Effects of rosiglitazone on fasting plasma fibroblast growth factor-21 levels in patients with type 2 diabetes mellitus

Ke Li*, Ling Li1,*, Mengliu Yang, Haihong Zong2, Hua Liu3 and Gangyi Yang

Department of Endocrinology, the Second Affiliated Hospital, Chongqing Medical University, 400010 Chongqing, People’s Republic of China, 1The Key Laboratory of Laboratory Medical Diagnostics in the Ministry of Education and Department of Clinical Biochemistry, Chongqing Medical University, 400016 Chongqing, People’s Republic of China, 2Department of Medicine/Endocrinology, Albert Einstein College of Medicine, 1301 Morris Park Avenue, Bronx, New York 10461, USA and 3Department of Pediatrics, University of Mississippi Medical Center, 2500 North State Street, Jackson, Mississippi 39216-4505, USA

(Correspondence should be addressed to G Y Yang; Email: gangyiyang@yahoo.com.cn)

*(L Li and K Li contributed equally to this work)

Abstract

Objective: Fibroblast growth factor-21 (FGF-21) has recently been characterized as a potent metabolic regulator, but its pathophysiologic roles in humans remain unknown. This study aimed to investigate the effects of rosiglitazone on plasma FGF-21 levels in patients with type 2 diabetes mellitus (T2DM).

Design and methods: Thirty patients with new-onset T2DM (nT2DM), 34 type 2 diabetic patients with poor glycemic control (pT2DM) after the treatment with single hypoglycemic agent metformin, and 30 sex- and age-matched normal glycaemic controls (NGT) participated in the study. The pT2DM group was treated with rosiglitazone for 12 weeks. Plasma FGF-21 levels were measured with a RIA. The relationship between plasma FGF-21 levels and metabolic parameters was also analyzed.

Results: Fasting plasma FGF-21 levels were higher in nT2DM and pT2DM groups than in the control (1.81 \pm 0.64 vs 1.87 \pm 0.63 vs 1.52 \pm 0.61 \mu g/l, P < 0.05), but there was no difference between nT2DM and pT2DM groups. Fasting plasma FGF-21 levels were decreased significantly in pT2DM group after the treatment with rosiglitazone compared with pre-treatment (1.59 \pm 0.63 vs 1.87 \pm 0.64 \mu g/l, P < 0.05). In all diabetic patients, multiple regression analysis showed that HbA1c, fasting insulin, and homeostasis model assessment-insulin resistance index were independently associated with plasma FGF-21 levels.

Conclusions: In pT2DM patients, plasma FGF-21 levels are increased, but significantly decreased after the treatment with rosiglitazone on top of ongoing metformin therapy. These data suggest that rosiglitazone may play a role in lowering FGF-21 levels in T2DM patients.

European Journal of Endocrinology 161 391–395

Introduction

Impaired insulin-stimulated glucose turnover in insulin-dependent peripheral tissues such as liver, muscle, and adipocytes is a major characteristic of type 2 diabetes. Fibroblast growth factor-21 (FGF-21) is a liver-derived endocrine factor that influences insulin sensitivity in adipocytes and whole-body glucose homeostasis in animal models (1). A recent report has shown that FGF-21 is a potent activator of glucose transport in mouse adipocytes, and its glucose-lowering effect was through an insulin-independent mechanism (2). Mice with over-expression of FGF-21 were protected from diet-induced obesity (2). Zhang et al. observed that serum FGF-21 levels in overweight/obese Chinese subjects were higher than in lean Chinese individuals, and that the FGF-21 levels correlated positively with adiposity as well as fasting insulin (FINS) and triglycerides (TGs) (3). The authors speculated that the increased serum FGF-21 levels in obese individuals could be a result of compensatory responses or resistance to FGF-21 actions. The anti-diabetic effects of FGF-21 and its regulatory mechanism in humans remain unknown despite the research efforts done in animals.

Rosiglitazone, an agonist of the peroxisome proliferators-activated receptor-\(\gamma\) (PPAR-\(\gamma\)), regulates the expression of genes controlling glucose homeostasis and lipid metabolism. Rosiglitazone has been widely used as a pharmacological agent in clinic to alleviate peripheral insulin resistance (IR) and enhance glucose transport in adipose tissue (4, 5). Previous studies have suggested a functional interplay between FGF-21 and PPAR-\(\gamma\)-signaling pathways (6, 7). Muise et al. reported that circulating levels of FGF21 protein were increased in db/db mice treated with the PPAR-\(\gamma\) agonists (8).

Since the role of FGF21 in human physiology is unknown, it is important to characterize the effect of
common anti-diabetic treatment on the plasma levels of FGF21. Since monotherapy with rosiglitazone has limited effect on plasma glucose, the metformin was combined to control the high plasma glucose level. We present here a cross-sectional study of FGF-21 levels in different populations as well as the effects of rosiglitazone on the plasma FGF-21 levels in patients with type 2 diabetes.

Patients and methods

Subjects

Ninety-four Chinese volunteers were involved in this study and categorized into three groups. The first group comprised of 30 otherwise healthy individuals except the diagnosis of new-onset type 2 diabetes mellitus (nT2DM). The diagnostic criteria of type 2 diabetes were based on a 75 g oral glucose tolerance test (OGTT) recommended by World Health Organization criteria (9). These patients had not undertaken any diabetic medications/diet prior to the present study.

The second group of 34 patients was type 2 diabetes patients with poor glycemic control (pT2DM) even after the treatment with metformin. The selection criteria included: 1) 40–70 years of age without the presence of major diabetic complications and major organ diseases; 2) fasting blood glucose levels between 7.0 and 13.9 mmol/l after more than 3 months of treatment with metformin; and 3) body mass index (BMI) within the range of 20–30 kg/m².

Thirty healthy volunteers who responded to our advertisement and age- and BMI-matched with the diabetic group, were chosen as the normal glycemic control group (NGT). Their non-diabetic statuses were confirmed with a normal OGTT.

This study was carried out in accordance with the recommendations of the Declaration of Helsinki. The study was approved by the Human Research Ethics Committee of Chongqing Medical University. An informed consent was obtained from all participants in this study.

Study design

Rosiglitazone (4 mg/day) was added to the previous metformin regimen in patients of pT2DM group throughout the 12-week period of study. No change in medication and dosages was made during the study. No subject dropped out of the study. The NGT control and the nT2DM group did not receive any medication.

Plasma biochemical parameters and FGF-21

Blood samples were taken before and after the 12 weeks of treatment for the measurements of metabolic parameters and plasma FGF-21 levels. Typically, blood samples were collected either after an overnight fast or 2 h after a 75 g OGTT. Plasma samples were collected by centrifugation at 4 °C and kept at −80 °C for further use.

Plasma FGF-21 levels were determined by RIA (Phoenix Pharmaceuticals, Inc., Belmont, CA, USA) using 125I-labeled FGF-21 as tracer. The linear range of the assay was 0.5–5.0 μg/l, and the standard range was 0.234–30 μg/l. The inter- and intra-assay coefficients of variation were 4.9 and 13% respectively. Insulin was measured in deproteinized serum by RIA using human insulin as standards (Linco, St Charles, MO, USA). Free fatty acids (FFA) were measured with a commercial assay kit (Randox Laboratories Ltd, Antrim, UK). Plasma glucose was assayed using the glucose oxidase method. HbA1c was measured by isoelectric focusing. TG, cholesterol, high-density lipoprotein (HDL), and low-density lipoprotein (LDL) concentrations were determined enzymatically. Percent body fat was determined by bioelectrical impedance analysis (Tanita, Inc., Tokyo, Japan). The homeostasis model assessment of IR (HOMA-IR) and the HOMA of β-cell insulin secretion (HOMA-IS) were calculated from FINS and glucose levels using the following equations:

\[
\text{HOMA} - IR = \text{fasting insulin} (\text{mU/l}) \\
\times \text{fasting blood glucose} (\text{mmol/l}) / 22.5;
\]

\[
\text{HOMA} - IS = (20 \times \text{fasting insulin} (\text{mU/l})) / (\text{fasting blood glucose} (\text{mmol/l}) - 3.5)
\]

(Matthews et al. 1985).

Statistical analysis

Statistical analyses were performed using the SAS 8.0 software (SAS Inc., Cary, NC, USA). Since the distributions of plasma insulin, TG, HOMA-IR, and HOMR-IS values were skewed, logarithmically transformed values were used for statistical analysis. Baseline characteristics of case and control subjects were compared by t-test or ANOVA. The paired t-test was used to compare differences in biochemical characteristics and FGF-21 levels between pre- and post-treatment with rosiglitazone in pT2DM group. One-way ANOVA and Tukey’s honestly significant difference post hoc test were performed to test the changes between the groups. Bivariate correlation and multiple regression analyses were used to examine the association between fasting plasma FGF-21 levels and the values of other biomarkers. All of the statistical analyses were two-sided, and all data are presented as means ± S.D. or medians (interquartile ranges) with a P value <0.05 considered statistically significant.
Results

The clinical characteristics and fasting plasma FGF-21 levels

The clinical characteristics of the three groups did not show significant difference in gender distribution, age, BMI, waist-to-hip ratio (WHR), percent body fat, systolic, and diastolic blood pressure (Table 1). The fasting levels of TG, HDL, LDL, FFA, and post-prandial insulin (PINS) are comparable between the groups. The pT2DM group has higher total cholesterol (TC) than the other two groups ($P<0.05$). Both pT2DM and nT2DM groups had significantly higher fasting blood glucose, 2-h post-prandial blood glucose (2hPBG), FINS, HbA1c, HOMA-IR, and fasting plasma FGF-21 levels, but lower HOMA-IS than the NGT group. The fasting blood glucose, 2hPBG, and HbA1c in nT2DM group were significantly higher than in pT2DM group. There was no significant difference in FINS, HOMA-IR, HOMA-IS, and fasting plasma FGF-21 levels between the pT2DM and nT2DM groups.

Relationship between fasting plasma FGF-21 levels and metabolic parameters

In NGT group, fasting plasma FGF-21 levels correlated positively with BMI ($r=0.39$, $P=0.031$) in simple regression analysis, while in multiple stepwise regression analysis, BMI was independently related to plasma FGF-21 levels. The multiple regression equation was: $Y_{FGF-21} = -0.602 + 0.088X_{BMI}$. In all diabetes patients, gender, age, BMI, WHR, TG, TC, LDL, HDL-C, FFA, FINS, HbA1c, BP, FINS, PINS, HOMA-IR, and HOMA-IS were included in the multiple regression. Multiple regression analyses with backward exclusion showed that HbA1c, FINS, and HOMA-IR were independently related to fasting plasma FGF-21 levels. The multiple regression equation was

$$Y_{FGF-21} = 3.012 - 0.242X_{HbA1c} - 0.101X_{FINS} + 1.273X_{HOMA-IR}.$$  

The effects of rosiglitazone on clinical characteristics and FGF-21 levels in pT2DM group

To examine the effect of rosiglitazone on type 2 diabetes, we added rosiglitazone to the metformin regimen in pT2DM group. After 12 weeks treatment with rosiglitazone and metformin, HbA1c, FBG, 2hPBG, FINS, and HOMA-IR in pT2DM patients were significantly declined (Table 2). Interestingly, fasting plasma FGF-21 levels were also significantly decreased (1.59 ± 0.63 vs 1.87 ± 0.64 µg/l, $P<0.05$). There was no significant change in BMI, percent body fat, and HOMA-IS, while

Table 1 Clinical characteristics and fibroblast growth factor-21 (FGF-21) levels of study subjects.

<table>
<thead>
<tr>
<th>Group</th>
<th>pT2DM</th>
<th>nT2DM</th>
<th>NGT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (M:F)</td>
<td>11:23</td>
<td>12:18</td>
<td>11:19</td>
</tr>
<tr>
<td>Age (years)</td>
<td>57.26±8.56</td>
<td>58.20±6.80</td>
<td>57.93±6.46</td>
</tr>
<tr>
<td>Disease duration (years)</td>
<td>4.6±0.30</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
<td>25.15±2.95</td>
<td>24.18±2.78</td>
<td>23.94±2.55</td>
</tr>
<tr>
<td>WHR</td>
<td>0.87±0.05</td>
<td>0.89±0.08</td>
<td>0.87±0.05</td>
</tr>
<tr>
<td>Body fat (%)</td>
<td>32.48±6.62</td>
<td>31.93±7.89</td>
<td>28.60±7.54</td>
</tr>
<tr>
<td>SBP (mmHg)</td>
<td>124.77±10.9</td>
<td>125.63±19.76</td>
<td>117.47±9.35</td>
</tr>
<tr>
<td>DBP (mmHg)</td>
<td>75.21±6.79</td>
<td>78.10±10.34</td>
<td>73.60±6.58</td>
</tr>
<tr>
<td>TG (mmol/l)</td>
<td>1.69 (0.67–5.81)</td>
<td>1.33 (0.45–4.03)</td>
<td>1.07 (0.60–4.11)</td>
</tr>
<tr>
<td>TC (mmol/l)</td>
<td>5.12±0.87*†</td>
<td>5.46±0.80</td>
<td>4.21±1.06</td>
</tr>
<tr>
<td>HDL (mmol/l)</td>
<td>1.30±0.32</td>
<td>1.24±0.27</td>
<td>1.21±0.42</td>
</tr>
<tr>
<td>LDL (mmol/l)</td>
<td>2.88±0.73</td>
<td>2.66±0.63</td>
<td>2.52±0.77</td>
</tr>
<tr>
<td>FFA (µmol/l)</td>
<td>0.69±0.27</td>
<td>0.70±0.27</td>
<td>0.59±0.18</td>
</tr>
<tr>
<td>HbA1c (%)</td>
<td>6.77±1.16*†</td>
<td>8.39±2.48*</td>
<td>5.42±0.38</td>
</tr>
<tr>
<td>FFBG (mmol/l)</td>
<td>7.99±1.25*†</td>
<td>9.85±4.11*</td>
<td>5.36±0.47</td>
</tr>
<tr>
<td>2hPBG (mmol/l)</td>
<td>14.02±3.75*†</td>
<td>18.51±7.81*</td>
<td>6.02±0.91</td>
</tr>
<tr>
<td>FINS (µU/l)</td>
<td>10.77 (5.84–37.80)*</td>
<td>8.91 (6.17–29.45)*</td>
<td>9.89 (3.07–24.74)</td>
</tr>
<tr>
<td>PINS (µU/l)</td>
<td>36.13 (11.26–122.28)</td>
<td>26.16 (8.77–98.88)</td>
<td>35.01 (16.13–86.20)</td>
</tr>
<tr>
<td>HOMA-IR</td>
<td>4.08 (1.77–13.67)*</td>
<td>4.39 (2.14–13.28)*</td>
<td>2.26 (0.79–6.03)</td>
</tr>
<tr>
<td>HOMA-IS</td>
<td>50.54 (22.82–162.92)*</td>
<td>42.46 (11.07–236.57)*</td>
<td>112.64 (26.71–249.90)</td>
</tr>
<tr>
<td>FGF-21 (µg/l)</td>
<td>1.87±0.64*</td>
<td>1.81±0.63*</td>
<td>1.52±0.61</td>
</tr>
<tr>
<td>ACE inhibitors</td>
<td>3</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>β-Blockers</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Diuretics</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Statins</td>
<td>5</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Fibrates</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Data are means ± s.d. or medians (interquartile ranges) versus NGT group *$P<0.05$; T2DM group versus nT2DM group †$P<0.05$. pT2DM, type 2 diabetes mellitus with poor glycemic control; nT2DM, new-onset type 2 diabetes mellitus; NGT, normal glycaemic control; BMI, body mass index; WHR, waist-to-hip ratio; SBP, systolic blood pressure; DBP, diastolic blood pressure; TG, total triglyceride; TC, total cholesterol; HDL, high-density lipoprotein; LDL, low-density lipoprotein; FFA, free fatty acids; FFBG, fasting blood glucose; 2hPBG, 2-h post-prandial blood glucose; FINS, fasting insulin; PINS, 2-h post-prandial insulin; HOMA-IR, HOMA-insulin resistance index; HOMA-IS, HOMA-β-cell insulin secretion index; FGF-21, fibroblast growth factor-21.
Data are means ± s.d. or medians (interquartile ranges) versus pre-treatment *P<0.05. Pre-treatment, pre-treatment with rosiglitazone; post-treatment, post-treatment with rosiglitazone; BMI, body mass index; WHR, waist-to-hip ratio; SBP, systolic blood pressure; DBP, diastolic blood pressure; TG, total triglyceride; TC, total cholesterol; HDL, high-density lipoprotein; LDL, low-density lipoprotein; FFA, free fatty acids; FBG, fasting blood glucose; 2hPBG, 2-h post-prandial blood glucose; FINS, fasting insulin; PINS, 2-h post-prandial insulin; HOMA-IR, HOMA-insulin resistance index; HOMA-IS, HOMA-β-cell insulin secretion index; FGF-21, fibroblast growth factor-21.
Declaration of interest
The authors have nothing to disclose.

Funding
This work was supported by research grants from the National Natural Science Foundation of China (30871199 and 30771037), Chongqing Municipal Education Commission (KJ050304), and Chongqing Medical University (XBZD200704).

References
6 Wang H, Quang L & Farmer SR. Identification of a domain within peroxisome proliferator-activated receptor gamma regulating expression of a group of genes containing fibroblast growth factor 21 that are selectively repressed by SIRT1 in adipocytes. Molecular and Cellular Biology 2008 28 188–200.