14 kg/month respectively) (Lieberman et al., 2005). Furthermore, the CAFE (Comparison of Atypical Anti-psychotics for First Episode) study showed that the 80% of olanzapine-treated patients had significant weight gain (average 1.76 kg/month), compared with 57.6% of risperidone (average 1.28 kg/month), and 50% of quetiapine (average 1.29 kg/month) (Patel et al., 2009) after 52 weeks’ treatment (Patel et al., 2009). Compared with FGAs, olanzapine is a less potent antagonist at the dopamine D2 receptor (D2R), having a pharmacological binding profile by binding at a wide range of non-dopaminergic G-protein-coupled receptors including serotonin 5-HT2A (5-HT2A-R) and 5-HT2C (5-HT2C-R), histamine H1 (H1R) and muscarinic M1 receptors (Nasrallah, 2008, Lian et al., 2013). Among these receptors, the dopamine D2 and 5-HT2 receptors play critical roles in the therapeutic effects of olanzapine and other SGAs (Meltzer and Massey, 2011, Ginovart and Kapur, 2012).

Dopamine receptor occupation (which for most antipsychotics is within the range of 65-78%), especially at the D2R, is crucial to achieve the optimal therapeutic effects of most antipsychotics with minimal EPS (Seeman, 2011, Ginovart and Kapur, 2012). Three major
dopaminergic pathways involved in the actions of antipsychotics, which are the mesolimbic, mesocortical, and nigrostriatal pathways (Kapur and Mamo, 2003). D₂R blockade of the mesolimbic pathway, in which dopaminergic neurons project from the ventral tegmental area (VTA) to the nucleus accumbens (NAc), is the major mechanism by which antipsychotics control positive schizophrenia symptoms (Seeman, 2011, Ginovart and Kapur, 2012). The mesocortical pathway, in which the dopaminergic neurons project from the VTA to the cortex, including the prefrontal cortex (PFC) and cingulate cortex (Cg), is involved in the cognitive deficits and the negative symptoms of schizophrenia (Volk, 2010, Ginovart and Kapur, 2012); By contrast, EPS are related to the D₂R blockade in the nigrostriatal pathway, in which dopaminergic neurons project from the substantia nigra (SN) to the caudate putamen (CPu) (Ginovart and Kapur, 2012). However, recent evidence indicates that the nigrostriatal pathway is also involved in the pathophysiology of schizophrenia and antipsychotic treatment (Howes et al., 2012).

Serotonin receptors such as 5-HT₂₅R and 5-HT₂₃R are G protein-coupled receptors which are linked to an intracellular molecular signal-transduction cascade, and which have been implicated in the therapeutics of SGAs and various neuropsychiatric disorders (Horacek et al., 2006, Meltzer and Massey, 2011). It has been hypothesized that a relatively high 5-HT₂₅R antagonistic affinity compared to the D₂R is the basis for the difference between the majority of SGAs and FGAs (Meltzer and Massey, 2011), although some of SGAs (such as Amisulpride) have low affinity for 5-HT₂₅R (Leucht et al., 2009). Additionally, the high 5-HT₂₅R and 5-HT₂₃R affinity of most SGAs including olanzapine has been demonstrated to facilitate dopamine release in the PFC and hippocampus (Kuroki et al., 2008). The 5-HT₂₃R antagonists may increase dopamine levels in the NAc and PFC (Di Matteo et al., 2001). There is evidence that a combination of 5-HT₂₅R and 5-HT₂₃R blockades is more efficient
than the 5-HT₂AR blockade alone at increasing dopamine release in the NAc and PFC, which would improve cognitive deficits (Horacek et al., 2006). Therefore, the functional combination of the 5-HT₂ and D₂ receptors is crucial to the therapeutic efficacy of olanzapine.

The histaminergic H₁R is involved in the regulation of body weight, food intake and energy expenditure, which is a key contributor for body weight gain induced by olanzapine (a potent H₁R antagonist) (Kim et al., 2007, Deng et al., 2010). Our previous study targeting the H₁R showed that short-term (2 weeks) co-treatment of betahistine (an H₁R agonist and H₃R antagonist) and olanzapine can reduce about 45% the body weight gain induced by olanzapine treatment in drug-naïve rats (Deng et al., 2012). Consistently, the co-treatment of olanzapine, betahistine and reboxetine (a selective norepinephrine reuptake inhibitor) was found to reduce the olanzapine-induced weight gain following short-term (6 weeks) treatment in first-episode schizophrenia patients (Poyurovsky et al., 2013). Importantly, patients with schizophrenia or other mental disorders (such as bipolar disorder) often face chronic and repeated treatments with antipsychotics. Antipsychotic treatments induce severe weight gain not only in drug-naïve patients, but also in chronic patients with previous antipsychotic exposure and repeated treatments (Lieberman et al., 2005). In a chronic rat model with repeated olanzapine exposure, we recently found that chronic (5 weeks) co-treatment with betahistidine is also effective in reducing olanzapine-induced weight gain (Lian et al., 2014).

A key issue is whether chronic betahistine co-treatment affects the therapeutic efficacy of olanzapine. Our previous study found that a short-term (2 weeks) co-treatment of olanzapine and betahistine does not influence the effect of olanzapine on dopamine D₂ and 5-HT₂AR bindings in the PFC, Cg, NAc, CPu, SN, and VTA in drug naïve rats (Lian et al., 2013). This may explain why betahistine does not affect the therapeutic efficacy of olanzapine observed
in short-term therapy in first-episode, drug-naïve schizophrenia patients (Poyurovsky et al., 2005, Lian et al., 2013). However, in the clinic, chronic schizophrenia patients normally have previously experienced antipsychotic exposure when they are prescribed an antipsychotic treatment. Therefore, we mimicked the repeated treatment condition in which rats had an early olanzapine exposure and was followed by chronic treatment of olanzapine and/or betahistine. Since it is not clear whether chronic co-treatment with betahistine affects the therapeutic effects in chronic patients with repeated second generation antipsychotics (SGAs) treatments, or affects the D₂R and 5-HT₂R neurotransmission, this study investigated the effects of chronic co-treatment of olanzapine and betahistine on the 5-HT₂A,R, 5-HT₂C,R and D₂R binding in a rat model with repeated olanzapine treatment.

2. Experimental Procedures

2.1. Animal treatment and administration

Female Sprague Dawley rats (201-225g) were obtained from the Animal Resources Centre (Perth, WA, Australia). After one week of habituation, they were housed individually with *ad-libitum* access to water and standard laboratory chow (3.9 kcal/g; 10% fat, 74% carbohydrate, 16% protein) at 22°C under a 12 hour light-dark cycle (light cycle from 07:00-19:00 and dark cycle from 19:00-07:00) throughout the study (Deng et al., 2012, Lian et al., 2013). The animals were then trained for one week to self-administer specially prepared cookie-dough pellets by metal spoon without the drug (0.3 g) and handled to minimise stress throughout the experiment. The drug powder containing cornstarch (30.9%), sucrose (30.9%), gelatine (6.3%), casein (15.5%), fibre (6.4%), minerals (8.4%) and vitamins (1.6%), and then mixed with water (Deng et al., 2012). Rats were randomly administered different drugs 3 times per day orally (07:00, 15:00, 23:00 h). Briefly (Figure 1), rats were treated with olanzapine (1 mg/kg, t.i.d., n=12) or vehicle (n=12) for 3.5 weeks, and the drug treatment
was then withdrawn from Day 23 for 19 days. From week 6, the two groups were divided into 4 groups (n=6) for further treatment for 5 weeks: (1) olanzapine (1 mg/kg, t.i.d.), (2) betahistine (9.6 mg/kg, t.i.d.), (3) co-treatment of olanzapine and betahistine (same doses as above), and (4) control (vehicle). The olanzapine dosage used is equivalent to the recommended dosage for treating schizophrenia patients, and it was translated based on body surface area according to the FDA guidelines for clinical trials (FDA, 2005, Reagan-Shaw et al., 2008). This dosage is behavioural and pharmacologically effective (Weston-Green et al., 2011, Deng et al., 2012, Lian et al., 2013). The betahistine dosage can effectively decrease body weight gain (Szelag et al., 2001, Tarricone et al., 2010). In the rat, the half-lives of olanzapine are 2.5 hours and 5.1 hours in the plasma and brain, respectively, and they are maintained at a high level for 8 hours (Aravagiri et al., 1999). However, in humans, the half-life of olanzapine in plasma is 24.2 hours, compared to 72 hours in the brain (Tauscher et al., 2002). Betahistine has 3-4 hours of plasma half-life in humans with one day of urine excretion, but no data have shown the half-life of betahistine in rats (Botta et al., 2001). All of the experimental procedures were approved by the Animal Ethics Committee, University of Wollongong, Australia (AE11/10); and complied with the Australian Code of Practice for the Care and Use of Animals for Scientific Purposes (2004).

2.2. Histology

Forty eight hours after the last drug treatment, and the following euthanasia, the brain tissue was immediately removed, frozen in liquid nitrogen, and stored at -80°C until analysis. Six brains were randomly selected from each treatment group and sectioned coronally at -18 °C into 14 μm using a cryostat (Leica CM1850, Leica Microsystems, Germany) for receptor autoradiography. Sections were thaw-mounted onto Polysine™ Microscope Slides (Menzel GmbH & Co. KG, Braunschweig, Germany) and stored at -20 °C. A set of sections from each
animal was stained with 0.5% cresyl violet solution (Nissl staining) and used to confirm of anatomical structures.

2.3. Receptors autoradiography and quantification

2.3.1. Receptors autoradiography

Procedures for $^{3}H$ketanserin binding to the 5-HT$_{2A}$R has been successfully performed in our laboratory (Kang et al., 2009, Lian et al., 2013). Briefly, brain sections were thawed and then pre-incubated for 15 minutes in 170 mM Tris buffer (pH 7.4) at room temperature. For total binding, sections were incubated with 2 nM $^{3}H$ketanserin (Specific activity: 67 Ci/mmol; PerkinElmer, Waltham, MA, USA) in 170 mM Tris buffer for 2 hours at room temperature. Non-specific binding was determined by incubating subsequent sections with 2 nM $^{3}H$ketanserin and 2 µM spiperone (Sigma Pharmaceuticals, Melbourne, VIC, Australia). Sections were washed in Tris buffer (pH 7.4) four times for 2 minutes at 4°C, dipped in ice-cold milliQ H$_2$O water to remove buffer salts, and then gently air dried under a stream of cool air.

The procedures for bindings of $^{3}H$mesulergine (to 5-HT$_{2C}$R and 5-HT$_{2A}$R), $^{3}H$paroxetine (to 5-HTT) and $^{3}H$raclopride (to D$_{2}$R) autoradiography are well established in our laboratory and are similar to the 5-HT$_{2A}$R binding procedures as described above. In brief, the brain sections were incubated with 5 nM $^{3}H$mesulergine (84.5 Ci/mmol), 0.6 nM $^{3}H$paroxetine (20.8 Ci/mmol) and 5nM $^{3}H$raclopride (60.1 Ci/mmol) (PerkinElmer), respectively. Non-specific binding are detected at the presence of 100 nM spiperone and 10 µM mianserin for $^{3}H$mesulergine binding, 10 µM fluoxetine for $^{3}H$paroxetine binding, and 10 µM butaclamol for $^{3}H$raclopride binding (du Bois et al., 2006, du Bois et al., 2008, Lian et al., 2013).
2.3.2. Quantitative analysis of autoradiography

All of the receptor binding slides were exposed to Kodak BioMax MR film for 2-3 months, together with autoradiographic standards ([³H]microscales from Amersham), in X-ray film cassettes. This was followed by the analysis of binding images using the Multi-Analyst image analysis system (Bio-Rad, USA), connected to a GS-800 Imaging Densitometer (Bio-Rad, USA). The specific binding was calculated by subtracting non-specific binding from total binding. A set of sections from each animal were stained with 0.5% cresyl violet solution (Nissl staining) and used to confirm anatomical structures. Specific brain regions in this project were identified by reference to the Nissl-stained sections and a standard rat brain atlas (Paxinos and Watson, 2007).

2.4. Statistical analysis

Statistical analysis was performed using SPSS (IBM version 19.0, SPSS Inc., NY, USA). The Kolmogorov-Smirnov test was used to examine whether data from all experiments are normally distributed. Two-way ANOVAs (OLANZAPINE × BETAHISTINE) were used to analyse receptor binding density in the relevant rat brain regions. The post-hoc Dunnett-T test was used to analyse the relationships among the measurements. The Mann-Whitney U test was applied to the data without abnormal distribution. All data were expressed as mean ± SEM, and statistical significance was accepted when $p<0.05$.

3. Results

Body weight and energy data have been reported previously (Lian et al., 2014). Briefly, the olanzapine-only treatment significantly increased weight gain and food intake/feeding.
efficiency, while the co-treatment of olanzapine and betahistine significantly reduced about 51% weight gain and feeding efficiency compared to the olanzapine-only treatment (Lian et al., 2014).

3.1. [³H]ketanserin binding to 5-HT\textsubscript{2A}R

Two-way ANOVAs revealed the significant effects of the OLANZAPINE factor on 5-HT\textsubscript{2A}R in the PFC (F\textsubscript{1,20}=36.028, p<0.001), Cg (F\textsubscript{1,20}=10.691, p=0.004), NAc core (NAcC) (F\textsubscript{1,20}=15.663, p=0.005), NAc shell (NAcS) (F\textsubscript{1,20}=6.224, p=0.021), and SN (F\textsubscript{1,20}=7.046, p=0.015). However, there was no significant effect of the BETAHISTINE factor in these brain nuclei, and, there was no significant interaction between the two factors (all p>0.05).

The olanzapine-only treatment significantly influenced the levels of 5-HT\textsubscript{2A}R binding density (Table 1). Post-hoc analysis identified a significant decrease in 5-HT\textsubscript{2A}R binding in the PFC, Cg, NAcC, NAcS (all p<0.01), and SN (p<0.05) in the rats receiving the olanzapine-only treatment (Table 1). The olanzapine-only treatment did not significantly decrease 5-HT\textsubscript{2A}R binding in the VTA (p>0.05; Table 1). Compared to the control, the levels of 5-HT\textsubscript{2A}R binding density were also significantly decreased by O+B co-treatment in the PFC, Cg, NAcC and NAcS (all p<0.01), but not in the VTA and SN (p>0.05; Table 1). However, there were no significant differences in 5-HT\textsubscript{2A}R binding between the olanzapine-only and O+B co-treatment groups in these brain regions (all p>0.05, Table 1). In addition, the betahistine-only treatment did not affect 5HT\textsubscript{2A}R binding compared to the control (all p>0.05; Table 1).

3.2. [³H]mesulergine binding to 5-HT\textsubscript{2C}R and 5-HT\textsubscript{2A}R

The altered of [³H]mesulergine binding density induced by olanzapine was observed in several brain regions (Table 2). Two-way ANOVAs showed a significant effect of the
OLANZAPINE factor on $[^3]$Hmesulergine binding density in the PFC ($F_{1,20}=17.918$, $p<0.001$), Cg ($F_{1,20}=64.387$, $p<0.001$), NAcC ($F_{1,20}=15.576$, $p=0.001$), and NAcS ($F_{1,20}=17.384$, $p<0.001$). There was a tendency to significance of the OLANZAPINE factor on $[^3]$Hmesulergine binding in the CPu ($F_{1,20}=4.145$, $p=0.055$). However, there were no significant effects of the BETAHISTINE factor and no interaction between the two factors (all $p>0.05$).

Post-hoc analysis revealed that significant attenuation of the $[^3]$Hmesulergine binding density was caused by the olanzapine-only treatment in the PFC, Cg, NAcC, and NAcS (all $p<0.01$) compared with the control, but not in the CPu and SN ($p>0.05$) (Table 2). Furthermore, compared with the control, the $[^3]$Hmesulergine binding level was also significantly decreased by the co-treatment with O+B in the PFC and CPu ($p<0.05$), and the Cg, NAcC, and NAcS ($p<0.01$) (Table 2). However, there was no significant difference in the $[^3]$Hmesulergine binding between the co-treatment of O+B and the olanzapine-only treatment, or between the control and betahistine-only groups (Table 2).

### 3.3. $[^3]$Hparoxetine binding to 5-HTT binding

Two-way ANOVAs revealed the significant effects of the OLANZAPINE factor in the Cg ($F_{1,20}=18.189$, $p<0.001$), NAcC ($F_{1,20}=9.862$, $p=0.005$) and NAcS ($F_{1,20}=22.853$, $p<0.001$). There was borderline significance for the OLANZAPINE factor in the PFC ($F_{1,20}=4.076$, $p=0.057$). However, there was no significant effect of the BETAHISTINE factor, and no interaction between the two factors.

The 5-HTT binding density was significantly lower in the olanzapine-only group than in the controls in the PFC and NAcC ($p<0.05$), as well as the Cg and NAcS (all $p<0.01$). Similar to
the olanzapine-only treatment, the co-treatment of O+B also significantly decreased 5-HTT binding in the Cg \( (p<0.01) \) and NAcS \( (p<0.05) \) compared with the control, and tended to decrease 5HTT binding in the PFC \( (p=0.059) \) and NAcC \( (p=0.089) \) (Table 3). However, the olanzapine-only and O+B co-treatment had no effect on the 5-HTT binding in the CPu and VTA (Table 3). Furthermore, there was no significant difference between the olanzapine-only treatment and the co-treatment of O+B. Also, the betahistine-only treatment did not affect the 5-HTT binding in any of the brain region (Table 3).

3.4. \[^{3}H\]raclopride binding to \( \text{D}_2 \text{R} \)

Two-way ANOVAs (OLANZAPINE × BETAHISTINE) revealed significant effects of the OLANZAPINE factor on the PFC \( (F_{1,20}=5.857, p=0.025) \), NAcC \( (F_{1,20}=20.631, p<0.001) \), NAcS \( (F_{1,20}=19.065, p<0.001) \), Cg \( (F_{1,20}=10.924, p=0.004) \) and CPu \( (F_{1,20}=21.025, p<0.001) \), as well as significant effects of the BETAHISTINE factor on the NAcC \( (F_{1,20}=6.438, p=0.020) \), NAcS \( (F_{1,20}=4.802, p=0.040) \) and CPu \( (F_{1,20}=8.690, p=0.008) \). However, no significant interaction was detected between the two factors.

Post-hoc tests showed that the olanzapine-only treatment significantly increased \( \text{D}_2 \text{R} \) binding density in the NAcC, NAcS and CPu (all \( p<0.01 \)), as well as the Cg \( (p<0.05) \), while it tended to increase \( \text{D}_2 \text{R} \) binding in the PFC \( (p=0.076) \). The betahistine-only treatment significantly decreased \( \text{D}_2 \text{R} \) binding density in the CPu and NAcC \( (p<0.05) \) compared to the control (Table 4). The co-treatment of the O+B group had a significantly lower \( \text{D}_2 \text{R} \) binding levels in the NAcC \( (p<0.01) \) and NAcS \( (p<0.05) \) than the olanzapine-only treatment group. The O+B co-treatment group had no significant change in \( \text{D}_2 \text{R} \) binding in the CPu compared with the olanzapine-only group \( (p=0.107) \) (Table 4).
4. Discussion

The present study using female rats provides the first evidence of the effects of chronic olanzapine and/or betahistine treatment on the 5-HT$_{2A}$R, 5-HT$_{2C}$R, 5-HTT and D$_2$R bindings in the brain regions involved in the therapeutic efficacy of olanzapine. Olanzapine-only and O+B co-treatment had similar effects in down-regulating the 5-HT$_{2A}$R, 5-HT$_{2C}$R and 5-HTT binding density in various brain regions, particularly the PFC, NAcC, NAcS and Cg. In contrast, the D$_2$R binding density was significantly up-regulated by the olanzapine-only treatment in the Cg, NAcC, NAcS and CPu, while it was down-regulated by the betahistine-only treatment in the NAcC and NAcS. Importantly, the betahistine co-treatment reversed the D$_2$R up-regulation induced by olanzapine in the NAcC and NAcS.

The female rats were used in this study, because the olanzapine-induced weight gain model has been well established and validated in female rats in our and other laboratories (Choi et al., 2007, Weston-Green et al., 2011, Deng et al., 2012). Clinically, it is also a common observation that female patients have a much higher risk than males for SGA-induced weight gain side-effects (Gebhardt et al., 2009, Seeman, 2009, Weston-Green et al., 2010, Treuer et al., 2011). Furthermore, in this study, rats were closely housed in a room occupied by only female rats. Our pre-experiments have shown that, under this rearing condition, the estrus cycles of all female rats are synchronized (Lian et al., 2013).

SGAs such as olanzapine and clozapine have been reported to attenuate 5-HT$_{2A}$R binding and mRNA expression, which are involved in the therapeutic effects of SGAs (Tarazi et al., 2002, Lian et al., 2013). Coinciding with these findings, this study revealed that chronic olanzapine treatment significantly reduced 5-HT$_{2A}$R binding density in the PFC, Cg, NAcC, NAcS and SN, strongly implicated in the therapeutics of antipsychotics (Kuroki et al., 2008, Meltzer and
Massey, 2011). Notably, the chronic O+B co-treatment had similar effects in down-regulating 5-HT_{2A}R binding as the olanzapine-only treatment in rats on chronic and repeated olanzapine treatment, although the chronic betahistine-only treatment did not affect 5-HT_{2A}R binding. Consistent with findings in this study, our previous study found that short-term O+B co-treatment had similar down regulatory effects as the olanzapine-only treatment on 5-HT_{2A}R binding density in drug-naïve rats (Lian et al., 2013). These results suggest that both early olanzapine exposure and chronic betahistine co-treatment do not influence olanzapine’s actions on 5-HT_{2A}R.

Besides 5-HT_{2A}R, most of SGAs have a high binding affinity with 5-HT_{2C}R which is involved in the antipsychotic drug action (Meltzer and Massey, 2011). Several studies have revealed the association between the polymorphism of the 5-HT_{2C}R gene/its promoter region and clinical response to antipsychotic (including olanzapine) treatment (Reynolds et al., 2005). Similar to 5-HT_{2A}R binding, the 5-HT_{2C}R binding is down-regulated in response to olanzapine and other SGAs treatment (Tarazi et al., 2002, Zhang and Malhotra, 2011). In this study, [³H]mesulergine was used to examine 5-HT_{2C}R density, although we should consider the limitation that [³H]mesulergine has also high affinity with 5-HT_{2A}R (Abbas et al., 2009). Consistent with previous reports, this study revealed that decreased [³H]mesulergine binding density in the PFC, Cg, NAcC, and NAcS after chronic olanzapine treatment. It should also be noted that chronic O+B co-treatment had a similar attenuation effect as olanzapine-only treatment on the [³H]mesulergine binding, while the betahistine-only treatment had no significant effects on the [³H]mesulergine binding in these brain regions. Consequently, this study provided further evidence that chronic O+B co-treatment would have similar effects on 5-HT translations through 5-HT_{2A}R and 5-HT_{2C}R.
As an integral membrane protein, 5-HTT terminates the action of serotonin by transporting serotonin from synaptic spaces into presynaptic neurons (Zhang and Malhotra, 2011, Lian et al., 2013). Variations in several 5-HTT gene polymorphisms have been associated with the response to olanzapine and other SGAs (Zhang and Malhotra, 2011). For example, a repeat length polymorphism 5-HTT-LPR (a 44bp insertion/deletion in the promoter region) has shown that the short allele of 5-HTT-LPR is associated with poor response to olanzapine, clozapine, and risperidone treatment (Vazquez-Bourgon et al., 2010, Zhang and Malhotra, 2011). However, the exact role of 5-HTT in the olanzapine treatment of schizophrenia symptoms is still not clear. Our previous study revealed that short-term treatment of olanzapine and co-treatment of O+B down-regulated 5-HTT bindings in the SN and VTA of drug-naïve rats (Lian et al., 2013). In this study, chronic olanzapine treatment significantly decreased the 5-HTT binding density in the PFC, Cg, NAcC, and NAcS. The present results suggest that the 5-HT uptake in the PFC, Cg and NAc may contribute to therapeutic effects of chronic olanzapine treatment. In addition, a similar decrease of 5-HTT binding density was also revealed in rats with O+B co-treatment. Thus co-treatment with betahistine should not affect olanzapine’s action on 5-HTT. However, although 5-HTT binding was down-regulated in both short-term treatment in drug-naïve subjects and chronic olanzapine treatment, this effect occurred in different brain regions. Further study is necessary to determine the contributing factors (short-term vs. chronic or drug-naïve vs. repeated treatment) for these differences.

In terms of D2R binding, in this study chronic olanzapine treatment (3 mg/kg/day, t.i.d.) up-regulated the D2R binding levels in the Cg, NAcC, NAcS and CPu. This result corresponds to a previous report that chronic treatment of olanzapine (5mg/kg/day via osmotic minipumps) caused an increase in D2R binding in the PFC, CPu, and NAc (Tarazi et al., 2001). However,
olanzapine was found only having a tendency to increase D₂R binding density in the PFC, but not significance in this study. It is worth noting that a previous study reported a significant increase of D₂R binding in the PFC following 4 weeks treatment of olanzapine (Tarazi et al., 2001). This discrepancy could be due to different radioactive ligands used in this ([³H]Raclopride) and Tarazi et al. ([³H]nemonapride) studies, or most possibly a higher olanzapine dosage (5 mg/kg/day via osmotic minipump) used in Tarazi et al than in this study (3 mg/kg/day, t.i.d. via orally feeding in cookie dough) (Tarazi et al., 2001, Lian et al., 2014).

In fact, some studies using olanzapine treatment at lower doses (1-2mg/kg/day) or short-term treatment (~2 weeks) did not affect D₂R binding (Han et al., 2009, Lian et al., 2013). It has been well documented in both humans and laboratory animals that D₂R up-regulation induced by chronic antipsychotic (including olanzapine) treatment may lead to a state of “dopaminergic supersensitivity” (Samaha et al., 2007, Seeman, 2011). This “dopaminergic supersensitivity” is characterized by an increased vulnerability to psychosis (termed “antipsychotic-induced supersensitivity psychosis” in humans), and to psychomotor activating effects of the dopamine agonist, which may lead to treatment failure over time (Samaha et al., 2007). Furthermore, it is worth noting that chronic olanzapine treatment is still associated with some risks for EPS, although at a much lower rate than FGAs (Kantrowitz and Citrome, 2008). The D₂R binding up-regulation in the CPu observed in the chronic olanzapine treatment in this and other studies may partially explain its risk for the development of EPS (Tarazi et al., 2001). It is interesting that this is the first study to reveal the effect of chronic betahistine treatment in decreasing D₂R binding in the NAc and CPu, which was not observed in our previous study with a short-term (2-weeks) treatment at a lower dose (2.67mg/kg vs. 9.6mg/kg in this study) (Lian et al., 2013). The betahistine dosage (9.6 mg/kg) applied in this present study is equal to about 93 mg in human (60 kg body weight) based on dosage translation between species according to body surface area followed...
the FDA guideline (FDA, 2005, Reagan-Shaw et al., 2008). Betahistine has 3-4 hours of plasma half-life in humans with one day of urine excretion (Botta et al., 2001). Although there is no data available for the half-life of betahistine in rats, it is reasonable to suppose that betahistine is most likely to have a shorter half-life in rats than in humans. This dosage (9.6 mg/kg, t.i.d) should be relevant to the human dosage (48 mg, t.i.d.) used to attenuate olanzapine-induced weight gain in the clinical trials (Poyurovsky et al., 2005, Poyurovsky et al., 2013). Therefore, 9.6 mg/kg was used in this study, which should be appropriate for investigating the effect of co-treatment with betahistine in relieving olanzapine-induced body weight gain in rats. More importantly, co-treatment with betahistine significantly reversed D_{2}R binding up-regulation in the NAc and there was a trend towards reversing it in the CPu. Therefore, co-treatment with betahistine may be able to reduce the “dopaminergic supersensitivity” and EPS caused by chronic antipsychotic (olanzapine) treatment, although further clinical studies are necessary. On the other hand, betahistine may affect olanzapine’s action on dopamine D_{2}R. Notably, that histamine H_{3}R can form intramembrane interactions with D_{2}R (Ferrada et al., 2008), and negatively modulate dopaminergic transmission via interactions with D_{2}R (Panula and Nuutinen, 2013). Since betahistine is a patent H_{3}R antagonist (and also a H_{1}R agonist), it is probable that the H_{3}R antagonist property of betahistine plays a key role in attenuating the D_{2}R binding density observed in this study.

In summary, this study revealed the effects of chronic olanzapine and/or betahistine treatment on the 5-HT_{2A}R, 5-HT_{2C}R, 5-HTT and D_{2}R bindings in the brain regions involved in the therapeutic effects of antipsychotics (Kuroki et al., 2008). The effects of co-treatment with O+B on 5-HT_{2A}R binding is in line with our previous short-term study showed that both olanzapine-only and co-treatment of O+B have similar effects in decreasing 5-HT_{2A}R binding density (Lian et al., 2013). The present study also showed that both olanzapine-only and
O+B co-treatment has similar effects in attenuating $5$-$\text{HT}_2\text{C}R$ and $5$-$\text{HTT}$ levels. Therefore, these results suggested that chronic O+B co-treatment does not affect olanzapine’s actions on $5$-$\text{HT}$ neurotransmission. While up-regulation of D$_2$R binding in the Cg, NAc, and CPu was observed in rats treated with chronic olanzapine treatment, chronic betahistine treatment decreased D$_2$R binding density. Since the up-regulation of D$_2$R binding is associated with “dopaminergic supersensitivity” (or “antipsychotic-induced supersensitivity psychosis”) that may lead to treatment failure over time (Samaha et al., 2007), the observation that O+B co-treatment tends to reverse the up-regulation of D$_2$R binding caused by chronic olanzapine treatment is promising for further investigation as whether co-treatment with betahistidine can prevent the “dopaminergic supersensitivity” caused by chronic antipsychotic treatment.

**Acknowledgements**

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References

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Experimental design

- **Olanzapine** (1 mg/kg, t.i.d., n=12)
- **Vehicle** (t.i.d., n=12)
- **Control** (Vehicle, n=6)
- **Beta histine** (9.6 mg/kg, t.i.d., n=6)

**Figure 1.** Outline of the experimental design.
Table 1
The effects of chronic olanzapine and/or betahistine treatment ($n = 6$/group) on [$^3$H]ketanserin binding to the 5-HT$_{2A}$ receptors (fmole/mg tissue).

<table>
<thead>
<tr>
<th>Group</th>
<th>Control</th>
<th>Olanzapine</th>
<th>Betahistine</th>
<th>O + B</th>
</tr>
</thead>
<tbody>
<tr>
<td>PFC</td>
<td>126.3 ± 13.2</td>
<td>55.1 ± 3.9**</td>
<td>115.9 ± 7.6</td>
<td>72.3 ± 10.9**</td>
</tr>
<tr>
<td>Cg</td>
<td>89.0 ± 14.3</td>
<td>45.2 ± 4.4**</td>
<td>80.6 ± 11.0</td>
<td>54.2 ± 10.9**</td>
</tr>
<tr>
<td>NAcC</td>
<td>62.0 ± 9.5</td>
<td>28.0 ± 4.1**</td>
<td>50.2 ± 8.1</td>
<td>27.9 ± 5.5**</td>
</tr>
<tr>
<td>NAcS</td>
<td>70.4 ± 10.7</td>
<td>32.8 ± 4.1**</td>
<td>57.3 ± 14.0</td>
<td>42.2 ± 10.9**</td>
</tr>
<tr>
<td>VTA</td>
<td>48.6 ± 11.9</td>
<td>26.8 ± 6.0</td>
<td>50.1 ± 10.9</td>
<td>41.9 ± 6.7</td>
</tr>
<tr>
<td>SN</td>
<td>54.8 ± 11.3</td>
<td>23.6 ± 8.1</td>
<td>59.9 ± 8.6</td>
<td>44.0 ± 7.0</td>
</tr>
</tbody>
</table>

*Abbreviations: Cg, cingulate cortex; NAcC, nucleus accumbens, core; NAcS, nucleus accumbens, shell; O + B, olanzapine and betahistine co-treatment; PFC, prefrontal cortex; SN, substantia nigra; VTA, ventral tegmental area. Data shown are the mean values ± SEM. *p < 0.05, **p < 0.01 vs. control.

Table 2
The effects of chronic olanzapine and/or betahistine treatment ($n = 6$/group) on [$^3$H]mesulergine binding to the 5-HT$_{2C/2A}$ receptors (fmole/mg tissue).

<table>
<thead>
<tr>
<th>Group</th>
<th>Control</th>
<th>Olanzapine</th>
<th>Betahistine</th>
<th>O + B</th>
</tr>
</thead>
<tbody>
<tr>
<td>PFC</td>
<td>75.2 ± 9.9</td>
<td>30.3 ± 6.8**</td>
<td>70.5 ± 8.7</td>
<td>43.5 ± 8.3*</td>
</tr>
<tr>
<td>Cg</td>
<td>58.8 ± 4.9</td>
<td>17.0 ± 3.2**</td>
<td>54.2 ± 7.2</td>
<td>19.3 ± 2.4**</td>
</tr>
<tr>
<td>NAcC</td>
<td>51.4 ± 1.7</td>
<td>25.4 ± 6.8**</td>
<td>53.4 ± 10.4</td>
<td>20.6 ± 8.0**</td>
</tr>
<tr>
<td>NAcS</td>
<td>50.5 ± 3.9</td>
<td>25.6 ± 6.6**</td>
<td>56.0 ± 9.6</td>
<td>21.8 ± 7.0**</td>
</tr>
<tr>
<td>CPU</td>
<td>30.4 ± 4.1</td>
<td>21.0 ± 6.3</td>
<td>34.1 ± 10.2</td>
<td>16.9 ± 3.2*</td>
</tr>
<tr>
<td>SN</td>
<td>29.1 ± 10.7</td>
<td>28.2 ± 4.8</td>
<td>28.3 ± 4.3</td>
<td>30.7 ± 1.5</td>
</tr>
</tbody>
</table>

*Abbreviations: Cg, cingulate cortex; CPU, caudate putamen; NAcC, nucleus accumbens, core; NAcS, nucleus accumbens, shell; O + B, olanzapine and betahistine co-treatment; PFC, prefrontal cortex; SN, substantia nigra. Data shown are the mean values ± SEM. *p < 0.05, **p < 0.01 vs. control.
Table 3
The effects of chronic olanzapine and/or betahistine treatment ($n = 6$/group) on $[^3]H$paroxetine binding to 5-HTT (fmole/mg tissue).

<table>
<thead>
<tr>
<th>Group</th>
<th>Control</th>
<th>Olanzapine</th>
<th>Betahistine</th>
<th>O + B</th>
</tr>
</thead>
<tbody>
<tr>
<td>PFC</td>
<td>312.9 ± 23.8</td>
<td>234.9 ± 30.9$^*$</td>
<td>266.9 ± 19.4</td>
<td>222.6 ± 42.2</td>
</tr>
<tr>
<td>Cg</td>
<td>200.1 ± 30.0</td>
<td>101.8 ± 18.7$^{**}$</td>
<td>194.9 ± 20.8</td>
<td>97.6 ± 20.6$^{**}$</td>
</tr>
<tr>
<td>NAcC</td>
<td>149.7 ± 15.0</td>
<td>95.7 ± 13.5$^*$</td>
<td>182.4 ± 30.0</td>
<td>86.2 ± 31.3</td>
</tr>
<tr>
<td>NAcS</td>
<td>169.4 ± 10.4</td>
<td>64.2 ± 13.0$^{**}$</td>
<td>193.5 ± 28.4</td>
<td>89.0 ± 29.0$^*$</td>
</tr>
<tr>
<td>CPU</td>
<td>120.2 ± 13.7</td>
<td>102.1 ± 18.4</td>
<td>121.8 ± 26.8</td>
<td>116.4 ± 13.4</td>
</tr>
<tr>
<td>VTA</td>
<td>118.3 ± 10.6</td>
<td>114.4 ± 10.7</td>
<td>120.8 ± 10.5</td>
<td>105.5 ± 14.8</td>
</tr>
</tbody>
</table>

*Abbreviations:* Cg, cingulate cortex; CPU, caudate putamen; NAcC, nucleus accumbens, core; NAcS, nucleus accumbens, shell; O + B, olanzapine and betahistine co-treatment; PFC, prefrontal cortex; VTA, ventral tegmental area. Data shown are the mean values ± SEM. $^*$p < 0.05, $^{**}$p < 0.01 vs. control.

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Table 4
The effects of chronic olanzapine and/or betahistine treatment ($n = 6$/group) on $[^3]H$raclopride binding to D$_2$R (fmole/mg tissue).

<table>
<thead>
<tr>
<th>Group</th>
<th>Control</th>
<th>Olanzapine</th>
<th>Betahistine</th>
<th>O + B</th>
</tr>
</thead>
<tbody>
<tr>
<td>PFC</td>
<td>12.9 ± 1.9</td>
<td>24.0 ± 5.8</td>
<td>10.6 ± 2.0</td>
<td>23.9 ± 7.7</td>
</tr>
<tr>
<td>Cg</td>
<td>15.9 ± 1.6</td>
<td>25.4 ± 3.9$^*$</td>
<td>11.5 ± 3.3</td>
<td>24.7 ± 4.3</td>
</tr>
<tr>
<td>NAcC</td>
<td>21.6 ± 3.8</td>
<td>38.0 ± 3.3$^{**}$</td>
<td>17.2 ± 2.7$^*$</td>
<td>27.5 ± 1.5##</td>
</tr>
<tr>
<td>NAcS</td>
<td>22.8 ± 3.7</td>
<td>38.8 ± 3.1$^{**}$</td>
<td>19.5 ± 2.8</td>
<td>29.3 ± 1.7#</td>
</tr>
<tr>
<td>CPU</td>
<td>29.1 ± 1.3</td>
<td>41.6 ± 4.1$^{**}$</td>
<td>19.3 ± 2.2$^*$</td>
<td>33.9 ± 3.4</td>
</tr>
<tr>
<td>SN</td>
<td>11.1 ± 1.3</td>
<td>20.3 ± 4.5</td>
<td>13.2 ± 5.1</td>
<td>12.4 ± 2.9</td>
</tr>
</tbody>
</table>

*Abbreviations:* Cg, cingulate cortex; CPU, caudate putamen; NAcC, nucleus accumbens, core; NAcS, nucleus accumbens, shell; O + B, olanzapine and betahistine co-treatment; PFC, prefrontal cortex; SN, substantia nigra. Data shown are the mean values ± SEM. $^*$p < 0.05, $^{**}$p < 0.01 vs. control. #p < 0.05, ##p < 0.01 vs. olanzapine.