Effect of rosiglitazone on plasma adiponectin levels and arterial stiffness in subjects with prediabetes or non-diabetic metabolic syndrome

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Abstract

Objective: Thiazolidinediones have favorable influences on surrogate markers of atherosclerosis such as adiponectin, and arterial stiffness in diabetic patients. However, it is not well known whether these beneficial effects occur in subjects without diabetes, such as prediabetes or the non-diabetic metabolic syndrome (MetS). The present study was therefore designed to evaluate the effectiveness of the insulin-sensitizing agent rosiglitazone on circulating adipocytokine levels and brachial-ankle pulse wave velocity (baPWV) in non-diabetics.

Design and methods: Ninety-nine subjects with prediabetes or non-diabetic MetS were randomly assigned to either rosiglitazone or an untreated control group (50 and 49 subjects respectively). The rosiglitazone group was treated daily for 12 weeks with 4 mg rosiglitazone. All subjects received a 75 g oral glucose test (OGTT) before and after treatment. In addition, baPWV, together with the levels of adiponectin, resistin, and high sensitivity C-reactive protein (hsCRP) were determined.

Results: Rosiglitazone treatment significantly increased circulating adiponectin levels ($P < 0.001$) relative to the control group ($P = 0.21$). Plasma resistin levels were unchanged in both the rosiglitazone-treated and -untreated groups, but baPWV and hsCRP were significantly decreased ($P < 0.001$ and $P = 0.003$ respectively) in the rosiglitazone group only. Multiple linear regression analysis showed that changes in plasma adiponectin and baPWV were significantly affected by rosiglitazone treatment.

Conclusions: These data suggest that rosiglitazone may have an anti-atherogenic effect in subjects with prediabetes or non-diabetic MetS.

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Introduction

Thiazolidinedione (TZD), a peroxisome proliferator-activated receptor (PPAR)-γ agonist is an insulin-sensitizing agent and is used to treat patients with type 2 diabetes (T2DM). PPAR-γ is found most abundantly in adipocytes (1) but it is also expressed in endothelial cells, vascular smooth muscle cells (VSMCs), macrophages, and T cells (2). PPAR-γ agonists reduce the cytokine-induced expression of adhesion molecules in endothelial cells (3), and also inhibit VSMC migration, growth, and proliferation (4). These studies suggested that PPAR-γ agonists may inhibit atherosclerotic disease progression. Several human studies have shown that TZDs have beneficial effects on the surrogate endpoints of atherosclerosis, such as high sensitivity C-reactive protein (hsCRP) (5) and carotid intima-media thickness (IMT) (6) in T2DM. Recently, the results of the PROactive (PROspective pioglitAzone Clinical Trial In macroVascular Events) study (7) showed that pioglitazone reduces the composite of all causes of mortality, non-fatal myocardial infarction, and stroke in patients with T2DM who have a high risk of macrovascular events. Moreover, recent data suggest that the beneficial effects of TZDs can be extrapolated to non-diabetic subjects (8, 9).

Pulse wave velocity (PWV) is a non-invasive means of measuring arterial stiffness for assessment of atherosclerosis, and many articles have been published on the relationship between PWV and the development of atherosclerotic disease (10, 11). Moreover, PWV is believed to be a risk marker (12) and prognostic predictor of atherosclerosis (13). Recently, one study (5) reported that pioglitazone treatment significantly...
reduced brachial-ankle PWV (baPWV), independently of changes in parameters related to glucose metabolism, in T2DM. However, to the best of our knowledge, no article has been published concerning the effect of TZDs on PWV in non-diabetics.

Adipose tissue is now known to express and secrete a variety of bioactive peptides, which are collectively known as adipokines (14). These factors include adiponectin, leptin, tumor necrosis factor-α, plasminogen activator inhibitor-1, and resistin (14). Adiponectin is an adipokine that is highly specific for adipose tissue. Adiponectin may have anti-inflammatory and anti-atherogenic properties (15) and is considered to be an independent risk factor for cardiovascular disease (16). It was recently reported that rosiglitazone increases plasma adiponectin levels in subjects with T2DM (17); however, it is not known whether the level of this protective adipokine is increased by TZDs in subjects with prediabetes or the non-diabetic metabolic syndrome (MetS).

Prediabetes (18) and MetS (19) are high-risk states for diabetes and cardiovascular disease respectively. We hypothesized that TZDs may have vasoprotective effects in prediabetes or non-diabetic MetS. This study was therefore undertaken to evaluate the effectiveness of the insulin-sensitizing agent rosiglitazone on circulating adipokine levels, which are known to be related to atherosclerosis like adiponectin, and baPWV as a marker of arterial stiffness in subjects with prediabetes or non-diabetic MetS.

Materials, subjects and methods

Study subjects and study protocol

A total of 99 subjects (52 men and 47 women, mean age 53.5±11.4 years) with prediabetes (31 subjects) or non-diabetic MetS (68 subjects) participated in this study. Prediabetes was defined as a fasting plasma glucose (FBS) level of 100–125 mg/dl or a 2-h plasma glucose level of 140–199 mg/dl by a 75 g oral glucose tolerance test (OGTT) according to the criteria of the American Diabetes Association (18). MetS was defined using the criteria of the National Cholesterol Education Program Adult Treatment Panel III (20), modified in accordance with the World Health Organization’s proposed waist circumference cut-off points for Asians (21). Subjects with MetS were required to conform with three or more of the following criteria: (a) a waist circumference of ≥90 cm in men and ≥80 cm in women, (b) serum triglycerides of ≥150 mg/dl, (c) high-density lipoprotein (HDL) cholesterol levels <40 mg/dl in men and <50 mg/dl in women, (d) impaired fasting glucose of 110–125 mg/dl, and (e) a blood pressure of ≥130/85 mmHg or treated hypertension.

Subjects who had taken a stable dose of anti-hypertensive or lipid-lowering drugs for at least 4 weeks before the study were enrolled, and these medication dosages were maintained throughout the study. The major exclusion criteria were: diabetes mellitus as defined by the American Diabetes Association, a history of treatment or a diagnosis of diabetes mellitus, overt liver disease (aspartate aminotransferase or alanine aminotransferase >2.5 times the reference level), alcohol or drug abuse, hormone replacement therapy, edema or renal insufficiency with a serum creatinine level ≥2.0, and heart failure. Informed consent was obtained from all subjects before participation, and the study was approved by the institutional review board of our institution.

Ninety-nine subjects were randomly assigned to each group, 50 to the rosiglitazone treatment group and 49 to the non-treated control group. Rosiglitazone group members received 4 mg rosiglitazone (Glaxo-Smith-Kline, UK) daily for 12 weeks, and liver function tests were monitored at baseline and at 4-week intervals during the study period. At baseline and after 12 weeks, all subjects were given a 75 g OGTT. BaPWV, together with adiponectin, resistin and hsCRP levels, and anthropometric data were also obtained. Oral and written information was given by a specialized nurse and dietitian to all subjects about the health benefits of a healthy, low cholesterol diet, and physical activity of moderate intensity for at least 150 min per week.

Biochemical analyses and baPWV

Blood samples were drawn after an overnight fast and immediately centrifuged. Serum total cholesterol, triglycerides, HDL cholesterol, and liver enzyme levels were determined enzymatically using a chemical analyzer (Hitachi 747, Tokyo, Japan). Plasma glucose was measured using the glucose oxidase method, and serum insulin levels were measured by immunoradiometric assay (Biosource, Nivelles, Belgium). The homeostasis model of assessment (HOMA), a parameter of insulin resistance, was calculated using baseline glucose and insulin levels as: fasting glucose (mmol/l) × fasting insulin (μU/ml)/22.5.

hsCRP levels were measured using a CRP ELISA kit (Immunodiagnostik, Bensheim, Germany), and its intra- and interassay coefficients of variation were 6.5% and 10.4% respectively. Serum adiponectin and resistin concentrations were determined using enzyme-linked immunosorbent assay using kits developed by the KOMED Institute for Life Science (Seoul, South Korea) (22). The inter- and intra-assay coefficients of variation for adiponectin were 4.63% and 2.72% and for resistin they were 5.60% and 3.73% respectively.

After a subject had rested in a supine position for 5 min, baPWV was measured using a volume-plethysmographic apparatus (model BP-203RPE II; Colin, Komaki, Japan). This instrument simultaneously records baPWV, and the brachial and ankle blood pressures on the left and right sides. Details of this method, its validity, and
its reproducibility have been described previously by Yamashina et al. (23) and Kubo et al. (24). The inter-
observer and intra-observer coefficients of variation were 8.4% and 10.0% respectively. In this study, 

baPWV was calculated as the mean of the left and 

right baPWV values.

Statistical analysis

All statistical analyses were performed using SAS ver-

sion 9.1 (SAS institute Inc., Cary, NC, USA). Data are 

expressed as means±S.D. Variables that did not show 
normal distribution were log-transformed for 

subsequent analysis. The rosiglitazone-treated and 

-untreated groups were compared at baseline using the 

Student's t-test, the chi-squared test, or Fisher's 

exact test as appropriate. Analysis of changes between 

baseline and week 12 was performed using the 

Student's t-test between two groups, and by using the 
paired t-test within groups. Multiple regression analysis 

using the changes of baPWV or adiponectin as a de-

pendent variable was conducted to determine the relative 

contributions made by each of the following 

independent variables: age, gender, body mass index 

(BMI), weight, waist, fasting glucose, post-OGTT glu-

cose, hemoglobin A1c (HbA1c), HOMA, cholesterol, 

HDL, cholesterol, triglyceride, hsCRP, and systolic and 
diastolic blood pressure. The stepwise variable selection 

method was used to choose significant predictor vari-

ables. Statistical significance was accepted for P 

values of <0.05.

Results

Baseline characteristics and safety profile

The study was fully completed by 85 subjects (45 in the 

rosiglitazone group and 40 in the control group). The 
most frequent reason for early termination was patient 

decision to refuse further study (five in the control 
group). Three subjects were unwilling to attend 

follow-up, four subjects were excluded by the exclusion 
criteria from the study soon after randomization, and 
two subjects in the rosiglitazone group withdrew 
because of untoward side-effects. Of these two, one 
experienced dizziness and palpitation, and the other 
one a mild liver transaminase elevation (from 30 to 

75 IU/l in alanine aminotransferase). No other side-
effects, e.g. serious edema or dyspnea were observed. 

Baseline characteristics were similar in both groups,

except for a significantly higher mean systolic blood 

pressure in the rosiglitazone group (Table 1).

Changes in various parameters in the two 
groups

Anthropometric and metabolic parameters The effects of rosiglitazone on anthropometric and meta-
bolic parameters compared with the control group 

are summarized in Table 2. Only FBS and HOMA 

were significantly different between baseline and week 

12 in the two groups. Whereas FBS and HOMA 
increased in the control group, FBS decreased and 

HOMA was unchanged in the rosiglitazone group. 

Over the 12-week period, rosiglitazone treatment sig-

ificantly reduced fasting and post-OGTT plasma glu-
cose (P = 0.002 and P = 0.032 respectively), and 

post-OGTT insulin levels (P = 0.044). Systolic and dias-
tolic blood pressures (P = 0.001 and P < 0.001 

respectively) were significantly reduced, but lipid pro-
files were unchanged in the rosiglitazone group. In 

the control group, serum triglyceride levels were signifi-
cantly reduced, blood pressures were unchanged, and 

FBS levels were increased.

Various atherosclerotic markers including adiponec-

tin and baPWV As shown in Fig. 1, rosiglitazone 
treatment significantly increased circulating adiponec-
tin levels (from 2.71±2.17 to 7.07±1.77 μg/ml, 
P < 0.001), and significantly reduced baPWV (from 

1478.2±254.6 to 1390.2±253.3 cm/s, P < 0.001) 

and hsCRP (from 0.16±2.32 to 0.09±2.67 mg/dl, 
P < 0.01), but no changes were observed in the control 

group. Plasma resistin levels were unchanged in both 
groups. The effect of rosiglitazone on atherosclerotic 
markers was not influenced by the presence of MetS. 

In the roglitazone group, those without and with 

MetS (15 and 30 subjects respectively) according to 

the modified National Cholesterol Education Program 

Adult Treatment Panel III, showed similar changes in 
adiponectin levels (3.70 vs 5.19 μg/ml, P = 0.2683), 

PWV (−80.40 vs −91.85 cm/s, P = 0.7691) and 

hsCRP (−0.07 vs −0.10 mg/dl, P = 0.5494).

Factors determining the changes in adiponec-
tin and PWV (Table 3) Changes in adiponectin level 

were significantly associated with treatment status 

(use of rosiglitazone or control) and triglyceride level 

by multiple regression analysis. Age and changes in 

HOMA were borderline significant (P = 0.052 and 
P = 0.065 respectively). Treatment status was attribu-
ted to 34.8% of variance (r^2 = 0.348), whereas the r^2 

of the final model, where all significant variables 

were entered, was 0.429. On the other hand, treatment 

status, age, and changes in diastolic blood pressure 

and triglyceride were identified as being independently 

related to baPWV by multiple regression analysis 

(r^2 = 0.312).

Discussion

PWV is a non-invasive straightforward measure for 
evaluating arterial wall stiffness, and several studies 
have indicated that this is a good marker of vascular 
damage. More recently, PWV was considered a risk
Table 1 Baseline characteristics of subjects in the rosiglitazone (n = 45) and control (n = 40) groups. *Geometric mean and s.d. values are given. Logarithmic transformed values were used.

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th>Rosiglitazone</th>
<th>P value†</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex (%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>23 (57.5)</td>
<td>26 (57.8)</td>
<td>0.9794</td>
</tr>
<tr>
<td>Female</td>
<td>17 (42.5)</td>
<td>19 (42.2)</td>
<td></td>
</tr>
<tr>
<td><strong>Distribution of subgroup (%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prediabetes without MetS</td>
<td>13 (32.5)</td>
<td>15 (33.3)</td>
<td>0.9654</td>
</tr>
<tr>
<td>With MetS</td>
<td>27 (67.5)</td>
<td>30 (66.7)</td>
<td></td>
</tr>
<tr>
<td><strong>Age (years)</strong></td>
<td>53.4±9.9</td>
<td>54.2±11.9</td>
<td>0.7448</td>
</tr>
<tr>
<td><strong>BMI at baseline (kg/m²)</strong></td>
<td>26.2±2.8</td>
<td>27.1±3.2</td>
<td>0.1384</td>
</tr>
<tr>
<td><strong>Weight (kg)</strong></td>
<td>68.4±9.9</td>
<td>70.9±11.6</td>
<td>0.2878</td>
</tr>
<tr>
<td><strong>Systolic blood pressure (mmHg)</strong></td>
<td>127.8±11.4</td>
<td>133.6±13.0</td>
<td>0.0336</td>
</tr>
<tr>
<td><strong>Diastolic blood pressure (mmHg)</strong></td>
<td>82.2±10.9</td>
<td>86.0±9.5</td>
<td>0.0958</td>
</tr>
<tr>
<td><strong>Fasting glucose (mmol/l)</strong></td>
<td>6.1±0.6</td>
<td>6.2±0.6</td>
<td>0.4794</td>
</tr>
<tr>
<td><strong>Post OGTT glucose (mmol/l)</strong></td>
<td>8.5±2.0</td>
<td>8.2±2.0</td>
<td>0.4741</td>
</tr>
<tr>
<td><strong>HbA1c (%)</strong></td>
<td>5.8±0.4</td>
<td>5.8±0.4</td>
<td>0.6544</td>
</tr>
<tr>
<td><strong>Fasting insulin (pmol/ml)</strong>*</td>
<td>71.0±10.0</td>
<td>68.2±10.0</td>
<td>0.5555</td>
</tr>
<tr>
<td><strong>Post OGTT insulin (pmol/ml)</strong>*</td>
<td>307.0±13.6</td>
<td>299.9±15.1</td>
<td>0.9009</td>
</tr>
<tr>
<td><strong>HOMA index</strong>*</td>
<td>2.7±1.4</td>
<td>2.6±1.4</td>
<td>0.7126</td>
</tr>
<tr>
<td><strong>Total cholesterol (mmol/l)</strong></td>
<td>5.3±1.0</td>
<td>5.3±0.9</td>
<td>0.9493</td>
</tr>
<tr>
<td><strong>Triglyceride (mmol/l)</strong>*</td>
<td>2.0±0.0</td>
<td>1.2±0.3</td>
<td>0.6295</td>
</tr>
<tr>
<td><strong>HDL cholesterol (mmol/l)</strong></td>
<td>2.9±1.0</td>
<td>3.0±0.7</td>
<td>0.5795</td>
</tr>
<tr>
<td><strong>hsCRP (mg/dl)</strong>*</td>
<td>0.12±2.0</td>
<td>0.16±2.32</td>
<td>0.1416</td>
</tr>
<tr>
<td><strong>Serum adiponectin (μg/ml)</strong>*</td>
<td>1.99±2.21</td>
<td>2.71±2.17</td>
<td>0.0750</td>
</tr>
<tr>
<td><strong>Resistin (ng/ml)</strong>*</td>
<td>1.36±5.01</td>
<td>2.50±3.32</td>
<td>0.0517</td>
</tr>
<tr>
<td><strong>baPWV (cm/s)</strong></td>
<td>1437.0±227.1</td>
<td>1478.2±254.6</td>
<td>0.4350</td>
</tr>
</tbody>
</table>

† P values are by Student's t-test or Fisher's exact test (for β-blocker and Fibrate).

Table 2 Changes of anthropometric and metabolic parameters from baseline to week 12 in the rosiglitazone and control groups. *Geometric mean and s.d. values are given.

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th>Rosiglitazone</th>
<th>P value§</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BMI (kg/m²)</strong></td>
<td>26.1±2.8</td>
<td>25.9±2.7</td>
<td>0.5454</td>
</tr>
<tr>
<td><strong>Weight (kg)</strong></td>
<td>68.4±9.9</td>
<td>67.9±9.7</td>
<td>0.3851</td>
</tr>
<tr>
<td><strong>Systolic blood pressure (mmHg)</strong></td>
<td>127.8±11.4</td>
<td>125.9±12.8</td>
<td>0.1422</td>
</tr>
<tr>
<td><strong>Diastolic blood pressure (mmHg)</strong></td>
<td>82.2±10.9</td>
<td>81.6±11.3</td>
<td>0.0549</td>
</tr>
<tr>
<td><strong>Fasting glucose (mmol/l)</strong></td>
<td>6.1±0.6</td>
<td>6.4±0.7</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td><strong>Post OGTT glucose (mmol/l)</strong></td>
<td>8.5±2.0</td>
<td>8.4±2.5</td>
<td>0.2377</td>
</tr>
<tr>
<td><strong>HbA1c (%)</strong></td>
<td>5.8±0.4</td>
<td>5.7±0.3</td>
<td>0.6589</td>
</tr>
<tr>
<td><strong>Fasting insulin (pmol/ml)</strong>*</td>
<td>71.0±10.0</td>
<td>85.4±10.0</td>
<td>0.0738</td>
</tr>
<tr>
<td><strong>Post OGTT insulin (pmol/ml)</strong>*</td>
<td>307.0±13.6</td>
<td>304.2±13.6</td>
<td>0.1210</td>
</tr>
<tr>
<td><strong>HOMA index</strong>*</td>
<td>2.7±1.4</td>
<td>3.3±1.4</td>
<td>0.0095</td>
</tr>
<tr>
<td><strong>Total cholesterol (mmol/l)</strong></td>
<td>5.3±1.0</td>
<td>5.1±1.1</td>
<td>0.6132</td>
</tr>
<tr>
<td><strong>Triglyceride (mmol/l)</strong>*</td>
<td>2.0±0.0</td>
<td>1.6±0.0</td>
<td>0.5910</td>
</tr>
<tr>
<td><strong>HDL cholesterol (mmol/l)</strong></td>
<td>1.1±0.3</td>
<td>1.2±0.3</td>
<td>0.6655</td>
</tr>
<tr>
<td><strong>LDL cholesterol (mmol/l)</strong></td>
<td>2.9±1.0</td>
<td>2.9±1.0</td>
<td>0.7821</td>
</tr>
</tbody>
</table>

† Significant changes from baseline to week 12 are indicated by *P < 0.05, **P < 0.01 and ***P < 0.001 (paired t-test).

§ P values were obtained using Student's t-test based on changes between baseline and week 12 in each group.

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marker (12) and a prognostic predictor of atherosclerosis (13). On the other hand, baPWV is a newly developed device that uses a volume-rendering method. This instrument determines baPWV with simultaneous oscillometric measurement of pulse waves in all four extremities in a short period of time (24). Values of baPWV correlated well with values of aortic PWV (23) and, furthermore, flow-mediated dilation of brachial artery, carotid IMT, and baPWV and heart-carotid PWV were also significantly related to each other (25). Recently, Koji et al. (26) reported that baPWV had a negative predictive value for the presence of coronary artery disease, and suggested that baPWV is a marker of early stage atherosclerosis. Importantly, their results indicate that increased arterial stiffness occurs before the clinical manifestations of atherosclerotic cardiovascular diseases.

The present study demonstrates, for the first time, that the TZD rosiglitazone significantly reduces PWV in non-diabetics. The results of a recent study (27) that investigated the effects of non-TZDs on PWV in African-American subjects with insulin resistance and a normal glucose tolerance test were reported. Interestingly, the effect of non-TZDs on PWV in non-diabetics was the exact reverse of ours. In this study (27), a significant increase in PWV was observed in both glipizide- and metformin-treated groups during the follow-up period. Compared with these observations, the

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**Table 3** Multiple regression analysis using the changes of adiponectin or baPWV as dependent variables.

<table>
<thead>
<tr>
<th>Independent variables</th>
<th>Change in adiponectin</th>
<th>Change in baPWV</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>β</td>
<td>s.e.</td>
</tr>
<tr>
<td>Treatment</td>
<td>4.956</td>
<td>0.682</td>
</tr>
<tr>
<td>Change in triglyceride</td>
<td>-0.006</td>
<td>0.002</td>
</tr>
<tr>
<td>Age</td>
<td>0.060</td>
<td>0.030</td>
</tr>
<tr>
<td>Change in HOMA</td>
<td>0.548</td>
<td>0.293</td>
</tr>
<tr>
<td>Change in diastolic blood pressure</td>
<td>0.739</td>
<td>0.428</td>
</tr>
</tbody>
</table>

* All variables left in the model are significant at the 0.1500 level.

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Figure 1 Changes of various atherosclerotic parameters between baseline and week 12 in the rosiglitazone and control groups. *Geometric mean and s.e.m. are given. §P values were obtained using Student’s t-test based on changes between baseline and week 12 in each group.
observed favorable effect of rosiglitazone on PWV in non-diabetics is promising.

During rosiglitazone treatment, no reduction in HOMA was observed, whereas HOMA increased in the control group. We do not know exactly why this somewhat unexpected finding was observed. One possible explanation is that TZDs may mainly act on postprandial insulin sensitivity in prediabetes or non-diabetic MetS in Koreans. Actually, post-OGTT insulin levels were also significantly decreased in the rosiglitazone group compared with the control group. Another possible explanation is the short-term treatment of relatively low doses of rosiglitazone. According to Raskin et al. (28), rosiglitazone monotherapy (2 mg twice daily) for 8 weeks did not reduce plasma insulin concentrations compared with placebo in T2DM (28). In the present study, rosiglitazone-treated subjects showed a small decrease in fasting blood glucose (3.9% from baseline) without a reduction in HbA1c levels. Moreover, changes in PWV were not associated with changes in glucose level or HOMA by multiple regression analysis. In addition, lipid profiles were unchanged in the rosiglitazone group, whereas serum triglyceride levels were significantly reduced in the control group. These results, which contradict previous findings in the literature, are probably because of the encouragement of patients to adhere to a low cholesterol diet throughout the study.

The data presented here suggest that the observed reduction in PWV in the rosiglitazone group may have resulted from additional effects of rosiglitazone beyond metabolic control. A possible explanation for the observed PWV change might be that rosiglitazone directly affects PPAR-γ activation in the vascular wall. Much evidence favors the direct vascular effects of PPAR-γ agonists on atherosclerosis. PPAR-γ is expressed in endothelial cells, VSMCs, macrophages, and T cells, and it may have various anti-atherogenic properties in the vascular wall. Several studies have suggested that TZDs enhance vasorelaxation in vascular smooth muscle (29, 30). Recently, Hetzel et al. (31) found that short-term treatment (21 days) of rosiglitazone in healthy subjects significantly improved vascular endothelial function without changes in blood glucose level, lipid profile, and HOMA. In our study, systolic and diastolic blood pressures were found to be significantly reduced in the rosiglitazone group; this is compatible with results obtained in non-diabetic hypertensive patients (32). Summarizing the results of these studies (29–31) with those of the present study, it is postulated that the observed PWV change is mediated primarily by the direct action of rosiglitazone on the vascular wall.

Little information is available concerning the effects of TZDs on plasma adiponectin levels in non-diabetics, and even where data were not obtained in a randomized manner (33, 34). In the present study, rosiglitazone treatment markedly increased circulating adiponectin levels by 160% (P < 0.001), whereas no change was observed in the control group (P = 0.21). This increment in adiponectin levels is similar in magnitude to that observed in T2DM (17). Yang et al. (17) observed an increase in plasma adiponectin along with weight gain after rosiglitazone treatment in T2DM. Unlike reports in T2DM including those of Yang et al. (17), rosiglitazone treatment showed no evidence of weight gain in the present study, and it was not different from results observed in non-diabetics (8, 9). In view of adiponectin’s likely favorable effect on atherosclerosis, our findings suggest that rosiglitazone may have had an anti-atherogenic effect in subjects with prediabetes or non-diabetic MetS. In addition to favorable changes in adiponectin levels, hsCRP levels were significantly reduced by rosiglitazone. The mean reduction in CRP of 43% due to rosiglitazone treatment in this study was of the same order of magnitude as the reduction achieved by high dose statin (40 mg atorvastatin) in subjects with impaired fasting glucose (35).

Resistin is a newly discovered adipocytokine. Initial studies in rodents have suggested that circulating resistin levels are markedly elevated in obese mice, and that these are reduced by rosiglitazone (36). However, human resistin shares only 64% homology with murine resistin and is expressed at very low levels in adipocytes (37). Numerous epidemiological studies in humans have failed to provide a clear and consistent link between resistin expression in adipose tissue or circulating resistin levels and adiposity or insulin resistance (37). Contrary to these reports, Reilly et al. (38) suggested that resistin may represent a novel link between metabolic signals, inflammation, and atherosclerosis. Although it has been reported that TZDs reduce plasma resistin levels in T2DM patients (39), no report is available concerning their effects in non-diabetics. In the present study, plasma resistin levels were found to be unchanged by rosiglitazone. Thus, the role of resistin in atherosclerosis and the relationship between TZD and resistin levels require further study.

Several limitations of our study must be acknowledged. First, the study was not performed in a double-blind placebo-controlled fashion. Thus, it is possible that the rosiglitazone group had more intensive lifestyle changes than the control group, which could have exaggerated the favorable effect of rosiglitazone. However, post-hoc analysis revealed no significantly different lifestyle changes between the groups (data not shown). Second, our study was performed using a small number of subjects over a short period of time. Whether the observed favorable effects of rosiglitazone on various surrogate markers of atherosclerosis in non-diabetics translate into actual benefits in terms of cardiovascular morbidity and mortality must await further investigation.

In conclusion, this study has clearly demonstrated that rosiglitazone treatment for 12 weeks leads to favorable effects on plasma adiponectin, hsCRP, and baPWV in subjects with prediabetes or non-diabetic MetS. Thus
the present findings suggest that rosiglitazone has a vasoprotective effect in these two subpopulations.

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