Association of variants in gastric inhibitory polypeptide receptor gene with impaired glucose homeostasis in obese children and adolescents from Berlin

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Abstract

Objective: In the past 20 years, obesity has become a major health problem due to associated diseases like type 2 diabetes mellitus. The gastric inhibitory polypeptide receptor (GIPR) modulates body weight and glucose homeostasis and, therefore, represents an interesting candidate gene for obesity and the comorbidity impaired glucose homeostasis. Recently, a GIPR variation was found to be associated with impaired insulin response in humans.

In this study, we screened the GIPR gene for mutations and examined the association between three single-nucleotide polymorphisms (SNPs; rs8111428, rs2302382, rs1800437) and childhood obesity, as well as impaired glucose homeostasis.

Methods: The coding region of the GIPR was screened for mutations by direct sequencing. We genotyped three known SNPs in 2280 healthy normal weight (1696) and obese (584) children and adolescents. Genotyping was performed using the SNaPshot protocol, the iplex, and matrix-assisted laser desorption ionization time-of-flight spectrometry technique. Obesity was defined by a body mass index SDS above 2; homeostatic model assessment was calculated.

Results: No evidence for an association was found between the SNPs and the obesity phenotype. Significant association was found between the minor allele C of the SNP rs1800437 and elevated homeostasis model of insulin resistance values (P ≤ 0.001). No further sequence variations in the GIPR were found to be associated with childhood obesity.

Conclusion: Variations of the GIPR sequence are not associated with childhood obesity. This study points to a potential role for rs1800437 in glucose homeostasis. Further studies are necessary to confirm these results.

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Introduction

The gastric inhibitory polypeptide (GIP) is a 42-amino acid incretin released from endocrine K cells of the duodenum and the small intestine after oral glucose uptake (1, 2). Binding to its GIP receptor (GIPR), mainly expressed on the pancreatic β-cells (3, 4), it induces an activation of these cells with an increase in insulin release after meals. GIPR is a member of the G-protein-coupled receptor (GPCR) superfamily, and acts through the activation of adenylyl cyclase (5).

Gipr knockout studies show that GIPR⁻⁻⁻⁻ mice are resistant to diet-induced obesity (3, 6), and show improved insulin sensitivity in aged GIPR⁻⁻⁻⁻ mice compared with wild-type mice (4). High-fat diet-induced obese mice, treated with a GIP antagonist, present a reduction in body weight, triglyceride, and cholesterol levels and an improvement of insulin sensitivity (7). Furthermore, double knockout mice for GIPR and leptin are also resistant to diet-induced obesity (3). Recent studies showed, as well, that vaccination against GIP in mice has a preventive effect for the development of obesity (8). Along with a second incretin glucagon-like peptide 1 (GLP-1), the signaling pathway of GIP represents a target for pharmacological therapies for type II diabetes mellitus as shown in initial studies in mice (9). The role of GIPR single-nucleotide polymorphisms (SNPs) on the glucose and insulin homeostasis was recently shown by identifying a GIPR variant associated with lower 2-h insulin levels in non-diabetic patients (10).

Different association studies of SNPs in the GIPR have been reported so far albeit varying effects of these SNPs were found in association with obese phenotypes in adults (11, 12). Based on the assumption, that in
children the genetic impact on obesity and its comorbidities is higher, we investigated whether two intronic SNPs (rs8111428 and rs2302382), and the exonic rs1800347 (Glu354Gln) of GIPR are associated with severe obesity and elevated homeostasis model assessment values for insulin resistance (HOMA-IR) in children.

Sequencing of GIPR was performed to detect other possible variations within GIPR that might be associated with childhood obesity and impaired glucose homeostasis.

Materials and methods

Study population

We examined 2280 children and adolescents aged 2.5–18 years from Berlin. They were either recruited from the obesity outpatient clinic of the ‘Sozialpädiatrisches Zentrum’ at the Otto-Heubner-Centrum for pediatrics, Charité Berlin (n = 657) or from schools as part of the Berlin school children’s cohort (BSCOC) conducted at the Institute of Experimental Pediatric Endocrinology at the Charité Berlin (n = 1623) (13). No information on the degree of kinship was available for the girls of BSCOC. About 46% of all recruited children and adolescents had a migratory background with one or both parents not being German. Information on the ethnic background was used to assess whether ethnic differences occurred between the allele frequencies for the three analyzed SNPs. As these analyses provided no evidence for differences in genotypes by self-reported migration background (data not shown), we decided to analyze all data jointly. The purpose of recruiting children was to increase the genetic impact on obesity development, since the time of environmental impact on obesity is reduced compared with adults. To analyze the association between childhood obesity and the SNPs rs8111428, rs2302382, and rs1800347 in and nearby GIPR (Fig. 1), 1696 normal weight or lean and 584 obese children were genotyped. HOMA-IR values were available for a total of 357 of the obese children; among them, sequencing of all 14 exons of GIPR was performed for 87 children to detect further variations that might be associated with obesity.

All patients or their parents gave informed consent. Children with endocrine disorders or syndromal obesity were excluded from the study.

Anthropometric and laboratory measurements

We examined body weight and body height in 2280 children, clothed in underwear. Body weight was assessed in grams and height in centimeters. The body mass index (BMI)-SDS were calculated using the data from Kromeyer-Hauschild et al. (14). Obesity in childhood and adolescence was defined as BMI-SDS > 2, which corresponds to the 97.7th gender- and age-adjusted BMI percentile for children (15). This corresponds to the cut-off point proposed by the Childhood Group of the International Obesity Task Force (IOTF) as definition of obesity in children (16). In the analyses, dichotomized BMI-SDS was used as outcome variable.

SDS values give a better feasibility of comparison of highly obese children and adolescents (17).

Fasting serum was used for insulin and glucose assessment using commercially available assays. The HOMA-IR was calculated as HOMA = insulin × glucose/22.5 (mmol/l) (18). The 95th HOMA-IR percentile as estimated by Allard et al. (18) was used to dichotomized HOMA-IR for the analyses (18).

Table 1 summarizes the anthropometric data of the association study population (total sample), and Table 2 summarizes the anthropometric data of the obese children explored in the sequencing study.

SNP analysis and sequencing of GIPR

DNA was extracted and purified from EDTA blood using a DNA-extracting procedure from Qiagen, or extracted and purified from chewed chewing gum as DNA source using the extracting procedure from Promega.

The GIPR genotype information was downloaded from the International HapMap Project (Build 36.2; www.hapmap.org) according to which, all three SNPs had a minor allele frequency larger than 5% in the CEU (Utah residents with Northern and Western European ancestry from the CEPH collection) population.

Subjects were either genotyped using the SNaPshot technique from Applied Biosystems (Darmstadt, Germany), or using the matrix-assisted laser desorption ionization time-of-flight spectrometry (MALDI-TOF) from Sequenom (Hamburg, Germany). The calling rate was 98.8% for rs8111428, 98.3% for rs2302382, and 97.4% for rs1800437. PCR was done for the 14 exons and the intron/exon boundaries, using primers assessed by Primer3 (19). GIPR was sequenced using an ABI 3130xl capillary DNA sequencer (Applied Biosystems).

Except for rs1800437, no evidence for deviations from Hardy–Weinberg equilibrium (HWE) was detected (all P > 0.10). However, we observed evidence for deviations from HWE from rs1800437 in the obese
children \((P=0.03)\) and in both HOMA-IR groups \((P=0.05 \text{ and } P=0.005)\). Most likely, these deviations also indicate the genetic association with HOMA-IR, which we observed.

**Statistical analysis**

All statistical analyses were performed using the SPSS 17 program (Munchen, Germany). All genotype distributions were explored for deviations from HWE using an exact test. The dichotomized BMI-SDS and the HOMA-IR data were also analyzed by an exact version of Pearson’s \(\chi^2\) test for \(2 \times 3\) tables. The significance level of each test was set to \(\alpha=0.05\) (two-sided). We applied no correction for multiple testing, and all \(P\) values reported are two-sided.

**Results**

We analyzed the association of genetic variants in the GIPR with childhood obesity and dichotomized HOMA-IR. No evidence for an association could be found between obesity and the three analyzed SNPs rs8111428, rs2302382, and rs1800437. Though, we observed that the A-allele of the SNP rs2302382 was descriptively more often present in obese children than in normal weight or lean children (Table 3).

However, evidence for an association was found between the minor allele C of the SNP rs1800437 and increased dichotomized HOMA-IR values (odds ratio estimate \(\hat{OR}_{CC \text{ versus } CG\&G\&} = 5.48\); exact 95% confidence interval 1.73...22.80; \(P=0.001\); Table 4).

For sensitivity analyses, we performed stratified analyses by ethnicity and gender. We observed no large impact on the reported genetic association with obesity and dichotomized HOMA-IR (data not shown). Independent of genotype, however, we were able to replicate the known higher frequency of obesity in German children of Arabian and the Turkish ethnicity \((20, 21)\) when compared with children of German ethnicity. This difference in obesity prevalence was also observable for HOMA-IR. For 357 of the children and adolescents, a HOMA-IR value was assessed with 47.1% of the children having a HOMA-IR value above the 95th percentile according to Allard et al.; a total of 74.5% of the children with HOMA-IR values below the 95th percentile were of German origin, whereas only 59.2% of the children above the 95th percentile were of German origin. Nevertheless, the ethnical mixture of the population studied does not seem to bias the results as no significant differences between the allele frequencies could be detected for the three SNPs analyzed in the HOMA-IR study in children and adolescents of German and Turkish origin. Furthermore, all children, for whom HOMA-IR values were assessed, were obese, regardless of their ethnicity. Unfortunately, it was only possible to achieve meaningful evaluations for German and Turkish children and adolescents because the sample number was too low for the other ethnical groups. In the HOMA-IR study group, the German children and adolescents had a mean BMI-SDS of 2.82, and children and adolescents of Turkish origin had a mean BMI-SDS of 2.93. In addition, the children and adolescents analyzed in our study do not show any significant difference in terms of BMI between the two groups, HOMA-IR values below (mean BMI-SDS = 2.78) and above the 95th percentile (mean BMI-SDS = 2.95). Therefore, even if Turkish children are generally more prone to obesity, our study group was homogeneous in terms of BMI, and we finally decided to integrate all children and adolescents in the calculation, independently of their ethnical background. In terms of other factors, such as the socio-economical status, we could not make any reliable statements due to a lack of sufficient information.

In the sequencing study, a total of five SNPs, rs4803845, rs5390, rs12709891, rs11672660, and rs34783010 (Fig. 1) were detected among 87 children (Table 5). All variants were found in non-coding regions of the GIPR and were already known from the HapMap database. None of the variations showed evidence for an association with childhood obesity. Though, some evidence for a potential association of the A-allele with elevated HOMA-IR levels was provided for the SNP rs12709891 \((P=0.069)\). Furthermore, we detected the variation Tyr240His in exon 8, which occurred in one normal weight child with normal HOMA-IR level but
severely increased triglyceride levels. As the two sisters of this child were obese but do not carry the mutation, no further studies of this variant were performed to examine the association with obesity and impaired insulin sensitivity.

## Discussion

So far, the role of genetic variations within the GIPR gene for different phenotypes like obesity and glucose metabolism remains controversial (12, 13), though physiological studies (3, 5, 9) clearly demonstrated the important role of the GIPR in weight regulation and glucose homeostasis.

We found evidence for a significant association between the minor allele of the exonic SNP rs1800437 of the GIPR and an elevated HOMA-IR value (above the 95th percentile) in these children and adolescents. The presence of the minor allele C induces an exchange from the amino acid glutamate to glutamine in transmembrane domain six (TM6; Fig. 2). Functional studies analyzing the impact of the amino acid exchange induced by rs1800437 on receptor function have not been published so far. However, naturally occurring mutations in other GPCRs, like the TSH receptor, indicate that the TM6 is highly susceptible for constitutive activation (22). Consistent with these data, one study reported an artificial activating mutation Thr340Pro in TM6 of the GIPR, which leads to an increase in basal cAMP release under feeding conditions. However, in the case of inactivating variations within GIPR, a smaller effect on the phenotype expression might be accentuated by the common pathway in the β-cell, which results in insulin release under feeding conditions. However, in the case of variations leading to constitutive activation of GIPR, the receptor effect of the activated GIPR is present in fasting state without ligand binding as both incretins are only secreted after nutrient intake.

Table 3 Genotype and allele frequencies for normal weight or lean and obese children for the three analyzed single-nucleotide polymorphisms (SNPs).

<table>
<thead>
<tr>
<th>SNP</th>
<th>Group</th>
<th>Genotypes, n (frequency)</th>
<th>Frequency of allele</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>rs8111428</td>
<td>Obese children</td>
<td>367 (0.630) AA</td>
<td>192 (0.330) AG</td>
<td>0.800 A</td>
</tr>
<tr>
<td></td>
<td>Normal weight or lean children</td>
<td>1088 (0.650) AA</td>
<td>515 (0.228) AG</td>
<td>72 (0.032) GG</td>
</tr>
<tr>
<td>rs2302382</td>
<td>Obese children</td>
<td>349 (0.602) CC</td>
<td>202 (0.348) AC</td>
<td>29 (0.050) AA</td>
</tr>
<tr>
<td></td>
<td>Normal weight or lean children</td>
<td>1031 (0.620) CC</td>
<td>547 (0.329) AC</td>
<td>84 (0.037) AA</td>
</tr>
<tr>
<td>rs1800437</td>
<td>Obese children</td>
<td>344 (0.616) GG</td>
<td>180 (0.323) CG</td>
<td>34 (0.061) CC</td>
</tr>
<tr>
<td></td>
<td>Normal weight or lean children</td>
<td>984 (0.592) GG</td>
<td>571 (0.344) CG</td>
<td>107 (0.064) CC</td>
</tr>
</tbody>
</table>

Table 4 Allele frequency of the single-nucleotide polymorphisms (SNPs) rs8111428, rs2302382, and rs1800437 and the homeostasis model assessment values for insulin resistance (HOMA-IR) status.

<table>
<thead>
<tr>
<th>SNP</th>
<th>Group</th>
<th>Genotypes, n (frequency)</th>
<th>Frequency of allele</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>rs8111428</td>
<td>HOMA-IR &lt;95th percentile</td>
<td>116 (0.614) AA</td>
<td>66 (0.349) AG</td>
<td>0.788 A</td>
</tr>
<tr>
<td></td>
<td>HOMA-IR ≥95th percentile</td>
<td>106 (0.639) AA</td>
<td>54 (0.325) AG</td>
<td>6 (0.036) GG</td>
</tr>
<tr>
<td>rs2302382</td>
<td>HOMA-IR &lt;95th percentile</td>
<td>111 (0.587) CC</td>
<td>71 (0.376) AC</td>
<td>7 (0.037) AA</td>
</tr>
<tr>
<td></td>
<td>HOMA-IR ≥95th percentile</td>
<td>105 (0.633) CC</td>
<td>52 (0.313) AC</td>
<td>9 (0.054) AA</td>
</tr>
<tr>
<td>rs1800437</td>
<td>HOMA-IR &lt;95th percentile</td>
<td>106 (0.582) GG</td>
<td>72 (0.396) CG</td>
<td>4 (0.022) CC</td>
</tr>
<tr>
<td></td>
<td>HOMA-IR ≥95th percentile</td>
<td>92 (0.594) GG</td>
<td>46 (0.297) CG</td>
<td>17 (0.110) CC</td>
</tr>
</tbody>
</table>

www.eje-online.org
Regarding their role for childhood and adolescence obesity, neither the three analyzed SNPs nor the five variants detected by sequencing provided evidence for a genetic association. Most likely, given the small genetic effect sizes reported for obesity so far (30), the power of our study has been too small to detect obesity effects related to these SNPs. So far, an association between variants in GIPR and obesity cannot be completely ruled out. Further investigation in much larger samples will be required to finally unravel the impact of GIPR as a gene for obesity.

Our findings concerning the role of GIPR as a candidate gene for insulin impairment are supported by the ‘Meta-Analyses of Glucose and Insulin-related traits Consortium’ (MAGIC) (10): very recently, within the scope of a meta-analysis of the MAGIC, Saxena *et al.* identified a variation in the GIPR (rs10423928) to be associated with increased 2-h glucose and an impaired insulin response on glucose challenge during oral glucose tolerance test. Additionally, this SNP is in strong linkage disequilibrium (LD) with the SNP rs1800437 showing association with elevated HOMA-IR levels in children. Both SNPs have an effect on the glucose homeostasis (10).

In sum, though this study could not provide evidence for a genetic association of all eight analyzed variants to childhood and adolescence obesity, the role of GIPR as a candidate gene for insulin impairment is strengthened as we observed evidence for an association of the exonic SNP rs1800437 and the elevated HOMA-IR values in a relatively small sample of only 357 children and as this SNP is in strong LD with another GIPR variation showing an effect on insulin secretion.

**Declaration of interest**

The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research reported.

**Funding**

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**Acknowledgements**

We thank Sabine Jyrch for her experimental assistance and Ingrid Rehwald for anthropometric measurements.

**References**


Table 5 Variations found by sequencing GIPR in 87 children with known homeostasis model assessment values for insulin resistance (HOMA-IR) levels.

<table>
<thead>
<tr>
<th>SNP</th>
<th>Group</th>
<th>Genotypes, n (frequency)</th>
<th>Frequency of allele</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>rs4803845</td>
<td>HOMA-IR &lt;95th percentile</td>
<td>37 (1.000) CC 0 (0.000) CT 0 (0.000) TT</td>
<td>1.000 C 0.000 T</td>
<td>0.198*</td>
</tr>
<tr>
<td>rs11672660</td>
<td>HOMA-IR &lt;95th percentile</td>
<td>36 (0.973) CC 1 (0.270) CG 0 (0.000) GG</td>
<td>0.986 C 0.014 G</td>
<td>0.495</td>
</tr>
<tr>
<td>rs5390</td>
<td>HOMA-IR ≥95th percentile</td>
<td>49 (0.980) CC 1 (0.020) CG 0 (0.000) GG</td>
<td>0.990 C 0.010 G</td>
<td></td>
</tr>
<tr>
<td>rs12709891</td>
<td>HOMA-IR &lt;95th percentile</td>
<td>37 (1.000) CC 0 (0.000) CA 0 (0.000) AA</td>
<td>1.000 C 0.000 A</td>
<td>0.069</td>
</tr>
<tr>
<td>rs11672660</td>
<td>HOMA-IR &lt;95th percentile</td>
<td>45 (0.900) CC 5 (0.100) CA 0 (0.000) AA</td>
<td>0.950 C 0.050 A</td>
<td></td>
</tr>
<tr>
<td>rs4803845</td>
<td>HOMA-IR &lt;95th percentile</td>
<td>22 (0.595) CC 14 (0.378) CT</td>
<td>1 (0.027) TT</td>
<td>0.783 C 0.217 T</td>
</tr>
<tr>
<td>rs5390</td>
<td>HOMA-IR ≥95th percentile</td>
<td>32 (0.640) CC 18 (0.360) CT</td>
<td>0 (0.000) TT</td>
<td>0.820 C 0.180 T</td>
</tr>
<tr>
<td>rs12709891</td>
<td>HOMA-IR ≥95th percentile</td>
<td>24 (0.649) GG 12 (0.324) GT</td>
<td>1 (0.027) TT</td>
<td>0.810 G 0.190 T</td>
</tr>
</tbody>
</table>

*For a binomial test.*

![Figure 2](http://www.ssfar-gphr.de/natural_all.php) (31).