Elevated plasma glucose-dependent insulinotropic polypeptide associates with hyperinsulinemia in metabolic syndrome

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Abstract

Background and aims: Metabolic syndrome (MS) is a high-risk condition for type 2 diabetes, a disease characterized by insulin resistance and insulin secretion abnormalities. Insulin resistance has been widely characterized in MS subjects while insulin secretion has been poorly investigated. The present study was hence undertaken to further investigate the α and β cell function and entero-insular axis in this pre-diabetic condition.

Materials and methods: Using 120' oral glucose tolerance test (OGTT, 75 g) and 60' intravenous glucose tolerance test (IVGTT, 0.3 g/kg), we studied α and β cell function, insulin resistance, and incretin levels in 96 subjects with normal fasting glucose and normal glucose tolerance to OGTT, with (MS+, n = 29) and without MS (MS−, n = 67).

Results: MS+ individuals showed in comparison with MS−: higher insulinogenic index (IG30) and higher area under the curve (AUC) (0–120) for glucose and insulin during the OGTT, P < 0.05; higher AUC (0–10) for glucose (P < 0.05) but similar first phase insulin secretion (P = NS) as measured by ΔAIRG and AUC (0–10) for insulin during the IVGTT; increased AUC (0–60) for insulin during the IVGTT (P = 0.04); higher GIP levels at 30' (P = 0.03), 60' (P = 0.01), 90' (P = 0.003), and 120' (P = 0.004); higher AUC (0–120) for GIP (P = 0.007); similar AUC (0–120) for GLP-1 during the OGTT; and delayed glucagon suppression after the OGTT.

Conclusion: NGT subjects with MS showed increased GIP secretion that could be responsible for the delayed glucagon suppression during the OGTT, thereby suggesting a role for incretins in regulating glucose homeostasis in this condition.
Research design and methods

Participants

We recruited a total of 139 subjects for this study. They were consecutively enrolled among patients attending our university hospital for cardiovascular risk evaluation. Inclusion criteria were: body mass index (BMI) ≥ 25 kg/m², fasting plasma glucose ≤ 100 mg/dl, and at least one or more components of the MS. Exclusion criteria were: previous history of diabetes, use of medications known to affect glucose metabolism, previous cardiovascular events, clinical evidence of advanced liver or renal disease, and/or a recent history of acute illness. The Local Ethics Committee approved the study, and after the nature of the study had been explained to each participant, informed written consent was obtained.

Experimental protocols

All 139 participants underwent standard blood testing after a 12-h overnight fast (plasma glucose, insulin, and lipids), anthropometric measurements, and blood pressure monitoring. Subjects were divided into two groups, with or without the MS (MS+ and MS−), according to the NCEP–ATPIII criteria (6). All subjects underwent a 75 g OGTT: samples for glucose, insulin, glucagon, GLP-1, and GIP measurements were drawn at baseline and every 30 min after glucose ingestion up to and including 120 min and distributed into chilled tubes containing EDTA, with the addition of aprotinin (500 kIU/ml blood), for the analysis of plasma glucagon, GLP-1, and plasma GIP. For the analysis of glucose, insulin, and C-peptide, blood was distributed into chilled tubes containing heparin. All tubes were immediately cooled on ice and centrifuged at 4 ℃ for 20 min. Plasma was stored at −20 ℃ until analysis. The impaired glucose tolerant and diabetic patients, according to the American Diabetes Association criteria (7) based on their 2-h post-OGTT glucose levels, were excluded from this study. Then, 29 normogluucose-tolerant MS+ and 67 normogluucose-tolerant MS− subjects were included in our study. After One week after the OGTT, these patients underwent a 60' IVGTT: at −1 min a bolus of 0.3 g/kg glucose was given; blood samples for glucose, insulin, and C-peptide measurements were drawn at baseline, 2', 3', 4', 5', 10', 15', 20', 25', 30', 40', 50', and 60'. Blood for glucose and insulin was sampled as for the OGTT.

Analytical procedures

Body weight and height were measured, and BMI was calculated as weight (kg)/height (m²). Waist circumference was measured in a standing position at the level of the umbilicus. Blood pressure was measured with a calibrated mercury sphygmomanometer when the subjects had rested in the supine position for 10 min. Plasma glucose was measured by the glucose oxidase method. Serum insulin was measured using a micro-particle enzyme immunoassay (Axsym System, Abbott Laboratories). C-peptide was measured using an ELISA kit (Millipore Corporation, Billerica, MA, USA; coefficient of variation (CV): inter-assay, 5.0–8.7%; intra-assay, 1.6–4%. Plasma glucagon was measured by a RIA (Millipore Corporation; accuracy, 97 ± 0.8%; precision CV: inter-assay, 11.7 ± 3.0%; intra-assay, 4.9 ± 1.3; sensitivity, the lowest level of human glucagon that can be detected by the assay is 18.453 ng/l + 2 s.d. when using a 100 μl sample size; specificity: glucagon 100%, oxyntomodulin <0.1%, human insulin non-detectable (ND), human C-peptide ND, somatostatin ND, and pancreatic polypeptide ND). GLP-1 (active) was measured using an ELISA kit (Millipore Corporation; accuracy, 86.9 ± 5.2%; precision CV: inter-assay, 8 ± 4.8%; intra-assay, 7.4 ± 1.1; sensitivity, the lowest level of GLP-1 that can be detected by this assay is 2 pmol/l (100 μl plasma size); specificity, GLP-1 (7–36), 100%; GLP-1 (7–37), 100%; GLP-1 (9–36), ND; GLP-2, ND; and Glucagon, ND). Total GIP was measured using an ELISA kit (Millipore Corporation; accuracy, 86.7 ± 3%; precision CV: inter-assay, 1.8–6.1%, intra-assay, 3.0–8.8%; sensitivity, the lowest level of human GIP that can be detected by the assay is 1.64 pmol/l when using a 20-μl sample size; specificity, the antibody pair used in this assay is specific to human GIP and does not significantly cross-react with glucagon, oxyntomodulin, GLP-1, and GLP-2. Serum total cholesterol, triglycerides, and HDL cholesterol were measured by available enzymatic methods. LDL cholesterol was calculated using the Friedewald formula.

Calculation

β cell function was assessed by the insulinogenic index (IG30) calculated as the change of insulin (pmol/l) divided by the change of glucose (mmol/l) during the first 30 min of the OGTT (ΔI0–30/ΔG0–30) (8). During the IVGTT, as an index of insulin secretion, we used mean incremental concentrations in the 3–10 min interval following glucose bolus, defined as acute insulin response to glucose (ΔAIRG).

ΔAIRG was divided by the incremental glucose peak, ΔGp, to obtain the same units as the OGTT indices (8). The area under the insulin, C-peptide, glucose, GLP-1, and GIP was calculated by the trapezoidal method. Insulin resistance was estimated using homeostasis model of assessment (HOMA-IR), calculated as previously described (9).

Statistical analysis

Statistical comparison and analyses of clinical and biomedical parameters were performed using Stat View version 6.0 for Windows. Data are given as means ± S.E.M. When necessary, numerical variables were logarithmically transformed to reduce skewness, and
values were expressed as arithmetic means. Statistical analysis included unpaired t-test, χ² test, ANOVA for continued variables. A P value < 0.05 was considered statistically significant.

Results

Clinical parameters

Clinical characteristics of the study participants are shown in Table 1.

There were no differences in age, blood pressure, CV, or BMI. Sex was not equally distributed in the different groups because of a higher number of women in the MS− group.

As expected, MS+ subjects had higher triglycerides (P < 0.001) and lower HDL cholesterol (P < 0.001) compared with controls. Fasting plasma glucose, albeit normal, was slightly, but significantly, higher in MS+ (P < 0.001).

HOMA-IR was increased in MS+ (P < 0.0001) and the difference was still maintained when age was used as a covariate (0.007).

Plasma glucose and insulin response during OGTT

As expected by our previous findings, MS+ individuals had elevated plasma glucose levels at baseline (P < 0.01) and at 30′ (P < 0.05; Fig. 1A). Glucose area under the curve (AUC) (0–120) was significantly higher in MS+ (848.3 ± 23.5 vs 775.67 ± 17.17 mmol/l×min, P = 0.01). Insulin plasma levels were statistically increased in MS subjects as shown in Fig. 1B. The early-phase insulin secretion was evaluated by islet-cell (IG30). In MS+, as previously reported (10), it was significantly and greatly increased (Table 2). Total insulin AUC (0–120) was also significantly higher in MS+ (Table 2).

| Table 1 Clinical and metabolic characteristics of normogluco-tolerant subjects with and without MS. Data are mean ± S.E.M. |
|-----------------|-----------------|-----------------|-----------------|
| **Age (years)** | **BMI (kg/m²)** | **Sex (F/M)** | **Fasting glucose (mmol/l)** | **Waist circumference (cm)** | **HDL cholesterol (mmol/l)** | **Triglycerides (mmol/l)** | **Systolic blood pressure (mmHg)** | **Diastolic blood pressure (mmHg)** | **Hypertension prevalence (no/yes)** | **HOMA-IR** | **Total cholesterol (mmol/l)** | **LDL cholesterol (mmol/l)** | **P value** |
| (n=29)          | (n=67)          |             |                  |                   |                     |                         |                           |                           |                               |          |                   |                   |          |
| 45 ± 2          | 40 ± 1          | NS          | 5.17 ± 0.11      | 4.78 ± 0.06       | 0.0004             | 1.03 ± 0.03          | 1.32 ± 0.03               | < 0.001                     | 2.2 ± 0.17                         | 1.21 ± 0.09 | < 0.001            | 128 ± 3           | 123 ± 2 | NS               | 79 ± 2          | 76 ± 1          | NS          | 3 ± 0.3         | 2 ± 0.13         | < 0.0001 |
| 45 ± 1          | 34 ± 1          | NS          | 4.78 ± 0.06      | 107 ± 2           | 103 ± 2             | 1.03 ± 0.03          | 1.32 ± 0.03               | < 0.001                     | 2.2 ± 0.17                         | 1.21 ± 0.09 | < 0.001            | 128 ± 3           | 123 ± 2 | NS               | 79 ± 2          | 76 ± 1          | NS          | 3 ± 0.3         | 2 ± 0.13         | < 0.0001 |

MS−, not significant.

Plasma glucose, insulin, and C-peptide response during IVGTT

MS+ subjects had elevated plasma glucose levels at baseline, 2′ (P = 0.03), 3′ (P = 0.03), and 4′ (P = 0.03; Fig. 1C). Glucose AUC (0–10) was statistically higher in MS+ (133.44 ± 3.89 vs 118.78 ± 4.72 mmol/l×min, P = 0.04), while glucose AUC (0–60) was not statistically different (576.39 ± 66.39 vs 527.17 ± 20.28 mmol/l×min, P = NS).

Basal insulin levels were higher in MS+ (97.23 ± 20.83 vs 55.56 ± 6.94 pmol/l, P = 0.03; Fig. 1D). The first phase of insulin release was evaluated by ΔAIRG. In MS+, it was not significantly different from controls (Table 2). To correct for the higher glucose level in MS+ subjects, ΔAIRG was divided by the incremental glucose peak, ΔGp. Similar to ΔAIRG, ΔAIRG/ΔGp was also not statistically different (Table 2). ΔAIRG correlated with HOMA-IR (r = 0.4, P < 0.05).

Furthermore, insulin AUC (0–10) was not significant in both groups, and total insulin AUC (0–60) was significantly higher in MS+ (P = 0.04; Table 2).

C-peptide levels were similar in the different time points among the groups as well as AUC (0–10) and AUC (0–60), as shown in Table 2.

Incretin secretion

Plasma concentrations of GIP and GLP-1 increased significantly after the OGTT.

GIP peaked at 30′ in both groups. MS+ individuals showed higher GIP levels at 30′ (64.2 ± 9.4 vs 44 ± 4.2 pmol/l, P = 0.03), at 60′ (59.26 ± 8.04 vs
Glucagon secretion

During the OGTT, plasma glucagon levels were slightly higher in MS+ subjects, although this difference was not statistically significant (85 ± 11 vs 67 ± 3 ng/l, P = 0.1). In both groups, glucagon levels declined in response to the glucose load (Fig. 2C). However, MS+ subjects showed delayed glucagon suppression reaching 28 and 71% of maximum glucagon suppression respectively, at 30’ and at 60’ of the OGTT in comparison with 81 and 100% in the MS− group at the same times. During the IVGTT, glucagon responses were similar in the two groups (P = NS; Fig. 2D).

Discussion

The main findings of our study are that NGT subjects with MS show an increased GIP secretion and a delayed glucagon suppression after the oral glucose load.

Elevated GIP levels have already been observed in type 2 diabetes (11) and in impaired glucose tolerant patients (11, 12), and described as a compensatory mechanism by which these subjects attempt to compensate for their reduced insulinitropic effect of GIP. The reduced insulinitropic response to GIP has been suggested as secondary to a reduction in the β cell mass and to impairments in the maximum insulin secretory capacity of the β cell (13). In our population, increased GIP levels could represent a compensatory mechanism in response to the increase of plasma glucose observed after the OGTT (AUC 0–120). We could speculate that this continuous stimulation of β cells from GIP could lead to an exhaustion of secretory machinery or even induce apoptosis.

The impairment of glucagon suppression that we found in these subjects could represent an immediate price to be paid for this compensatory mechanism. Since GIP has been shown to enhance β cell glucagon
secretion (5), in contrast with the glucagonostatic GLP-
1 (4), we can speculate that the increase of GIP could be
related to the failure of plasma glucagon concentrations
to decrease appropriately after the OGTT. In fact, even if
MS+ individuals showed no statistically significant
differences in plasma glucagon levels at different times,
they showed a delayed glucagon suppression reaching
28 and 71% of maximum glucagon suppression
respectively, at 30' and at 60' of the OGTT in
comparison with 81 and 100% in the MS− groups at
the same times. This event could represent an early
defect of β cell function. In contrast to the OGTT,
glucagon profiles during the IVGTT were similar
between the two groups (P=NS). This finding supports
the hypothesis of an incretin axis impairment to explain
the α and β cell changes observed in subjects with MS.
In contrast to GIP, GLP-1 was not significantly different
between the two groups. However, in a recent study,
subjects with MS had higher fasting GLP-1 levels than
those without, and circulating levels of GLP-1 were
associated with the number of the MS components (14).

Another finding of our study is that MS+ subjects
presented, overall, an increased insulin secretion during
the OGTT and IVGTT, but different early phases of insulin
secretion after the two loads. The insulinoenic index
(IG30), an index of early-phase insulin secretion during
the OGTT, was higher in MS+ subjects. Conversely,
during the IVGTT, a well-known test to study the direct
effect of glucose on β cell function, ΔAIRG was similar in
both study groups. These data, however, should be
interpreted with caution because a larger sample size
could disclose eventual differences. Similar findings were
also obtained when ΔAIRG was divided by the incre-
mental glucose peak, ΔGp. To correct the weight of
plasma glucose. The difference of early insulin secretion
that we found in response to oral or intravenous glucose,
if confirmed, argues against an effect of MS on the β cell
sensitivity to glucose, and in favor of a direct effect of gut
hormones in determining this change.

In a former study, we already showed that subjects
affected by MS had a significant increase of early-phase
insulin secretion in comparison with subjects without
MS, regardless of insulin resistance. This alteration
might be a premature feature of the β cell dysfunction
that eventually leads to overt diabetes (10). Several data
suggest that hyperinsulinemia might not only be an
adaptive response to insulin resistance, but a primary
defect of β cell function contributing to glucose
intolerance (15).

An impaired incretin effect has been previously
reported in other high-risk conditions for diabetes:
impaired glucose tolerance (IGT) subjects are charac-
terized by a partial inability of the entero-insular axis to
enhance insulin release, which consequently is driven
by glucose levels to a greater extent than in normal
glucose tolerance (NGT) (16); a reduced insulinotropic
effectiveness of GIP was observed in normal glucose-
tolerant first-degree relatives of patients with type 2
diabetes in comparison with healthy control subjects
(17); and a reduced insulinotropic effect of GLP-1
during the hyperglycemic clamp has been observed in
risk allele carriers of TCF7L2 rs7903146 (18). In the
present study, we did not evaluate the β cell respon-
siveness to incretin infusion. For this reason, we are not
able to say if the increased GIP secretion reported in MS
subjects could be related to an impaired insulinotropic
effect of the above hormone. With regard to incretin
secretion, no differences in GLP-1 and GIP response
were found in women with a history of gestational
diabetes compared with controls (19) either in women
with polycystic ovary syndrome (20) or in first-degree
relatives of diabetic patients (21).

In conclusion, this study shows that NGT subjects
with MS showed increased GIP secretion that could be
responsible for the delayed glucagon suppression during
the OGTT, thereby suggesting a role for incretins in
regulating glucose homeostasis in this condition.

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.

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