Metabolic recovery of adipose tissue is associated with improvement in insulin resistance in a model of experimental diabetes

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Abstract

Obesity and insulin resistance are highly correlated with metabolic disturbances. Both the excess and lack of adipose tissue can lead to severe insulin resistance and diabetes. Adipose tissue plays an active role in energy homeostasis, hormone secretion, and other proteins that affect insulin sensitivity, appetite, energy balance, and lipid metabolism. Rats with streptozotocin-induced diabetes during the neonatal period develop the classic diabetic picture of hyperglycemia, hypoinsulinemia, and insulin resistance in adulthood. Low body weight and reduced epididymal (EP) fat mass were also seen in this model. The aim of this study was to investigate the glucose homeostasis and metabolic repercussions on the adipose tissue following chronic treatment with antidiabetic drugs in these animals. In the 4th week post birth, diabetic animals started an 8-week treatment with pioglitazone, metformin, or insulin. Animals were then killed, EP fat pads were excised, and blood samples were collected for biological and biochemical assays. Pioglitazone and insulin treatments, but not metformin, reduced hyperglycemia, polydipsia, and polyphagia. Although all antidiabetic therapies improved insulin sensitivity, this was particularly noteworthy in the pioglitazone-treated rats. Furthermore, a recovery of adipose mass and insulin levels were observed in pioglitazone- and insulin-, but not metformin-treated animals. Treatments with insulin or pioglitazone were able to correct significantly, but not completely, the metabolic abnormalities, parallel to full recovery of adipose mass, indicating that not only the low insulin levels but also the lack of adipose tissue might play a significant role on the pathophysiology of this particular diabetes model. *Journal of Endocrinology* (2008) **198**, 51–60

Introduction

Hyperglycemia in diabetes mellitus (DM) is a result of inadequate insulin secretion and reduced systemic responsiveness to insulin (DeFronzo et al. 1992). Obesity, most notably central adiposity, is one of the main features of the metabolic syndrome, leading to a greater free fatty acid (FFA) flux, which inhibits insulin action in insulin-sensitive tissues (Randle et al. 1963). Insulin resistance coupled with obesity triggers many metabolic abnormalities that increase cardiovascular risk (Lebovitz et al. 1995). To reinforce this idea, the surgical removal of visceral adipose mass from obese animals not only improved insulin resistance but also reduced cardiovascular risk (Barzilai et al. 1999).

White adipose tissue (WAT) plays a crucial role in energy homeostasis to include insulin sensitivity, appetite control, energy balance, immunity, angiogenesis, blood pressure, and lipid metabolism, by secreting a wide range of bioactive proteins termed ‘adipokines’ (Fischer-Posovszky et al. 2007). Interestingly, both the excess (obesity) and lack (lipoatrophy) of WAT bring severe metabolic consequences such as insulin resistance, hypertriacylglycerolemia, diabetes, and fatty liver (Gavriloiva et al. 2000). These derangements are correctable by interventions on adipose tissue. Transplantation of WAT to a lipodystrophic animal results in impressive improvement in insulin sensitivity and glycemia (Gavriloiva et al. 2000). Hence, a critical amount of fat mass seems necessary to allow the adequate lipid storage avoiding other tissues or organs – skeletal muscle or liver – from the occurrence of abnormal intracellular lipid infiltration that aggravates insulin resistance (Kelley et al. 2002, Song 2002).

Thiazolidinediones (TZDs) are potent agonists of the peroxisome proliferator-activated receptor γ (PPAR-γ), a nuclear receptor expressed in insulin target tissues, such as WAT, skeletal muscle, and liver (Tontonoz et al. 1994, Parulkar et al. 2001). TZDs improve insulin sensitivity by increasing glucose utilization and inhibiting endogenous glucose production (Miyazaki et al. 2002, Boden et al. 2003). As WAT expresses the highest levels of PPAR-γ, it is a preferable target for TZD (Sharma & Staels 2007). Its insulin-sensitizing effect also includes stimulation of adipogenesis, increasing the number of small adipocytes, which are more insulin sensitive.
than the large and lipid-laden adipose cells (Tontonoz et al. 1994, Okuno et al. 1998). A known side effect of TZD use is weight gain (Fonseca 2003, Wilding 2006). In addition, TZDs improve lipid profile, lowering FFAs and increasing high density lipoprotein (HDL)-cholesterol levels in diabetic patients (Maggs et al. 1998).

Metformin, a biguanide widely used for DM therapy, has anti-diabetic effects relying on the improvement in peripheral insulin sensitivity without stimulating insulin secretion and weight gain (Natali & Ferrannini 2006). Additionally, metformin has beneficial effects on circulating lipid levels (Wu et al. 1990).

In our previous study, experimental diabetes was induced by streptozotocin (STZ) in rats during the neonatal period (5th day of life). As a result of β-cell cytotoxicity, these animals developed clinical features similar to the ones presented by diabetic patients, such as hyperglycemia, hypoinsulinemia, polyphagia, polydipsia, polyuria, and glycosuria. Such features persisted and were aggravated throughout adulthood (Takada et al. 2007). Interestingly, the rats also presented a lower body weight gain and a marked reduction in epididymal (EP) fat mass along with impaired glucose metabolism in isolated adipocytes. Therefore, considering the importance of WAT and its adipokines for the regulation of energy metabolism, the aim of this study was to evaluate the repercussions of long-term treatment from weaning to adulthood with anti-diabetic drugs on the adipose tissue metabolism in this diabetes model.

Materials and Methods

Materials

All chemicals and drugs: sodium citrate, STZ, collagenase, Earl’s salts, HEPES, BSA (EHB), sodium pyruvate, NaHCO3, sulfuric acid, isopropanol, and n-heptane were from Labsynth (Diadema, SP, Brazil), AMRESCO (Solon, OH, USA), or Sigma–Aldrich Chemical. Pioglitazone chloride, neutral protamine hagedorn (NPH) insulin, and metformin chloride were from Takeda Chemical Industries Ltd (Osaka, Japan), Novo Nordisk (Montes Claros, MG, Brazil) and Merck Santé respectively. Sodium thiopental was from Cristalia (Sao Paulo, SP, Brazil) and 2-deoxy-2-[^3H]-glucose and 2-[U-14C]-glucose were from Amersham Life Sciences. Primers, DNase 1, SuperScript II, Taq DNA polymerase, and dNTPs were from Invitrogen Life Technologies. All procedures were carried out according to the manufacturer’s instructions.

Animals

Five-day-old male Wistar rats were fasted (separated from their mothers) for 8 h. The diabetic (STZ) group was injected with STZ (120 mg/kg b.w., intraperitoneally) freshly diluted in citrate buffer (10 mM, Na citrate, pH 4.5). The non-diabetic control (C) group received only the vehicle in equivalent volume.

Treatment of animals

After weaning (21 days), glycemia was determined in STZ-treated animals and only those with levels above 150 mg/dl were selected for this study. The animals were then randomly divided into five groups and the treatment started in the 4th week after their birth. Group D, non-treated STZ-diabetic animals; STZ-diabetic treated groups: group M, metformin (diluted in drinking water, 450 mg/kg b.w.); group P, pioglitazone (orally, 5 mg/kg b.w.); and, group I, insulin (NPH insulin s.c. injected twice daily, 0.5 U/100 g b.w. at 0800 h and 1.0 U/100 g b.w. at 1600 h); and, finally group C, a non-diabetic control group.

The animals (three per cage) were kept under a 12 h light:12 h darkness cycle (lights on at 0700 h) at 23 °C and with full access to food (Nuvilab balanced chow pellets, Nuvital SA, Columbo, Brazil) and water for the following 9 weeks. Apart from each experimental group, another group of animals was individually monitored for water and food intake.

Body weight and glycemia were measured weekly from weaning to killing (12-week old). Tail blood was collected for glucose determination using a glucometer (Lifescan, Scotland, UK).

i.v. Glucose and insulin tolerance test (ivGTT and ivITT)

The tests were performed at 0800 h after 12 h of fasting. In 11-week-old animals, under slight anaesthesia (Sodium thiopental, 2 mg/100 g b.w.), the glucose load (75 mg glucose/100 g b.w.) was injected as a ‘bolus’ via dorsal vein of the penis and tail blood samples were collected at 0, 5, 20, and 60 min after injection for glucose determination.

A similar procedure was performed for ivITT. The insulin load (75 mU/100 g b.w.) was injected as a ‘bolus’ and the blood glucose levels were determined at 0, 3, 6, 9, 12, and 30 min after injection.

Killing

In the 12th week, the animals (12-h fasted) were decapitated under slight anesthesia (Na pentobarbital 4 mg/100 g b.w.) at 0800 h and trunk blood was collected. The serum was used for insulin, leptin, C-peptide, glucose, FFAs, and triacylglycerol (TAG) determinations. After abdominal wall opening, the EP fat pads were excised and processed for adipocyte isolation. The described procedures followed the institutionally approved protocol in accordance with the Ethical Principles in Animal Research adopted by the Institute of Biomedical Sciences Ethical Committee for Animal Research (CEEA) (no. 032/99) and the UFAW Handbook on the Care and Management of Laboratory Animals.

Adipocyte isolation

Adipocytes were isolated with collagenase as previously described (Rodbell 1964). The cell suspensions were kept in a 20% final concentration (corresponding to ~ 10^5 cells/ml).
and were maintained in water bath for 30 min before initiating the biological tests described below. Adipocyte viability and number were determined as previously described (Fine & Digirolamo 1997).

**Insulin-stimulated 2-deoxy-d-glucose uptake (2DGU)**

Isolated adipocytes (20% cell suspension in EHB buffer) were incubated in the presence or absence of a maximally insulin-stimulating concentration (10 nmol/l). After 30 min of incubation, basal and maximal rates of 2DGU (in triplicates) were evaluated according to protocols described elsewhere (Takada et al. 2007).

**Incorporation of d-[U-14C]-glucose into lipids, and its conversion into 14CO2**

From a 20% adipocyte suspension in Krebs/Ringer/phosphate buffer (pH 7.4), with BSA 1% and glucose 2 mmol/l (at 37°C) and saturated with a gas mixture of CO2 5%/O2 95%, 450 μl aliquots were transferred to polypropylene test tubes (17X100 mm), containing d-[U-14C]-glucose (1850 Bq per tube), in the presence or absence of insulin (10 nmol/l). These samples were then incubated (500 μl – final volumes) for 1 h at 37°C in orbital shaker water bath (150 r.p.m.) and the tubes (with a CO2 5%/O2 0, 5% atmosphere) were closed with a rubber stopper. At the end of incubation, the stopper was removed and 200 μl of H2SO4 (4 M) was quickly pipetted and another vial containing a piece of filter paper (2X4 cm) moistened with 200 μl of ethanolamine was placed (mouth to mouth) on top of incubation tubes. The assembled tubes were sealed with a band of parafilm and maintained for additional 30 min for collecting the 14CO2 released from the mixture. The vial on top of the incubation tubes was then disconnected, filled with scintillation cocktail (Universol, ICN Pharmaceuticals, Costa Mesa, CA, USA), and the radioactivity was counted in a β-counter (Beckman L5-8000, Palo Alto, CA, USA). The remaining reaction mixture was treated with 2.5 ml of Dole’s reagent (isopropanol, n-heptane, and H2SO4, 4:1:0.25 vol/vol per vol) for lipid extraction. The tube was vortexed three times in the next 30 min and 1:5 ml of n-heptane and 1:5 ml of distilled water were added, the tube was vortexed and the mixture decanted for 5 min. Five hundred microliters of the upper phase was collected in duplicates to a scintillation vial for the determination of radioactivity trapped into lipids. The results were expressed as nanomoles of 14CO2 released and of glucose incorporated into lipids per 106 cells X h.

**Measurement of lipolysis**

Lipolytic activity was performed in isolated adipocytes as described elsewhere (Borges-Silva et al. 2005). The glycerol content of incubated medium was measured using the free glycerol determination kit (Sigma–Aldrich) and was used as an index of lipolysis, expressed as nanomoles of glycerol released by 106 cells per hour.

**Hormones, fatty acids and glucose measurements**

Serum glucose, TAG, and FFA were determined by enzymatic methods using commercial kits (Glicose SL-e, CELM, Sao Paulo, Brazil; K 055-1, Quibasa, Belo Horizonte, MG, Brazil; HR (2), WAKO, Osaka, Japan respectively). Leptin, insulin, and C-peptide levels were quantified using rat leptin, insulin, and C-peptide RIA kits (Linco Research, St Charles, MO, USA).

**Estimated pancreatic insulin content (per 100 islets)**

Rat pancreatic islets were isolated by collagenase digestion as described elsewhere (Lacy & Kostianovsky 1967). One hundred islets per pancreas were pooled, homogenized, and insulin content was quantified using a rat insulin RIA kit (Linco Research).

**Reverse transcriptase-PCR (RT-PCR) assay for glucose transporter 4 (GLUT4) gene expression**

Total RNA was extracted from EP fat using Trizol solution (Invitrogen), according to the manufacturer’s specifications (Chomczynski & Sacchi 1987). After DNase treatment, cDNA was synthesized from 5 μg of total RNA using Moloney marine leukemia virus reverse transcriptase (Superscript II kit). We amplified 2 μl of the cDNA product on a Gradient Mastercycler (Eppendorf, Hamburg, Germany), using specific sets of primers: rat GLUT4: sense primer, 5′-GCTGTGCGATCTTTGATGACGG-3′; antisense primer, 5′-TGAAGAGGCAAGCAGGAGAAGTA-3′; rat RPL-37a: sense primer, 5′-CAAGGAAGTGCGDGATCTCGTG-3′; antisense primer, 5′-ACCAGGCAAGTCTACGGATGGTG-3′.

After initial denaturation at 95°C for 2 min, the temperatures and times used for GLUT4 were: 29 cycles at 95°C (30 s), 59.5°C (30 s), 72°C (45 s); and for RPL-37a (used as an internal constitutive control): 20 cycles at 95°C (30 s), 57-0°C (30 s), 72°C (30 s). The amplified products were resolved in a 2% agarose gel and analyzed by scanning densitometry (Eagle Eye-Stratagene, model 401304, software Eagle Sigh 3.2). Samples were normalized to the quantity of RPL-37a signal produced by RT-PCR and presented as arbitrary units (AU) of GLUT4 mRNA relative to control.

**Western blotting for GLUT4 protein**

Three subcellular membrane fractions of adipose tissue were prepared as described elsewhere (Okamoto et al. 2004). Tissue samples were homogenized and processed to obtain the following fractions: fat-free extract, plasma membrane (PM), and microsome. GLUT4 protein was assessed by western blotting method, as previously described (Okamoto et al. 2004). The intensity of the blots was quantified by densitometry using
Image Master 1D software (Pharmacia Biotech). Results were expressed as AU per microgram of total protein subjected to electrophoresis (AU/µg of protein), and GLUT4 content per gram of total EP fat pad (AU/g), normalizing as 100% the protein expression in control rat tissues.

Statistical analysis

Results were expressed as mean ± S.E.M. One-way ANOVA test was adopted to evaluate differences among groups. Bonferroni post hoc test was used to detect difference between groups. The analysis was performed by the statistical software package GraphPad Prism version 4.0 for Windows (GraphPad Software, San Diego, CA, USA). Differences were considered significant when $P<0.05$.

Results

Effect of treatment on body weight, glucose levels, food and water intake, and estimated pancreatic insulin content of 12-week-old animals. Values are mean ± S.E.M., $n=10$

<table>
<thead>
<tr>
<th></th>
<th>Group C</th>
<th>Group I</th>
<th>Group P</th>
<th>Group M</th>
<th>Group D</th>
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<tbody>
<tr>
<td>Body weight (g)</td>
<td>296.0 ± 8.6a</td>
<td>282.0 ± 9.1b,c</td>
<td>265.8 ± 5.6b,c</td>
<td>258.0 ± 8.7b,c</td>
<td>252.0 ± 6.9b</td>
</tr>
<tr>
<td>Lee index (g$^{1/3}$/cm)</td>
<td>29.4 ± 0.1a</td>
<td>29.2 ± 0.1b,a,c</td>
<td>24.6 ± 0.4a,c,d</td>
<td>30.1 ± 0.3b,a,c</td>
<td>28.9 ± 0.1b,a,c</td>
</tr>
<tr>
<td>Blood glucose (mg/dl)</td>
<td>116.2 ± 83.6a</td>
<td>144.2 ± 144.4,c,a</td>
<td>1403.3 ± 205.6a,c</td>
<td>151.8 ± 69.2b</td>
<td>174.9 ± 88.9b</td>
</tr>
<tr>
<td>Pancreatic insulin content (nM/islet)</td>
<td>42.7 ± 0.7a</td>
<td>26.4 ± 0.4a,c,d</td>
<td>32.8 ± 1.7a,d</td>
<td>30.1 ± 0.3b,a,c</td>
<td>33.8 ± 2.0b</td>
</tr>
<tr>
<td>Food intake (g/24 h)</td>
<td>50.0 ± 1.7a</td>
<td>50.9 ± 4.5b,a,b</td>
<td>51.0 ± 1.5a,b</td>
<td>83.9 ± 2.5a</td>
<td>117.5 ± 4.8c</td>
</tr>
<tr>
<td>Water intake (ml/24 h)</td>
<td>29.4 ± 0.1a</td>
<td>29.2 ± 0.1b,a,c</td>
<td>24.6 ± 0.4a,c,d</td>
<td>30.1 ± 0.3b,a,c</td>
<td>28.9 ± 0.1b,a,c</td>
</tr>
</tbody>
</table>

Letters after each value that are not shared mean that the results are significantly different ($P<0.05$).

Figure 1 Effect of insulin, pioglitazone, or metformin treatments on blood glucose profile in STZ-induced diabetes. Tail blood samples were weekly collected from awaken rats in fed state at 0800 h. Insert: area under the curve of blood glucose. Values are mean ± S.E.M., $n=10$. *Note that above each bar, there are letters. Bars sharing the same letters do not differ statistically. Letters not shared indicate statistically significant differences ($P<0.05$).

Table 1

Insulin and pioglitazone treatments increased adipose mass

Untreated diabetes significantly reduced the EP fat mass as well as the adipocyte size, which were corrected after insulin or pioglitazone treatments (Fig. 4A and B). Group M did not reproduce the same results and both the EP fat mass and the cell size did not differ from that of group D.

Effect of treatment on insulin-stimulated 2DGU

Significant reductions were seen in basal and maximally insulin-stimulated 2-DG uptake rates in group D. Both basal and maximal 2DGU rates were significantly recovered in I- and P-, but not M-treated rats, indicating an important improvement and an almost complete normalization (Fig. 5).

Insulin and pioglitazone increased GLUT4 protein and its mRNA expression

The GLUT4 protein and its mRNA content were also assessed in EP fat pads to check whether the improved insulin-stimulated 2-DG uptake (in groups I and P) has a molecular support by an up-regulation of this protein expression. Group D showed a significant reduction in GLUT4 levels in PM and microsomal (M) fractions, which apparently was not modified by metformin, but completely recovered by insulin or pioglitazone treatment (Fig. 6). When adjusted by fat pad weight (Table 3), the effects of the treatments became even clearer. Both P and I sustained the GLUT4 content in WAT at normal levels while M showed no effect. The defective expression of GLUT4 mRNA levels was only fully corrected by pioglitazone (112.3%) and insulin (96.6%) treatments (Fig. 7).

Effect of treatment on glucose oxidation and its incorporation into lipids

The glucose oxidation rates, significantly reduced in D group, were corrected by pioglitazone or insulin treatment, reaching values even higher than the ones found in group C (Fig. 8A). The ability of adipocytes to incorporate glucose into lipids was also improved in groups I and P. Metformin did not work on these aspects.

Insulin or pioglitazone reduced lipolytic activity

Figure 9 shows an elevated lipolytic activity in group D, which was partially reduced by metformin treatment. Pioglitazone and insulin therapies promoted significant reductions, with values even lower than that in group C ones.

Discussion

Early treatment with antidiabetic therapies ameliorated the metabolic condition, by improving fasting glucose levels and insulin sensitivity. However, the degree of improvement varied among the diabetic treated groups.

We detected no effect on body weight gain with metformin treatment, which confirms other studies associating this biguanide with no change or loss of body weight in diabetic patients (Després 2003, Setter et al. 2003). The insulin-sensitizing effects of metformin – mainly in liver and muscle – were capable of partially restoring the glucose and insulin homeostasis as seen by the reduced area under the glycemic curve (in ivGTT) and the increased glucose utilization by tissues – represented by $K_{ITT}$ values. On the other hand, the low pancreatic insulin content and reduced insulin and
C-peptide levels in group M indicate that the improvement in insulin sensitivity does not spare endocrine pancreas from exhaustion. This suggests that the β-cell damage was not corrected. As adipose tissue is not one of the main targets of metformin action, no improvement was seen in insulin sensitivity in the EP fat. As would be expected with the low insulin levels and the reduced responsiveness to insulin in isolated adipocytes in group M, these treated diabetic animals showed low GLUT4 content in PM and M fractions together with reduced GLUT4 mRNA expression in EP fat pad. Reduced incorporation of glucose into lipids (Fig. 8B) and increased lipolytic activity (Fig. 9) after metformin treatment might have contributed to the lack of recovery of fat mass seen in group M (Fig. 4). As a possible consequence of low fat mass, leptin levels in group M, similar to group D, were significantly reduced. Despite this, metformin was effective in reducing TAG levels. This effect may be attributed to the activation of the AMP-activated protein kinase pathway, possibly in the liver (Velasco et al. 1997).

Long-term treatment with pioglitazone or insulin decreased blood glucose levels significantly; however, it did not completely normalize them. Concurrently, these treatments regularized the food and water intake of the diabetic animals. The improvement in insulin levels can be explained as a consequence of better glycemic control promoted by these treatments. Conversely, C-peptide levels were only partially recovered in group P, without any changes noted in group I. As such, one could conclude that insulin treatment has no effect on C-peptide levels. However, this could be an inhibitory effect of exogenous insulin treatment, attempting to spare the endocrine pancreas from exhaustion. Pancreatic insulin content was fully recovered in groups I and, notably, in P. Pioglitazone as agonist of PPARγ might act directly on pancreatic islets since they express these nuclear receptors (Lupi et al. 2004). Other explanations for the improvement in pancreatic insulin content could be related to the better glycemic control or the anti-lipotoxicity effect of TZDs on β cells. As can be seen in Table 2, diabetic rats developed disturbances in lipid metabolism resulting in dyslipidemias with increased TAG and FFA levels. Excessive FFA

Table 2 Effect of treatment on serum insulin, leptin, C-peptide, triacylglycerol (TAG), and free fatty acid (FFA) levels in 12-h fasted animals. Values are mean±s.e.m., n=10

<table>
<thead>
<tr>
<th></th>
<th>Group C</th>
<th>Group I</th>
<th>Group P</th>
<th>Group M</th>
<th>Group D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin (ng/ml)</td>
<td>1.62±0.3a</td>
<td>1.29±0.2a,b,c</td>
<td>1.29±0.2a,b,c</td>
<td>0.52±0.1b</td>
<td>0.49±0.12b</td>
</tr>
<tr>
<td>Leptin (ng/ml)</td>
<td>4.0±0.5a</td>
<td>1.8±0.1b,c</td>
<td>3.6±0.3a</td>
<td>1.3±0.1b,c</td>
<td>1.4±0.3b</td>
</tr>
<tr>
<td>C Peptide (pM)</td>
<td>1268±3±146-1a</td>
<td>687±3±128-7b,c</td>
<td>878-6±124-0b,c</td>
<td>383±8±37-4b,c</td>
<td>488±4±40-0b</td>
</tr>
<tr>
<td>TAG (mg/dl)</td>
<td>75±9±10-6a</td>
<td>67±3±10-5a,b,b</td>
<td>73±5±7-9a,b,b</td>
<td>76±3±16-0a,b,b</td>
<td>127±8±12-0c</td>
</tr>
<tr>
<td>FFA (mmol/l)</td>
<td>0.75±0.02a</td>
<td>0.83±0.01a,b,c</td>
<td>0.76±0.02a,b,c</td>
<td>0.79±0.01a,b,c</td>
<td>0.86±0.02b</td>
</tr>
</tbody>
</table>

Letters after each value that are not shared mean that the results are significantly different (P<0.05).

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mobilization could impair β-cell function, resulting in proinflammatory and pro-apoptotic results, which contribute to a severe insulin degranulation of the pancreas (Grill & Björklund 2000). Based on our data, one might conclude that the excessive FFA mobilization from adipose tissue was avoided by Pi treatment (Table 2), greatly contributing to β-cell recovery.

Furthermore, the improvement on lipid metabolism promoted by pioglitazone may contribute to good insulin responsiveness, avoiding the accumulation of intracellular lipids in muscle or other extra-adipose tissues that might have resulted in the metabolic abnormalities observed in DM.

### Table 3

<table>
<thead>
<tr>
<th></th>
<th>PM</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group C</td>
<td>23 648 ± 2170</td>
<td>21 499 ± 1780</td>
</tr>
<tr>
<td>Group I</td>
<td>35 745 ± 5456</td>
<td>33 440 ± 2080</td>
</tr>
<tr>
<td>Group P</td>
<td>23 275 ± 2798</td>
<td>22 484 ± 2801</td>
</tr>
<tr>
<td>Group M</td>
<td>10 908 ± 861</td>
<td>9 392 ± 1308</td>
</tr>
<tr>
<td>Group D</td>
<td>9 391 ± 1350</td>
<td>9 771 ± 1890</td>
</tr>
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</table>

Letters after each value that are not shared mean that the results are significantly different (P<0.05).
responsiveness after insulin or pioglitazone treatment are the territory.

levels and ideal fat mass on glucose metabolism in this depot (Table 3), indicating the critical role of normal insulin accentuated the increase of GLUT4 levels in this adipose weight. Similarly, the recovery of fat mass in groups I and P group D were even lower when adjusted for total EP fat pad demonstrated that the GLUT4 protein levels presented by (Sandouk et al. 1993, Furuta et al. 2002). In our work, we also demonstrated that the GLUT4 protein levels presented by group D were even lower when adjusted for total EP fat pad weight. Similarly, the recovery of fat mass in groups I and P accentuated the increase of GLUT4 levels in this adipose depot (Table 3), indicating the critical role of normal insulin levels and ideal fat mass on glucose metabolism in this territory.

Additional data that reinforce the idea of better insulin responsiveness after insulin or pioglitazone treatment are the remarkable increase in glucose oxidation, incorporation into lipids and a drop in lipolysis, which even overcame group C response values. This also explains the recovery of adipose mass and adipocyte size seen in these groups.

The overcorrection in glucose oxidation promoted by P or I treatments could be explained by an increase in pyruvate dehydrogenase (PDH) activity. The effect of insulin in activating PDH in adipose tissue is already established (Mukherjee & Jungas 1975, Stansbie et al. 1976). Our study was the first to check the pioglitazone effect on glucose oxidation in isolated adipocytes. This effect could be related to the improvement on insulin levels. However, no study has evaluated the TZD effect on PDH activity in adipose tissue and therefore, further studies need to be performed to check the mechanisms behind this increase in glucose oxidation promoted by pioglitazone.

As can be seen in Table 2, pioglitazone was the only treatment to restore leptin levels. Interestingly, group I did not show an increase in leptin levels. The role of leptin in metabolism and insulin sensitivity is well established. The lack of leptin or the defect in its action can lead to insulin resistance, dyslipidemias, fatty liver, and diabetes (Van Dijk et al. 2003). However, the low levels of leptin shown in group I may indicate the involvement of other adipokines or tissues (mainly muscle and liver) in the improvement in metabolic parameters evaluated in these animals. On the other hand, the direct effect of insulin on leptin expression remains controversial (Russell et al. 1998, Kanu et al. 2003). Interestingly, in primary adipocyte culture, insulin alone showed no effect on leptin expression. However, in the presence of melatonin, insulin promoted an increase on leptin release, which indicates that insulin interacting synergistically with melatonin produces such a stimulatory effect (Alonso-Vale et al. 2005). In the present work, the serum samples were collected in the morning period when melatonin levels are low. This may be a reason for observing no increase in leptin levels in group I.

Our data might not agree with others, where pioglitazone alone did not exert any effect on glucose or lipid metabolism. In STZ-induced diabetic rats in adulthood, a 4-day pioglitazone treatment was unable to improve glucose levels or insulin resistance. However, when pioglitazone was associated with insulin, there was a complete recovery (Ikeda et al. 1990, Hofmann et al. 1991). A reasonable explanation for these discrepancies could be the time of diabetes induction (adulthood against neonatal period) and treatment duration (short×long term). Furthermore, induction of diabetes during the neonatal period could reflect a more natural progression of this disease, resembling that in human DM.

In this work, we demonstrated that early antidiabetic therapy was capable of partially correcting metabolic abnormalities previously described in this STZ model. All treatments succeeded in significantly reducing, but not normalizing glucose levels. This clearly indicates the participation of other tissues, mainly muscle and liver, on
glucose homeostasis. Interestingly, when pioglitazone was given to insulin-resistant animals, it promoted a recovery of adipose mass parallel to the improvement of insulin sensitivity and diabetic condition, while metformin was unable to promote any effect on adipose mass and on its insulin sensitivity. These data indicate that the intense reduction of adipose mass in this experimental model plays a significant role in the metabolic condition developed by these animals in adulthood as the recovery of adipose mass corrected considerably the DM metabolic abnormalities.

Declaration of Interest

The authors declare that there is no conflict of interest that would prejudice the impartiality of this scientific work.

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