20 YEARS OF LEPTIN

Role of leptin in human reproductive disorders

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Abstract

Leptin, as a key hormone in energy homeostasis, regulates neuroendocrine function, including reproduction. It has a permissive role in the initiation of puberty and maintenance of the hypothalamic–pituitary–gonadal axis. This is notable in patients with either congenital or acquired leptin deficiency from a state of chronic energy insufficiency. Hypothalamic amenorrhea is the best-studied, with clinical trials confirming a causative role of leptin in hypogonadotropic hypogonadism. Implications of leptin deficiency have also emerged in the pathophysiology of hypogonadism in type 1 diabetes. At the other end of the spectrum, hyperleptinemia may play a role in hypogonadism associated with obesity, polycystic ovarian syndrome, and type 2 diabetes. In these conditions of energy excess, mechanisms of reproductive dysfunction include central leptin resistance as well as direct effects at the gonadal level. Thus, reproductive dysfunction due to energy imbalance at both ends can be linked to leptin.

Key Words

- leptin
- metabolism
- reproduction
- neuroendocrinology

Introduction

In 1974, Frisch proposed that the ability to reproduce requires a certain threshold of body fat to serve as the minimal store of energy necessary for ovulation, menstruation, and intended pregnancy (Frisch & McArthur 1974). Leptin eventually emerged as the predominant candidate linking adipose tissue, energy availability, and reproductive function (Chan & Mantzoros 2005, Mantzoros et al. 2011). Leptin is a hormone produced primarily in adipose tissue, and concentrations of leptin are directly proportional to amount of body fat (Considine et al. 1996, Yannakoulia et al. 2003, Hamnvik et al. 2011). More importantly, leptin concentrations are very sensitive to energy deprivation – 3 days of fasting decreases the concentrations to 10% of baseline (Chan et al. 2003). Women with hypothalamic amenorrhea (HA), which is a state of chronic energy deprivation from excess energy expenditure, stress, and/or insufficient nutritional intake, also have hypoleptinemia (Miller et al. 1998, Andrico et al. 2002). HA is characterized by dysfunction of the hypothalamic–pituitary–gonadal (HPG) axis, leading to anovulation and cessation of menstrual cycles in the absence of organic disease. Treatment with leptin has been found to restore reproductive function in these women (Welt et al. 2004, Chou et al. 2011). On the opposite spectrum, hyperleptinemia seen in obesity may play a role in hypogonadism and subfertility due to the development
of leptin resistance, akin to insulin resistance. Thus, the regulatory effect of leptin on reproductive function appears to be U-shaped, with a protective role at low concentrations and pathological at high concentrations (Fig. 1; Table 1).

**Leptin in normal reproductive life**

**Puberty**

Similar to reproductive function, puberty has also been described to be ‘metabolically gated’ as a means to prevent fertility in conditions of energy insufficiency (Sanchez-Garrido & Tena-Sempere 2013). By signaling adequate energy stores, leptin was initially thought to be the trigger for the pubertal maturation. In girls, age at menarche has been found to be inversely related to serum concentrations of leptin and body fat (Mattkovic et al. 1997). In both girls and boys, leptin concentrations rise before pubertal transition, followed by an initial increase of follicle-stimulating hormone (FSH), luteinizing hormone (LH), and then sex steroids (Garcia-Mayor et al. 1997, Mantzoros et al. 1997a). In girls, however, leptin concentrations continue to rise, likely due to stimulatory effects of estrogen, while leptin concentrations decrease in boys, despite increasing BMI, due to the inhibitory effects of testosterone (Garcia-Mayor et al. 1997, Mantzoros et al. 1997a, Rosenbaum & Leibel 1999). Leptin, however, is currently thought to have a more permissive role in pubertal maturation, as the administration of exogenous leptin alone could not trigger early puberty in patients with congenital leptin deficiency (Farooqi et al. 2002). Thus, it is unlikely that the early onset of puberty observed in obese children can be attributed to hyperleptinemia alone, especially because hyperleptinemia is associated with its resistance or tolerance.

More recently, KISS1 neurons in the arcuate nucleus (ARC) have been attributed as the ultimate gatekeepers of puberty, through which multiple metabolic input converge in addition to leptin (Sanchez-Garrido & Tena-Sempere 2013). Leptin may directly and indirectly stimulate these neurons to secrete kisspeptins that then stimulate gonadotropin-releasing hormone (GnRH) neurons (Sanchez-Garrido & Tena-Sempere 2013); leptin itself cannot stimulate GnRH neurons as they do not express leptin receptors (Quennell et al. 2009). However, the direct effects of leptin on KISS1 neurons do not seem to be required for puberty, as the deletion of leptin receptors from KISS1 neurons does not seem to affect pubertal timing (Donato et al. 2011). Furthermore, the selective expression of leptin receptors on only KISS1 neurons did not result in pubertal development (Cravo et al. 2013). In addition to leptin, neurokinin B, which is co-expressed with kisspeptins, has also been found to convey metabolic information to KISS1 neurons in a stimulatory autocrine/paracrine manner, which is also important for the initiation of puberty (Navarro et al. 2012, Pinilla et al. 2012). Outside of KISS1 neurons in the arcuate nucleus, leptin may also act on glutamatergic neurons in the ventral premammillary nucleus, which has also been shown to stimulate GnRH neurons during the development of puberty (Elias 2012).

**Reproductive function**

As in puberty, the effect of leptin on reproductive function depends on the metabolic state and involves a large network of neurons, converging at the hypothalamus, which allows for redundancies (Elias & Purohit 2013). Intracerebroventricular administration of leptin stimulates LH secretion in feed-restricted, but not well-nourished, ovariectomized mammals (Henry et al. 1999, 2001, Morrison et al. 2001, Amstalden et al. 2002). Again, the complex metabolic regulation of reproduction likely centers around the KISS1 neurons, which receive input from multiple hormonal signals, including leptin, ghrelin, neuropeptide Y (NPY), melanocortins, insulin, and insulin-like growth factor (Pinilla et al. 2012). Although leptin inhibits neurons that produce agouti-related peptide...
(AgRP) and NPY and stimulates neurons to secrete melanocortins (processed from proopiomelanocortin (POMC)) to decrease satiety and food intake (Cowley et al. 2001), KISS1 neurons appear to have their own reciprocal innervations with AgRP/NPY and POMC neurons (Backholer et al. 2010). AgRP antagonizes melanocortin receptors, resulting in LH inhibition in female animal studies (Watanobe et al. 1999, Schioth et al. 2001, Vulliemoz et al. 2005), while the effects of NPY on gonadotropins have been contradictory and seem to depend on the sex steroid milieu (Kalra et al. 1987, McDonald et al. 1989, Sabatino et al. 1989, Reznikov & McCann 1993, Urban et al. 1996, Jain et al. 1999, Elias & Purohit 2013). Outside the arcuate nucleus, leptin also stimulate glutamergic neurons in the ventral premammillary nucleus and steroidogenic factor 1 neurons in the ventromedial nucleus of the hypothalamus to modulate reproductive function (Elias & Purohit 2013).

Leptin also seems to have redundant signaling pathways to centrally modulate reproductive effects. Although phosphorylation of signal transducer and activator of transcription 3 (STAT3) by leptin is critical for body energy homeostasis, it is not critical for reproductive function. The selective deletion of leptin-induced STAT3 signaling in female mice results in obesity and hyperphagia, but they maintain fertility (Bates et al. 2003). Similarly, selective deletion of leptin-induced phosphoinositide 3-kinase (PI3K) activity also results in

Table 1  Effect of leptin treatment in disorders associated with leptin deficiency and excess

<table>
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<tr>
<th>Disorder</th>
<th>Reproductive dysfunction</th>
<th>Effect of leptin treatment</th>
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<tr>
<td>Leptin deficiency</td>
<td>Delayed/arrested puberty</td>
<td>Permits onset of puberty in appropriately aged children</td>
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<td>Congenital leptin deficiency</td>
<td>Hypothalamic hypogonadism</td>
<td>Increases LH levels</td>
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<td>Menstrual abnormalities from luteal phase defect to amenorrhea</td>
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<td>Enlarged, polycystic ovaries</td>
<td>Dramatically decreases weight, food intake, and appetite</td>
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<td>Hyperandrogenesis</td>
<td>Improves insulin resistance</td>
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<td>Hyperinsulinemia, insulin resistance</td>
<td>Decreases free testosterone levels</td>
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<td>Normal pubertal onset</td>
<td>Increases SHBG levels</td>
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<td>Low amplitude/frequency of GnRH pulses</td>
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<td>Low/normal LH, FSH levels</td>
<td>Normalizes menses</td>
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<td>Low estradiol levels</td>
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<td>Anovulation</td>
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<td>Amenorrhea</td>
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<td>Sick euthyroid syndrome-like picture</td>
<td>Restores ovulation in 40%</td>
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<td>Growth hormone resistance</td>
<td>Restores menses in 70%</td>
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<td>Increases levels of free IGF1</td>
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<td>Improves bone mineral density</td>
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<td>In mice models</td>
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<td>Restores Kiss1 gene expression, normalizes LH and sex steroids</td>
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<td>Improves glucose control and variability</td>
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<td>Hypothalamic amenorrhea</td>
<td>Hypogonadotropic hypogonadism, infertility with uncontrolled disease</td>
<td>Unknown</td>
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<td>Type 1 diabetes</td>
<td>Hyperinsulinemia, insulin resistance</td>
<td>Modest weight loss, if any</td>
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<td>Increased levels of inflammatory markers, free fatty acids</td>
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<td>Polycystic ovaries</td>
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<td>Type 2 diabetes</td>
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FSH, follicle-stimulating hormone; GnRH, gonadotropin-releasing hormone; HPA, hypothalamic-pituitary-adrenal; IGF1, insulin-like growth factor 1; LH, luteinizing hormone; SHBG, sex hormone binding globulin.
fertile mice, despite features of obesity, glucose intolerance, and insulin resistance (Sadagurski et al. 2012, Elias & Purohit 2013). Mammalian target of rapamycin (mTOR) has been proposed to be an intracellular energy sensor and seems to be an important mediator of leptin signaling for reproductive function (Roa et al. 2009, Codner et al. 2012). Chronic activation of mTOR has been shown to partially reverse hypogonadism in caloric-restricted prepubertal female mice, while the blockade of mTOR activity blunts the positive effects of leptin on puberty in these mice (Roa et al. 2009).

Finally, leptin has also been found to have both stimulatory and inhibitory effects at the levels of the pituitary and gonads (Yu et al. 1997a,b, Agarwal et al. 1999, Tena-Sempere et al. 1999, 2000, Karamouti et al. 2009), and the effect of leptin may depend on metabolic status and sensitivity to leptin (Tena-Sempere 2007, Bluher & Mantzoros 2007). This is further discussed below in the clinical context of hyperleptinemia associated with type 2 diabetes mellitus and polycystic ovarian syndrome (PCOS).

**Pregnancy**

Concentrations of leptin rise continuously throughout pregnancy, fall considerably after birth, and then return to normal 6 weeks postpartum (Schubring et al. 1998). Although leptin concentrations correlate significantly with BMI during early pregnancy, the correlation coefficients drop with increasing gestational age until after delivery (Schubring et al. 1998). The additional source of leptin may be from the placenta and is regulated by human chorionic gonadotropin (hCG) and estradiol (Chardonnens et al. 1999, Maymo et al. 2009, Tessier et al. 2013). In pregnant rodents, central administration of leptin results in reduced food intake until mid-pregnancy when central resistance to leptin develops (Johnstone & Higuchi 2001, Mistry & Romsos 2002). In addition to an increase in plasma leptin-binding activity seen in pregnant rats (Seeber et al. 2002), progesterone, prolactin, and placental lactogen may also contribute to leptin resistance (Grueso et al. 2001, Naef & Woodside 2007, Brunton & Russell 2008). The development of hyperleptinemia and leptin resistance during pregnancy has been proposed to be a compensatory mechanism to allow for increased appetite and food intake to meet the energy needs of the developing fetus (Brunton & Russell 2008).

Leptin may also have important roles in the placenta, including nutrient delivery to the fetus, angiogenesis and vascular smooth muscle growth in chorionic villi, and immune modulation (Jansson et al. 2003, White et al. 2006, Bohlen et al. 2007, Garonna et al. 2011, Tessier et al. 2013). Although central leptin resistance appears to be physiologic in healthy pregnant women, obese pregnant women who have even higher concentrations of leptin appear to also have placental resistance that may be pathologic (Farley et al. 2010, Tessier et al. 2013). Higher degrees of maternal hyperleptinemia in obesity are associated with downregulation of leptin receptors in the placenta (Farley et al. 2010) and increased concentrations of the soluble form of leptin receptors that may prevent leptin binding and signaling (Challier et al. 2003). These disturbances in leptin physiology have been linked to gestational diabetes mellitus, fetal growth restriction, macrosomia, and preeclampsia, but the mechanisms of pathophysiology remains to be elucidated (Acromite et al. 2004, Tessier et al. 2013).

**States of leptin deficiency**

Hypoleptinemia is extremely rarely congenital. In these patients, the lack of leptin activity results in a drive to consume food and conservation of energy expenditure that does not feed back to the hypothalamus. Acquired relative hypoleptinemia is much more common, particularly seen in women with HA or anorexia nervosa. In these patients, hypoleptinemia reflects a state of chronic energy deficiency and leads to compensatory mechanisms. These mechanisms include hypogonadotropin hypogonadism, euthyroid sick syndrome, and other neuroendocrine abnormalities as well as deficits in bone metabolism and immune function (Chan et al. 2003, Chan & Mantzoros 2005, Dardeno et al. 2010).

**Congenital leptin deficiency**

Patients with complete leptin deficiency due to homozygous leptin gene mutations develop extreme obesity with hyperphagia, insulin resistance, and distinct neuroendocrine abnormalities, including hypogonadism (Farooqi et al. 2002, Licinio et al. 2004). Ozata et al. (1999) reported three adult patients, all of whom had delayed puberty and hypothalamic hypogonadism. The male patient had not entered puberty by the age of 23, with no facial hair, scant pubic and axillary hair, small penis and testes, and azospermia. His total testosterone concentration was 80 ng/ml (normal range: 241–827) with inappropriately normal gonadotropin concentrations. One of the female patients developed scanty menstrual bleeding every 7–8 months at the age of 29, while the
other female patient started regular menses at age of 35 though their cycles were found to have a luteal-phase defect. Ultrasonography of mammary gland had shown minimal to no glandular tissue for both women. Hypogonadism appeared to be due to a defect at the hypothalamic level as these patients had normal gonadotropin responses to GnRH stimulation (Ozata et al. 1999). Leptin treatment stimulated the onset of puberty in the male patient who then developed increased facial hair, acne, pubic and axillary hair, increased size of penis and testes, and normal ejaculatory patterns (Licinio et al. 2004). Furthermore, he reported improvements in muscle strength and wellbeing. The female patients developed regular menses with elevated mid-luteal phase progesterone concentrations indicating ovulation. After 6 months of leptin treatment, 24-h average concentrations of LH significantly increased from baseline, attributed to increased pulse amplitudes and not pulse frequency.

Results in children and adolescents confirm leptin’s role as a permissive factor in puberty. Treatment with leptin did not affect the prepubertal pattern of gonadotropin secretion in younger patients, but did initiate puberty in a child who was previously prepubertal despite a bone age of 12.5 years (Farooqi et al. 2012). Another case report describes a girl whose pubertal development had arrested at Tanner stage 3 (von Schnurbein et al. 2012). Before initiation of leptin therapy, LH and FSH were at prepubertal concentrations without any nocturnal pulsatility, and response to GnRH stimulation was low. After 11 weeks of therapy, basal and stimulated LH and FSH concentrations rose to pubertal concentrations and nocturnal pulsatility was restored; weight had not yet begun to fall at this time. Menarche occurred 76 weeks after initiation of treatment.

**Lipodystrophy**

Similar to patients with congenital leptin deficiency, patients with lipodystrophy, either due to a congenital or an acquired destruction of adipose tissue, are also hypoleptinemic and insulin resistant (Pardini et al. 1998, Nagy et al. 2003, Fiorenza et al. 2011). In addition to improving insulin resistance (Lee et al. 2006, Ebihara et al. 2007, Brennan et al. 2009, Magkos et al. 2011), leptin may also have beneficial effects on reproductive function of lipodystrophic women (Musso et al. 2005). Women with lipodystrophy usually have enlarged polycystic ovaries, hyperandrogenism, amenorrhea, and infertility (Pardini et al. 1998, Musso et al. 2005). In an open-label study of 10 women with generalized lipodystrophy, leptin treatment for 12 months decreased serum free testosterone concentrations by 50%, increased sex hormone-binding globulin (SHBG) concentrations, and increased the LH response to GnRH (Musso et al. 2005). SHBG is a sex steroid transport protein that decreases circulating concentrations of free testosterone, and low concentrations of SHBG have been associated with metabolic syndrome and type 2 diabetes (Brand et al. 2011). Eight of these women were amenorrheic before therapy, and leptin treatment induced normal menses in all these women (Musso et al. 2005). These improvements were likely due to both a direct effect of leptin on the reproductive system and an indirect effect through weight loss and increased insulin sensitivity. In contrast, the men with lipodystrophy had normal concentrations of testosterone, which increased with leptin treatment; LH response to GnRH was not affected (Musso et al. 2005).

Despite the low concentrations of leptin in these lipodystrophic patients, puberty does not seem to be affected. Musso et al. (2005) followed eight male patients from early childhood, and all underwent appropriate pubertal development unrelated to leptin therapy. Andreelli et al. (2000) described two female patients with Seip-Berardinelli syndrome, a form of generalized lipoatrophy starting in early infancy. Both patients underwent menarche between 11 and 12 years of age and had regular menses; one had become pregnant to term three times. Thus, very low concentrations of leptin may be sufficient to allow for progression through puberty in these patients.

**Hypothalamic amenorrhea**

More than 30% of cases of amenorrhea in women of reproductive age are attributed to HA (Reindollar et al. 1986). Given the prevalence of this condition, the relationship between HA and leptin has been well-studied. Compared with weight-matched (Miller et al. 1998, Andrico et al. 2002) and activity-matched (Thong et al. 2000, Cort et al. 2011) eumenorrheic controls, women with HA have lower leptin concentrations. Leptin concentrations also significantly increase in association with recovery from HA and anorexia nervosa (Misra et al. 2004, Dei et al. 2008, Kostrewa et al. 2013).

By signaling a state of energy deficiency, hypoleptinemia has been found to be a key mediator of neuroendocrine abnormalities seen in HA (Chan & Mantzoros 2005, Khan et al. 2012). In addition to dysfunctional HPG axis resulting in anovulation and estrogen deficiency to prevent pregnancy, other neuroendocrine axes are affected to serve as an adaptive response to negative
energy balance. These effects include increased concentrations of corticotropin-releasing hormone, adrenocorticotropic hormone (ACTH), and cortisol (Laughlin & Yen 1997, Genazzani et al. 2001, Gordon 2010); low to normal concentrations of thyrotropin, decreased concentrations of thyroid hormone, and increased concentrations of the inactive reverse triiodothyronine (Warren et al. 1999, Genazzani et al. 2006, Bomba et al. 2007); and growth hormone (GH) resistance with elevated concentrations of GH (Berga et al. 1989, Laughlin & Yen 1996, Laughlin et al. 1998) but decreased insulin-like growth factor 1 (IGF1) activity (Laughlin & Yen 1996, Genazzani et al. 1996, Chan et al. 2008). Two pivotal clinical trials have demonstrated how leptin treatment in physiological doses can restore normal neuroendocrine physiology as well as improve bone metabolism and immune function parameters. One is a proof-of-concept pilot study of 3 month duration (Welt et al. 2004), while the other is a randomized, placebo-controlled trial of 9 month duration (Chou et al. 2011).

In these two clinical trials, leptin replacement restored the HPG axis in hypothalamic amenorrheic women (Welt et al. 2004, Chou et al. 2011). Leptin treatment significantly increased LH concentrations, LH pulse frequency (but not amplitude), and estradiol and progesterone concentrations. In the open-label trial, pelvic ultrasonography documented increases in ovarian volume during the follicular phase and thicker endometrium after treatment (Welt et al. 2004). Significant increases in the number of dominant follicles and maximal follicular diameter were also observed. Five out of eight treated women developed menses, three of which were ovulatory. In the follow-up randomized controlled trial of 36 weeks duration, seven of ten participants receiving leptin therapy developed menses, compared with two of nine participants on placebo ($P=0.0046$; Chou et al. 2011). Four of the menstruating participants on leptin were determined to be ovulatory based on elevated serum progesterone concentrations during the mid-luteal phase. Of the five treated participants who regained menses and completed the study, three continued to have menses 16 weeks after discontinuation of leptin. One women became pregnant at 24 weeks. The improvements in reproductive function in these treated women were not due to changes in physical activity level, weight gain, or increase in fat mass. By signaling adequate energy stores, leptin seems to permit the return of reproductive function in HA, similar to its permissive role in the initiation of puberty (Licinio et al. 2004, Chan & Mantzoros 2005). Leptin treatment was also found to decrease cortisol concentrations, increase thyroid hormone concentrations, and tended to increase IGF1 concentrations (Welt et al. 2004, Chou et al. 2011).

In addition to its neuroendocrine effects, treatment with leptin, either directly and/or via normalization of neuroendocrine hormones, improves bone health. After a treatment duration of 2 years, lumbar bone mineral content and bone mineral density increased significantly from baseline by 6 and 4% respectively (Siennkiewicz et al. 2011). Albeit no direct comparison studies are available, this effect appears to be better than that of estrogen therapy, the use of which has been controversial (Ducher et al. 2011). In one of the largest randomized controlled trials, 2 years of oral contraceptives in oligo/amenorrheic runners resulted in a 1% gain in spine bone mineral density per year, which was similar to runners who regained periods spontaneously but significantly greater than those who remained oligo/amenorrheic (Cobb et al. 2007). Estrogen may have limited effects in amenorrheic athletes as it has primarily anti-resorptive effects on bone, and the markers of bone turnover in these women are already low (Ducher et al. 2011). Furthermore, estrogen therapy, unlike leptin replacement, does not address the disturbances in thyroid hormone, IGF1, and cortisol concentrations. Likewise, recombinant human IGF1 (Grinspoon et al. 2002) and androgens (Gordon et al. 1999) have been found to have modest responses in bone metabolism in women with anorexia nervosa, and a lesser response would be suspected in women with the less severe condition of HA.

Finally, leptin treatment has been shown to improve deficiencies in the immune system (Chan et al. 2005, Matarese et al. 2013). The women with HA in the randomized controlled trial were found to have reduced total number of lymphocytes, B cells, and natural killer cells, and leptin restored their total lymphocyte count with increases in CD4+ and CD8+ T-cell counts (Matarese et al. 2013). In contrast, the placebo-treated HA subjects experienced a decreasing trend in lymphocyte count to frank lymphopenia over time. Women with HA were also found to have reduced T-cell proliferative capacity, compared with normoleptinemic control women, and this was partially restored with leptin. In this small study, these effects of leptin were not associated with changes in serum hormone concentrations of cortisol, ACTH, or insulin; circulating cytokines (e.g., IL1, IL7, or IL15); or metabolic/inflammatory parameters (e.g., CD40–CD40 ligand, soluble TNF receptors, monocyte chemoattractant protein 1, myeloperoxidase, and C-reactive protein). In peripheral bone marrow cells, leptin treatment was found...
to upregulate genes involved in lymphocyte survival, proliferation, and migration (e.g., IL7, neurotrophin-3, ADAM-metallopeptidase 23 (ADAM23), and vascular adhesion molecule 1 (VCAM1)) and downregulate genes involved in apoptosis (e.g., B-cell chronic lymphocytic leukemia/lymphoma 10 (BCL10) and TP53-regulator of apoptosis 1 (TRAP1)) (Matarese et al. 2013).

As expected, women treated with leptin lost weight and fat mass. With careful monitoring and dose adjustments, however, weight can be maintained and loss of total body fat mass and percentage can be minimized on leptin therapy. In the placebo-controlled trial of leptin in women with HA, treatment dose was decreased if the participant lost >5% of her baseline weight (Chou et al. 2011). As a result, BMI did not change in the leptin group (20.8 ± 0.6 kg/m² at week 36 compared with 21.1 ± 0.6 kg/m² at baseline) compared with the placebo group (19.6 ± 0.4 kg/m² at week 36 compared with 19.8 ± 0.7 kg/m² at baseline; P=0.23). However, the leptin group did experience a progressive loss of total body fat mass and percentage with a mean loss of 2 kg of fat. The loss of fat was noted from both peripheral and central areas of distributions and reverted 16 weeks after discontinuation of leptin. Lean body mass was not affected (Brinkoetter et al. 2011). No changes in resting energy expenditure (measured by indirect calorimetric testing) or food intake (measured by 3-day food diaries) were noted, though the methods are not sensitive (Chou et al. 2011).

Type 1 diabetes

An interest for the use of leptin in patients with type 1 diabetes has recently emerged, though clinical studies are lacking. Many patients with type 1 diabetes have low concentrations of leptin (Kiess et al. 1998), possibly due to suppression by elevated circulating concentrations of free fatty acids and ketones from lipolysis seen in the state of insulin deficiency (Moon et al. 2013). In essence, uncontrolled type 1 diabetes represents a state of energy deficiency in that there is an inability to utilize available energy. Although not yet shown in humans, leptin treatment has been shown to improve glucose control as well as glucose variability via suppression of glucagon in rodent studies (Wang et al. 2010).

Before the use of insulin, type 1 diabetes patients experienced severe hypogonadism and low fertility rates, and although this improved with the introduction of insulin, inadequate control is still associated with hypogonadotropic hypogonadism with amenorrhea and delayed puberty (Codner et al. 2012). Both insulin deficiency and hyperglycemia have been found to disrupt the metabolic control of the HPG axis from the hypothalamus to the ovary (Codner et al. 2012). Leptin deficiency may also be contributing to hypogonadism in uncontrolled type 1 diabetes. In streptozotocin-induced diabetic rats, central infusion of leptin, but not insulin, restored hypothalamic Kiss1 gene expression and normalized LH and sex steroid concentrations (Castellano et al. 2006). Again, leptin treatment has not been studied in this context in humans, and glucose control would be the primary focus of treatment and this alone may improve reproductive function.

States of leptin excess

Obese individuals have an increased risk of hypogonadism and subfecundity (Ramlau-Hansen et al. 2007). Multiple factors adversely affecting reproduction function in obesity include increased inflammatory markers, increased concentrations of free fatty acids, hyperinsulinemia and insulin resistance, low concentrations of SHBG, and high concentrations of free androgens in women, all of which are often related to concentrations of adipokines, such as adiponectin, resistin, visfatin, and leptin (Jungheim et al. 2012, Chen et al. 2013).

Focusing on leptin, most obese individuals do not have congenital leptin deficiency and have high serum leptin concentrations (Considine et al. 1996) mainly due to diet-induced expansion of adipocytes (Moon et al. 2013). Despite hyperleptinemia, these patients are felt to be tolerant or resistant to the effects of leptin (Moon et al. 2011), and treatment with leptin in obese adults results in modest to no weight loss (Heymsfield et al. 1999, Moon et al. 2011). Based on in vitro and rodent studies, several mechanisms of leptin resistance have been proposed, including impaired transport across the blood brain barrier (El-Haschimi et al. 2000), impaired leptin signaling by suppressor of cytokine signaling 3 (SOCS3; Bjorbaek et al. 1998, Dunn et al. 2005), impaired leptin receptor trafficking (Bjornholm et al. 2007, Morrison et al. 2007), saturation of leptin signaling pathways (Moon et al. 2012), endoplasmic reticulum stress (Ozcan et al. 2009), and downmodulation of leptin’s neural circuitry (Pinto et al. 2004, Moon et al. 2013). A few of these mechanisms have been confirmed in human studies (Moon et al. 2011). In human adipose tissue and peripheral blood mononuclear cells, leptin signaling pathways have been confirmed to saturate near a concentration of 50 ng/ml and STAT3 signaling has been found to be inhibited by endoplasmic reticulum stress (Moon et al. 2011).
Central leptin resistance has been proposed as a mechanism for hypogonadotropic hypogonadism related to obesity (Teerds et al. 2011). This idea has been explored by Tortoriello et al. (2004) in a strain of diet-induced obese female mice with subsequent leptin resistance. High-fat diet was associated with more than a 60% decrease in natural pregnancy rates. Normal ovulatory response and pregnancy rates were achieved after exogenous gonadotropin stimulation, suggesting a hypothalamic defect. Indeed, PCR quantification of hypothalamic cDNA revealed a 100% upregulation of NPY and 50% suppression of GnRH compared with lean counterparts. Furthermore, there was 95% reduction in leptin receptor type B expression but no change in SOCS3 expression, suggesting the importance of decreased receptor availability in leptin resistance. Interestingly, fertility of male rats was not affected despite developing a similar degree of obesity and hyperleptinemia. The authors reason that this sexual dimorphism makes teleological sense as females require certain individuals predisposed to the adverse reproductive effects of central leptin resistance.

In addition to central effects, hyperleptinemia has also been found to directly affect gonadal tissue in both genders. To represent both genders, the effects of hyperleptinemia related to obesity will be further discussed in women with PCOS and men with type 2 diabetes mellitus.

**Polycystic ovarian syndrome**

Studies have been conflicting on whether women with PCOS have higher or similar concentrations of leptin compared with weight-matched controls, but, as expected, leptin concentrations correlate strongly with BMI in both groups (Brzchffia et al. 1996, Laughlin et al. 1997, Mantzoros et al. 1997b, Kowalska et al. 2001, Yildizhan et al. 2011). Women with PCOS may actually have higher free concentrations of leptin. Hahn et al. (2006) have found lower concentrations of soluble leptin receptors and have proposed this to be a mechanism to compensate for leptin resistance.

Leptin, however, does not appear to play a major role in HPG axis dysfunction or hyperandrogenemia. Leptin concentrations do not seem to correlate with concentrations of LH, testosterone, dehydroepiandrosterone sulfate, and estradiol (Brzchffia et al. 1996, Mantzoros et al. 1997b, Kowalska et al. 2001). Pulses of leptin have been found to synchronized with pulses of LH in patients with PCOS, as they are in regularly menstruating women (Sir-Petermann et al. 1999). However, the significance of this is unclear (Sir-Petermann et al. 1999). Leptin concentrations are negatively associated with SHBG and free concentrations of sex steroids (Laughlin et al. 1997, Hahn et al. 2006), although this may be related to the negative effect of insulin resistance on SHBG concentrations.

Although hyperleptinemia may not play a large role in the central dysfunction of PCOS women due to central leptin resistance, it may interfere with follicular development. Leptin receptors have been detected in granulosa and theca cells of human ovarian follicles (Cioffi et al. 1996, Agarwal et al. 1999). In an in vitro study, leptin has been shown to stimulate granulosa cells to secrete estradiol and progesterone at low concentrations but inhibit secretion at high concentrations (Karamouti et al. 2009). Leptin has also been found, in a dose-dependent manner, to inhibit IGFI augmentation of FSH-stimulated estradiol production by granulosa cells and LH-stimulated androgen production by theca cells, thus decreasing the substrate for estradiol (Agarwal et al. 1999). Clinically, however, no significant differences in serum leptin concentrations between ovulatory and anovulatory PCOS subjects have been found, therefore any role of leptin on follicular development may be mediated through differences in tissue sensitivity (Pirwany et al. 2001, Carmina et al. 2009).

Women with PCOS are also found to have lower rates of fertilization, implantation, and pregnancy per in vitro fertilization cycle, compared with infertile women with tubal blockage (Li et al. 2007). Fertile women with PCOS have lower concentrations of serum and follicular fluid leptin than infertile women with PCOS, adjusted for age and BMI (Mantzoros et al. 2000, Li et al. 2007). High concentrations of leptin in serum and follicular fluid were associated with downregulation of STAT3 phosphorylation in granulosa cells despite no change in leptin receptor or SOCS3 expression, and this may contribute to infertility in PCOS (Li et al. 2007).

Hyperinsulinemia and insulin resistance are also features of PCOS. Studies show that leptin concentrations do correlate with homeostasis model assessment insulin resistance index as well as triglyceride concentrations (Hahn et al. 2006, Pehlivanov & Mitkov 2009, Yildizhan et al. 2011). The interactions between leptin and insulin signaling pathways prove to be complex, with leptin differentially modifying the metabolic effects of leptin.
While leptin stimulates some effects of insulin, such as increasing glucose uptake in skeletal muscle and inhibiting hepatic glucose output, it also antagonizes other effects of insulin, such as the downregulation of phosphoenolpyruvate carboxykinase (PEPCK) expression and stimulation of insulin receptor substrate 1 (IRS1) phosphorylation and associated PI3K activity in hepatocytes (Moon et al. 2013). Furthermore, leptin and insulin may share mechanisms of resistance, specifically SOCS3 (Moon et al. 2013). This combination of leptin and insulin resistance may be important in the development of PCOS. Hill et al. (2010) have shown that deleting both leptin and insulin receptors in POMC neurons in female mice resulted in increased weight, insulin resistance, elevated testosterone concentrations, elevated LH concentrations, more degenerating ovarian follicles, and reduced fertility, all characteristics associated with PCOS. Deleting either the insulin or leptin receptor did not result in reduced fertility (Hill et al. 2010). However, obesity and insulin resistance are likely not the causes of PCOS in humans as some women with PCOS are lean and sensitive to insulin. It has been proposed that obesity and insulin resistance may amplify rather than cause the reproductive features of PCOS (Walters et al. 2012). In clinical trials treatment with insulin sensitizing medications, such as thiazolidinediones and metformin, did not seem to consistently lower leptin concentrations unless there was weight loss (Mantzoros et al. 1997b, Belli et al. 2004, Romualdi et al. 2008, Tfyali et al. 2011), further indicating the complexity of the insulin and leptin interplay.

To date no interventional trials to investigate the effect of leptin on the HPG axis, androgen concentrations, and metabolic parameters in women with PCOS have been performed. Given the high concentrations of leptin and its resistance, it is unlikely that the administration of leptin will provide the beneficial effects seen in the patients with lipodystrophy, hypoleptinemia, and PCOS features.

Diabetes mellitus type 2

At least 25% of men with type 2 diabetes have hypogonadotropic hypogonadism, and pathophysiological mechanisms may include insulin resistance and inflammation at the hypothalamus suppressing GnRH secretion (Dandona & Dhindsa 2011). Hyperleptinemia and central leptin resistance may also play a role. Leptin concentrations have been found to inversely correlate with testosterone concentrations, even after controlling for SHBG and estradiol, and leptin concentrations were the best hormonal predictor of low androgen concentrations in obesity (Isidori et al. 1999).

In addition to the effects of central leptin resistance, hyperleptinemia may also affect the HPG axis at the level of the testes. Leydig cells in rats and humans express leptin receptors, and in vitro studies in rats have demonstrated that leptin inhibits hCG-stimulated testosterone production by Leydig cells and testicular tissue (Banks et al. 1999, Caprio et al. 1999, Tena-Sempere et al. 1999, Aquila et al. 2005). In humans, hCG-induced testosterone production capacity has been found to be inversely related to serum leptin concentrations (Isidori et al. 1999). In addition, human spermatozoa also express leptin (Soyupek et al. 2005), which may act upon Leydig cells in a paracrine manner. In contrast to the blood–brain barrier, leptin transport across the blood–testis barrier does not seem to be limited by saturation (Banks et al. 1999).

In contrast to type 1 diabetes, clinical trials of leptin on type 2 diabetes have been carried out. Leptin has been shown to be largely ineffective in improving insulin resistance in obese subjects with type 2 diabetes (Mittendorfer et al. 2011, Moon et al. 2011). Presumably, additional exogenous leptin would also not affect the HPG axis.

Conclusion

In summary, leptin provides the brain metabolic information to determine whether the body’s energy stores are sufficient for reproduction. Clinical trials have shown that hypoleptinemia contributes to the pathology of HA, a state of chronic energy deficiency, and replacement with recombinant human leptin may serve as treatment option in select patients in the future. The role of leptin in states of energy excess, such as obesity, PCOS, and type 2 diabetes, is less clear but likely related to leptin resistance, and treatment to improve metabolic as well as reproductive parameters may require medications that promote leptin sensitivity. Given the prevalence of obesity, more research, from basic to translational to clinical, is warranted to further explore this possibility.

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. C Mantzoros has served as a consultant to AstraZeneca.

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