

# Adipocytokines in obesity and metabolic disease

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## Abstract

The current global obesity pandemic is the leading cause for the soaring rates of metabolic diseases, especially diabetes, cardiovascular disease, hypertension, and non-alcoholic hepatosteatosis. Efforts devoted to find cures for obesity and associated disorders in the past two decades have prompted intensive interest in adipocyte biology, and have led to major advances in the mechanistic understanding of adipose tissue as an essential endocrine organ. Adipose tissue secretes an array of hormones (adipokines) that signal key organs to maintain metabolic homeostasis, and their dysfunction has been causally linked to a wide range of metabolic diseases. In addition, obesity induces production of inflammatory cytokines (often referred to together with adipokines as adipocytokines) and infiltration of immune cells into adipose tissue, which creates a state of chronic low-grade inflammation. Metabolic inflammation has been increasingly recognized as a unifying mechanism linking obesity to a broad spectrum of pathological conditions. This review focuses on classic examples of adipocytokines that have helped to form the basis of the endocrine and inflammatory roles of adipose tissue, and it also details a few newly characterized adipocytokines that provide fresh insights into adipose biology. Studies of adipocytokines in clinical settings and their therapeutic potential are also discussed.

## Key Words

- ▶ adipocytokine
- ▶ obesity
- ▶ adipokine
- ▶ metabolic inflammation
- ▶ adipocyte

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## Introduction

In the past two decades, the world has seen a sustained increase in obesity, and the levels of overweight and obese persons worldwide have reached epidemic proportions (Finucane *et al.* 2011). It is well established that obesity induces all major metabolic disorders, especially diabetes, cardiovascular disease, hypertension, and fatty liver disease (Eckel *et al.* 2005). Mounting evidence also links obesity to a growing list of debilitating disorders including neurodegenerative disease, airway disorders, and cancer, all of which contribute to the staggering morbidity and mortality associated with obesity. Aimed at developing effective therapies for obesity and its associated disorders, scientists worldwide have intensified their efforts to elucidate the pathophysiological mechanisms by which

obesity induces or amplifies its major adverse consequences. The concept of an adipocytokine was developed in this process and dysfunction of adipocytokine pathways has been recognized as a key etiological factor of obesity-induced disorders. Furthermore, the rational manipulation of adipocytokines is becoming a promising avenue of therapy for obesity and associated metabolic abnormalities.

## Endocrine function of adipose tissue and adipokines

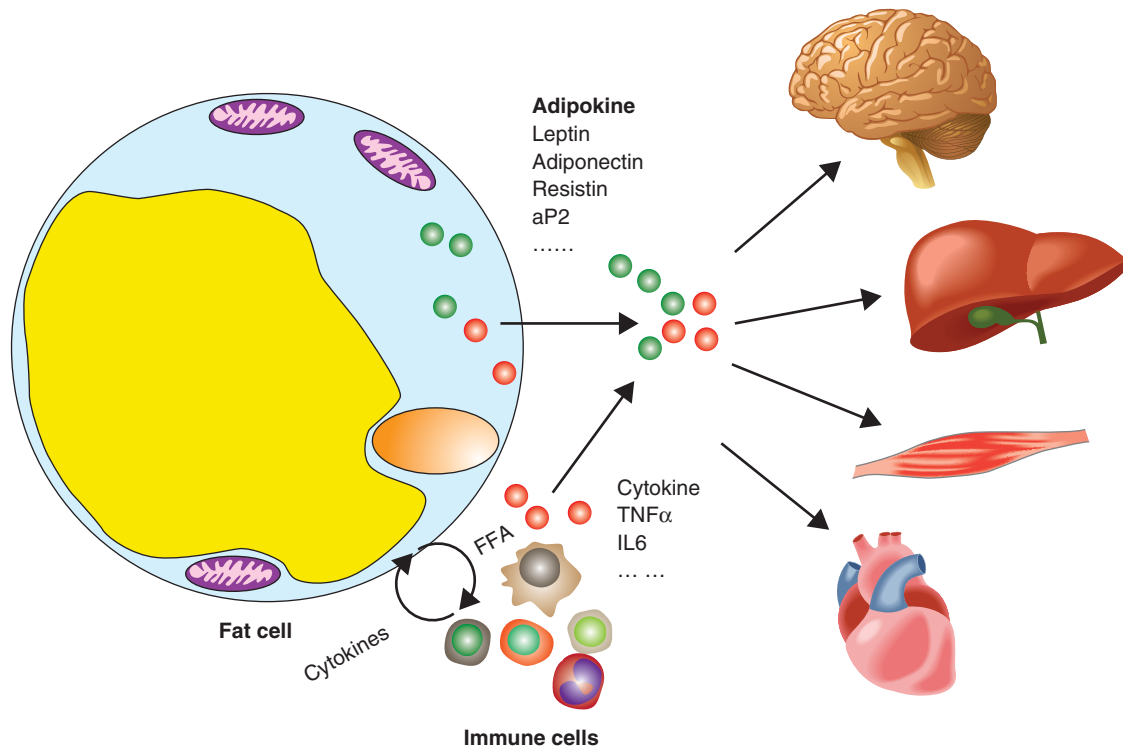
Obesity is the expansion of white adipose tissue (WAT), the most effective lipid storage organ in the body. In obese

subjects, white adipocytes in WAT have increased release of free fatty acids (FFAs) through lipolysis process leading to elevated serum fatty acid levels. This overflow of lipids from obese adipose depots has been considered a key reason for obesity-associated insulin resistance and hepato-steatosis for several decades (Randle *et al.* 1963, Samuel *et al.* 2010). But fatty acids in this setting have often been considered as a whole, and studies examining the distinct impact of individual lipid species have provided intriguing insights into the specificities of adipose-secreted lipids (Cao *et al.* 2008). In 1994, leptin was identified as an adipose-secreted hormone (adipokine) that exhibits potent anorexigenic effects, and this finding redefined WAT as an endocrine organ (Zhang *et al.* 1994). In the following two decades, several more adipokines were identified as critical regulators of systemic lipid and glucose homeostasis, and the list continues to grow (Fig. 1). Adipokines mediate the crosstalk between adipose tissue and other key metabolic organs, especially the liver, muscle, and pancreas, as well as the CNS (Rosen & Spiegelman 2006). Consistent with this notion, dysfunctions in adipokine pathways often result in impaired organ communications

and metabolic abnormalities in multiple tissues thereby constituting a critical pathological component in the development of metabolic disease (Trujillo & Scherer 2006).

### Metabolic inflammation and adipocytokines

Hotamisligil *et al.* (1993) showed that adipose tissue in obese mice secretes tumor necrosis factor  $\alpha$  (TNF $\alpha$ ), a proinflammatory cytokine typically produced by immune cells, and also demonstrated that adipocyte-derived TNF $\alpha$  plays a direct role in obesity-induced insulin resistance. This was the first functional link between obesity and inflammation, and over the years it has evolved into the concept of metabolic inflammation (Fig. 1), which has been widely accepted as an important mechanistic connection between obesity and its complications (Hotamisligil 2006). After TNF $\alpha$ , it was demonstrated that adipose tissue produces an array of cytokines and chemokines such as IL6 and MCP1, which either positively or negatively regulate systemic glucose and lipid metabolism. Interestingly some adipokines also exhibit features



**Figure 1**

Adipocytokines and metabolic inflammation in adipose tissue. Adipocytokines derived from adipose tissue are the results of intertwined interaction between adipocytes and immune cells that infiltrate adipose tissue. Adipocytokines mediate crosstalk among different cell populations

within adipose tissue and also travel to remote organs to regulate systemic energy metabolism. The level and action of adipocytokines are often altered in obese subjects, which contribute to obesity-induced disorders.

of cytokines or regulate inflammatory responses, and so these two groups of adipose-derived factors are often collectively referred to as 'adipocytokines' (Fig. 1). In 2003, two studies simultaneously reported that obesity induces macrophage infiltration of adipose tissue in both mice and humans (Weisberg *et al.* 2003, Xu *et al.* 2003b), which not only provided an explanation for the source of adipose-derived cytokines but also demonstrated for the first time the close juxtaposition between immune and metabolic cells in a metabolic organ. Adipose-resident macrophages are classified into two very distinct subtypes, M1, or classically activated, and M2, or alternatively activated. M1 macrophages secrete proinflammatory cytokines, such as TNF $\alpha$  and IL6, produce iNOS and reactive oxygen species (ROS), and cause insulin resistance. M2 macrophages produce IL10 and IL1 receptor antagonists and arginase-1 and have been implicated in tissue remodeling (Gordon 2003). Obesity causes a shift of macrophage subtypes in adipose tissue from M2 to M1 activation, leading to increased levels of proinflammatory cytokines and ROS, which induce insulin resistance (Lumeng *et al.* 2007). Meanwhile, the loss of certain beneficial effects associated with M2 macrophages might also contribute to the metabolic deterioration in obesity. For examples, M2 macrophages produce catecholamines that sustain adaptive thermogenesis (Nguyen *et al.* 2011), and lipolysis during fasting recruits macrophages that buffer local lipid increase and protect adipose function (Kosteli *et al.* 2010). Following macrophages, nearly every major type of immune cell has been identified in adipose tissue in recent years (Feuerer *et al.* 2009, Liu *et al.* 2009, Winer *et al.* 2009, Wu *et al.* 2011) and is actively involved in the endocrine function of adipose tissue in systemic metabolic regulation. Furthermore, the close physical and signaling interactions between immune and metabolic cells also exist in all major metabolic organs of obese subjects especially the liver, muscle, and pancreas, indicating that metabolic inflammation is a universal feature and a pathological basis for obesity-induced metabolic dysfunction.

There are a number of potential underlying causes for obesity-induced adipose inflammation. Adipose tissue expansion in the development of obesity can cause hypoxia which induce compensatory angiogenesis. Macrophages are recruited to the site to facilitate the vascularization process (Pang *et al.* 2008). Similar function of immune cells was also demonstrated in other metabolic tissues such as liver where Kupffer cell-secreted TNF $\alpha$  and IL6 in mouse liver are required for efficient liver regeneration (Abshagen *et al.* 2007). Infiltrated

macrophages in adipose tissues have also been proposed to be a mechanism to remove apoptotic cells (Cinti *et al.* 2005, Strissel *et al.* 2007). In addition, endotoxemia associated with altered gut permeability and obesity might potentiate adipose inflammation (Cani *et al.* 2007). Although accumulating evidence supports an overall negative effect of adipose inflammation on energy metabolism, it should bear in mind that not all metabolic inflammation is detrimental to metabolic homeostasis. Inflammation associated with adipose expansion or repair might be necessary for the body to adapt to the excess energy and maintain metabolic homeostasis (Ye & McGuinness 2013). In the same vein, certain cytokines stimulate energy expenditure and reduce food intake which might help to curtail obesity (Ye & Keller 2010). Therefore, the metabolic outcomes of adipose inflammation should always be considered in the context of their physiological underpinnings, and more studies are needed to fully understand the extent and mechanism of beneficial inflammatory responses associated with different stages of obesity.

## Key adipocytokines in metabolic regulation and obesity-induced metabolic disorders

### Leptin

Leptin was identified through positional cloning by Zhang *et al.* (1994), and is one of most potent adipocytokines in metabolic regulation. Leptin regulates body weight by signaling nutritional status to other organs especially the hypothalamus, which produces neuropeptides and neurotransmitters that modulate food intake and energy expenditure (Friedman & Halaas 1998). Leptin also has anti-diabetic effects independent of its regulation of body weight and energy intake (Kamohara *et al.* 1997). Leptin regulates hepatic lipogenesis by suppressing the expression of key enzymes in the fatty acid synthesis pathway (Cohen *et al.* 2002) and enhances muscle fatty acid oxidation by activating a critical energy sensor AMPK (Minokoshi *et al.* 2002).

At the signaling level, leptin activates the leptin receptor, which has multiple splicing isoforms, although the long isoform mediates all known leptin actions (Lee *et al.* 1996). There are multiple pathways downstream of the leptin receptor, each of which mediates different aspects of leptin activities (St-Pierre & Tremblay 2012). The main signaling branch of leptin is the JAK-STAT pathway, which regulates expression of anorexic neuropeptides (Baumann *et al.* 1996). This pathway is essential

for leptin regulation of energy balance but not its effects on reproduction (Bates *et al.* 2003). The anti-diabetic effect of leptin is mediated by centrally activating the phosphatidylinositol-3-kinase (PI3K)/AKT pathway that stimulates insulin sensitivity in the peripheral tissues (Morton *et al.* 2005).

In light of the significance of metabolic inflammation in the pathogenesis of metabolic disease, it is worth mentioning that leptin bears striking similarity to cytokines and modulates immune responses (De Rosa *et al.* 2007). Leptin is structurally similar to Class I helical cytokines and shares the same JAK–STAT pathway downstream of its receptor. Leptin expression can be induced by endotoxin or cytokine TNF $\alpha$  (Grunfeld *et al.* 1996). Conversely, leptin increases thymic secretion of acute-phase reactants and TNF $\alpha$  and promotes T helper 1 cell differentiation (La Cava & Matarese 2004). Leptin acts on T cell, macrophages, and other immune cells to stimulate the production of a wide spectrum of cytokines (La Cava & Matarese 2004). In light of the role of several cytokines in enhancing energy expenditure and suppressing food intake (Ye & Keller 2010), this proinflammatory action of leptin might contribute to its overall effects in body weight regulation. Interestingly, inflammation induced by metabolic stress also negatively regulates leptin signaling in a manner similar to insulin receptor signaling (Zhang *et al.* 2008). In addition, leptin has been implicated in a number of immune dysfunctions. For examples, leptin is able to reverse starvation-induced immunosuppression (Lord *et al.* 1998) and has been proposed to be a metabolic link to multiple sclerosis (Matarese *et al.* 2010).

Despite the thorough understanding of leptin's actions and numerous attempts to target leptin for obesity and metabolic disorders (Coppari & Bjorbaek 2012), leptin's clinical applications have been very limited. Leptin is used to treat genetically obese subjects carrying leptin mutations, but such mutations are extremely rare (Farooqi *et al.* 1999). Leptin is largely ineffective for treating regular obese patients due to leptin resistance caused by hyperleptinemia, and leptin administration into these individuals does not generate anorexic effects (Heymsfield *et al.* 1999). Leptin is successfully used to treat insulin resistance and hepatic steatosis in patients with congenital severe lipodystrophy who have very low levels of circulating leptin (Oral *et al.* 2002, Petersen *et al.* 2002). With increased mechanistic understanding of leptin resistance (St-Pierre & Tremblay 2012), it is still possible that approaches to enhance leptin sensitivity could help to revive some of stalled attempts to target leptin for anti-obesity and anti-diabetic therapies.

## Adiponectin

Several research groups identified adiponectin almost simultaneously as an abundantly secreted adipokine (Scherer *et al.* 1995, Hu *et al.* 1996, Maeda *et al.* 1996, Nakano *et al.* 1996). Recombinant adiponectin can enhance insulin action and partially reverse insulin resistance in obese mice (Berg *et al.* 2001, Yamauchi *et al.* 2001). Consistently, multiple groups have reported that adiponectin-deficient mice develop insulin resistance associated with high level of TNF $\alpha$  in adipose tissue and reduced responsiveness to PPAR $\lambda$  (Maeda *et al.* 2002, Nawrocki *et al.* 2006), although an independently generated adiponectin knockout mouse line has no change in insulin sensitivity (Ma *et al.* 2002). Adiponectin has also been reported to have antiatherogenic effects (Funahashi *et al.* 1999, Ouchi *et al.* 1999). In addition, adiponectin exhibits cardioprotective activity in ischemic heart disease through AMPK and cyclooxygenase 2 pathways (Shibata *et al.* 2005).

Adiponectin signaling is mediated by two adiponectin receptors, adipoR1 and adipoR2 (Yamauchi *et al.* 2003). AdipoR1 is ubiquitously expressed whereas adipoR2 is enriched in the liver tissue. Knockout of adipoR1 and adipoR2 abrogates adiponectin binding and causes lipid accumulation, inflammation, and insulin resistance (Yamauchi *et al.* 2007). Activation of adipoR1 in the liver and muscle tissues increases AMPK activity, which mediate the insulin sensitizing effect of adiponectin and also enhances fatty acid oxidation (Yamauchi *et al.* 2002). The adipoR2 pathway in the liver increases PPAR $\alpha$  and expression of its target genes, which also results in increased fatty acid oxidation (Yamauchi *et al.* 2007). Recently, it has been reported that a variety of downstream effects of the adiponectin receptor are mediated by ceramidase activity associated with adipoR1 and adipoR2 (Holland *et al.* 2011). Adiponectin also has anti-inflammatory effects that contribute to its protective role against metabolic stress in obesity. Adiponectin suppresses TNF $\alpha$  production in obese mice (Xu *et al.* 2003a), and adiponectin-deficient mice have high levels of TNF $\alpha$  in adipose tissue (Maeda *et al.* 2002). Low levels of plasma adiponectin are associated with C-reactive protein in humans (Ouchi *et al.* 2003). Adiponectin enhances the clearance of apoptotic cells by facilitating their opsonization and uptake by macrophages (Takemura *et al.* 2007). Some of the anti-atherogenic effects of adiponectin are also mediated by its role in the suppression of inflammatory responses. Adiponectin inhibits nuclear factor- $\kappa$ B (NF $\kappa$ B) activity and its downstream adhesion molecules



leading to reduced monocyte adhesion to endothelial cells (Ouchi *et al.* 1999, Okamoto *et al.* 2002). In addition, adiponectin confers vascular-protective activities by suppressing the apoptosis of endothelial cell (Kobayashi *et al.* 2004).

Clinical observations support the idea that plasma adiponectin levels are associated with obesity-induced disorders, especially diabetes. Plasma adiponectin levels are decreased in type 2 diabetic patients, and higher adiponectin levels are associated with low risk of diabetes (Li *et al.* 2009). Adiponectin levels are also negatively associated with adiposity and fasting glucose (Ryo *et al.* 2004). A multi-ethnic meta-analysis of a large cohort also demonstrated that numerous genetic loci associated with adiponectin levels influence risk of insulin resistance and type 2 diabetes (Dastani *et al.* 2012). Currently, several strategies to boost adiponectin levels or adiponectin receptor activities are being explored for the treatment of obesity-induced inflammation and insulin resistance (Yamauchi & Kadowaki 2008).

### Tumor necrosis factor $\alpha$

TNF $\alpha$  was the first cytokine identified in the adipose tissue of obese mice, marking the start of the metabolic inflammation concept (Hotamisligil *et al.* 1993). The direct involvement of TNF $\alpha$  in obesity-induced insulin resistance was confirmed by observations that TNF $\alpha$  treatment interferes with insulin signaling and blocks insulin actions (Hotamisligil *et al.* 1994). Mice lacking the functions of TNF $\alpha$  or its receptors are protected from obesity-induced insulin resistance and hyperglycemia (Uysal *et al.* 1997, 1998). It was initially thought that adipose-derived TNF $\alpha$  was produced mainly by adipocytes, but the parallel trend of macrophage infiltration and TNF $\alpha$  expression in adipose tissue of obese mice suggests that a significant portion of the adipose TNF $\alpha$  pool might be derived from macrophages and other immune cells. Interesting, FFA strongly stimulates TNF $\alpha$  production in macrophages (Nguyen *et al.* 2005) and in turn, TNF $\alpha$  stimulates lipolysis to increase fatty acid release from adipocytes (Wang *et al.* 2008). This FFA-cytokine cycle suggests that metabolic inflammation, once started, can use this self-perpetuating mechanism to further its inhibitory effects on insulin signaling and energy metabolism. In addition, TNF $\alpha$  directly stimulates hepatic lipogenesis *in vivo* (Feingold & Grunfeld 1987), and adipose-derived TNF $\alpha$  is also a major mechanistic link between obesity and cancer (Park *et al.* 2010).

TNF $\alpha$  exerts its effects through two distinct receptors, p55 and p75, which further activate JNK1 and inhibit I $\kappa$ B kinase (IKK)/NF $\kappa$ B pathways (Baud & Karin 2001). JNK1 can directly inhibit insulin signaling by phosphorylating insulin receptor substrate 1 (IRS1) on serine residues (Aguirre *et al.* 2002) and can also potentiate fatty acid-induced cytokine production (Nguyen *et al.* 2005). Consistent with these observations, JNK1 knockout mice are protected from obesity and insulin resistance (Hirosumi *et al.* 2002). IKK can also directly inhibit IRS1 function through serine phosphorylation in a manner similar to JNK1 (Gao *et al.* 2002) and also activate NF $\kappa$ B to produce inflammatory cytokines both in metabolic organs and myeloid cells. It has been demonstrated that systemic or selective inhibition of IKK in either hepatocytes or myeloid cells improves glucose metabolism in mice (Yuan *et al.* 2001, Arkan *et al.* 2005, Cai *et al.* 2005). TNF $\alpha$  also induces the expression of cytokine signaling 3 (SOCS3) suppressor, which inhibits insulin signaling by increasing ubiquitin-mediated IRS1 and IRS2 degradation (Emanuelli *et al.* 2001, Rui *et al.* 2002). Recently, a report has demonstrated that TNF $\alpha$  increase leptin receptor expression, raising an interesting possibility that TNF $\alpha$  might enhance leptin action (Gan *et al.* 2012), although the physiological relevance of this connection needs to be confirmed in an *in vivo* setting.

Numerous studies in humans have demonstrated strong associations between circulating TNF $\alpha$  and insulin resistance (Hivert *et al.* 2008) or other obesity-associated metabolic complications (Berg & Scherer 2005). However, attempts to block TNF $\alpha$  function in patients have not yet produced consistent metabolic outcomes. For example, neutralization of TNF $\alpha$  with an engineered antibody did not improve insulin sensitivity in type 2 diabetes patients (Ofei *et al.* 1996), whereas blockade of TNF $\alpha$  in patients with rheumatoid arthritis or psoriasis indeed improved their insulin resistance (Gonzalez-Gay *et al.* 2006, Lo *et al.* 2007). Considering the wide spectrum of inflammatory cytokines that are elevated in obesity, targeting TNF $\alpha$  alone might not have sufficient efficacy to improve systemic metabolic responses and might need to be considered in the context of managing the overall metabolic inflammation.

### Resistin

Resistin was initially identified in a screen for adipocyte genes that are suppressed by insulin-sensitizing drugs in rodents (Steppan *et al.* 2001). Depletion of circulating resistin by a neutralizing antibody improves insulin action

in obese mice, suggesting that resistin is an adipokine linking obesity to insulin resistance (Steppan *et al.* 2001). Subsequently, it was shown that resistin knockout mice on a high-fat diet have improved glucose metabolism mainly due to reduced glucose production in the liver (Banerjee *et al.* 2004). Resistin also increases the expressions of cytokines and adhesion molecules in murine vascular endothelial cells and contributes to atherogenesis (Burnett *et al.* 2005). Resistin circulates in two distinct assembly states, which exhibit differential activities in metabolic regulation (Patel *et al.* 2004). However, the relevance of resistin to human disease is complicated by the fact that rodent resistin is produced in adipocytes and human resistin is produced mostly in macrophages. Human and rodent resistin only shares 59% identity at the amino acid level, which is relatively low compared with other hormones (Ghosh *et al.* 2003). But interestingly, human resistin, when expressed in mouse macrophages, also induces insulin resistance (Qatanani *et al.* 2009) suggesting that human and mouse resistin might have similar function despite their different sites of production.

In humans, experimental endotoxemia induced elevated resistin and produced an insulin-resistant state (Lehrke *et al.* 2004). Epidemiological studies have associated elevated circulating resistin with increased risk for type 2 diabetes, inflammatory markers, myocardial infarction, and atherosclerosis (Burnett *et al.* 2005, 2006, Reilly *et al.* 2005, Heidemann *et al.* 2008, Chen *et al.* 2009). These studies support the idea that resistin levels could serve as an informative marker for metabolic disease in humans, and it will be of great interest to determine the therapeutic potential of resistin inhibition in future studies.

## IL6

IL6 is one of the major pro-inflammatory cytokines whose expression level increases in the adipose tissue of obese mice and patients, but its role in glucose metabolism has not been fully resolved. IL6 depletion in obese mice with a neutralizing antibody improves hepatic insulin action (Klover *et al.* 2005) while chronic infusion of IL6 causes insulin resistance in the liver of mice (Klover *et al.* 2003). Conversely, mice with targeted ablation of IL6 develop obesity and insulin resistance, which can be reversed by centrally delivered exogenous IL6 (Wallenius *et al.* 2002) suggesting that IL6 is required for the maintenance of whole-body glucose metabolism and metabolic homeostasis. An independently generated IL6-targeted mutation mouse line, however, does not develop obesity or insulin resistance and only exhibits elevated glucose level in a

glucose tolerance test (Di Gregorio *et al.* 2004). In a mouse model with adipose-specific ablation of JNK1, increased secretion of IL6 was proposed to be the primary reason for systemic insulin resistance (Sabio *et al.* 2008). There are several potential explanations for the seemingly contradictory data regarding IL6 in insulin action and glucose metabolism. Effects of acute vs chronic treatments need to be differentiated and dose and site of action of IL6 need to be carefully considered. In addition, IL6 produced by different organs might also contribute to its complex effects on metabolic regulation.

During exercise, IL6 is mainly released from working skeletal muscle. IL6 release from contracting skeletal muscle might mediate the beneficial effects associated with exercise, including increased glucose uptake and fatty acid oxidation (Febbraio & Pedersen 2002). It appears that activation of AMPK by IL6 mediates these effects (Al-Khalili *et al.* 2006). In addition, transgenically expressed human IL6 in mice increases leptin sensitivity and prevents diet-induced obesity (Sadagurski *et al.* 2010). However, the function of muscle-derived IL6 might also vary depending on its context. In a mouse model with muscle-specific disruption of PPAR $\lambda$  coactivator 1 $\alpha$  (PGC1 $\alpha$ ), muscle-secreted IL6 causes impaired insulin production from pancreatic islets and glucose intolerance (Handschin *et al.* 2007).

In patient studies, increased serum IL6 correlates with obesity and insulin resistance (Vozarova *et al.* 2001, Bastard *et al.* 2002, Spranger *et al.* 2003). The IL6 174G>C single nucleotide polymorphism (SNP) is associated with insulin resistance and metabolic syndrome (Fernandez-Real *et al.* 2000, Stephens *et al.* 2007). However, the mechanism of action of IL6 in human metabolism needs to be further studied to understand the therapeutic potential of IL6, partly due to the fact that there is low similarity between human and mouse IL6, and thus information generated from mouse studies cannot be readily applied to humans. To add to the complexity of IL6 signaling in human metabolism, two reports showed that MAB against the IL6 receptor, Tocilizumab, either increases or has no effects on insulin sensitivity in patients with rheumatoid arthritis (Schultz *et al.* 2010, Ogata *et al.* 2011, Ye & McGuinness 2013).

## Rbp4

Rbp4 is a transport protein for retinol in systemic circulation, and is mainly produced by the liver but also expressed in white adipocytes. Rbp4 was first characterized as an adipokine based on the finding that Rbp4 is highly

secreted from adipose tissue of Glut4-deficient mice and contributes to insulin resistance in this mouse model (Yang *et al.* 2005). In humans, higher Rbp4 levels are also associated with insulin resistance in obese and diabetic subjects (Graham *et al.* 2006). In addition, a number of Rbp4 SNPs have been identified and several of them are associated with increased risk for type 2 diabetes (Kovacs *et al.* 2007, Munkhtulga *et al.* 2007). However, several reports failed to detect the association of Rbp4 with insulin resistance (von Eynatten *et al.* 2007, Promintzer *et al.* 2007, Yao-Borengasser *et al.* 2007), potentially due to shortcomings in the methodologies for quantifying Rbp4 levels (Kotnik *et al.* 2011). In general, clinical studies on children and adolescents have been more consistent in supporting a role for Rbp4 in obesity and insulin resistance, suggesting that Rbp4 might be more involved in the early stages of metabolic syndrome (Kotnik *et al.* 2011).

### Secreted frizzled-related protein 5

Secreted frizzled-related protein 5 (Sfrp5) was recently identified as an anti-inflammatory adipocytokine (Ouchi *et al.* 2010). Sfrp5 is highly expressed in adipose tissue of lean mice but downregulated in obese mice. Targeted mutation of Sfrp5 in mice caused insulin resistance, glucose intolerance, and hepatosteatosis when the animals were fed a high-fat diet (Ouchi *et al.* 2010). Mechanistically, Sfrp5 activates JNK1 through noncanonical Wnt signaling to increase the levels of inflammatory cytokines and block insulin action (Ouchi *et al.* 2010). However, a second independently generated Sfrp5 mutation mouse line was reported to have different phenotypes, and accordingly the authors proposed a very different mechanism of actions for Sfrp5. In this study, Sfrp5-deficient mice were resistant to diet-induced obesity due to enhanced mitochondrial activities (Mori *et al.* 2012). Sfrp5 deficiency increased the expression of PGC1 and mitochondrial transcription factor A (Tfam), leading to increased mitochondrial biogenesis. Lack of Sfrp5 also stimulated mitochondrial respiration and gene expression through Wnt3a activity (Mori *et al.* 2012). The cause of these discrepancies is unclear. Human studies regarding Sfrp5 in metabolic disease have also given rise to conflicting data (Carstensen *et al.* 2013, Hu *et al.* 2013). Regardless, further studies about the function of Sfrp5 in metabolic regulation could provide important insights into adipose biology. Sfrp5 regulates multiple Wnt proteins that play a crucial role in adipogenesis (Cristancho & Lazar 2011). Dissecting the Sfrp5/Wnt

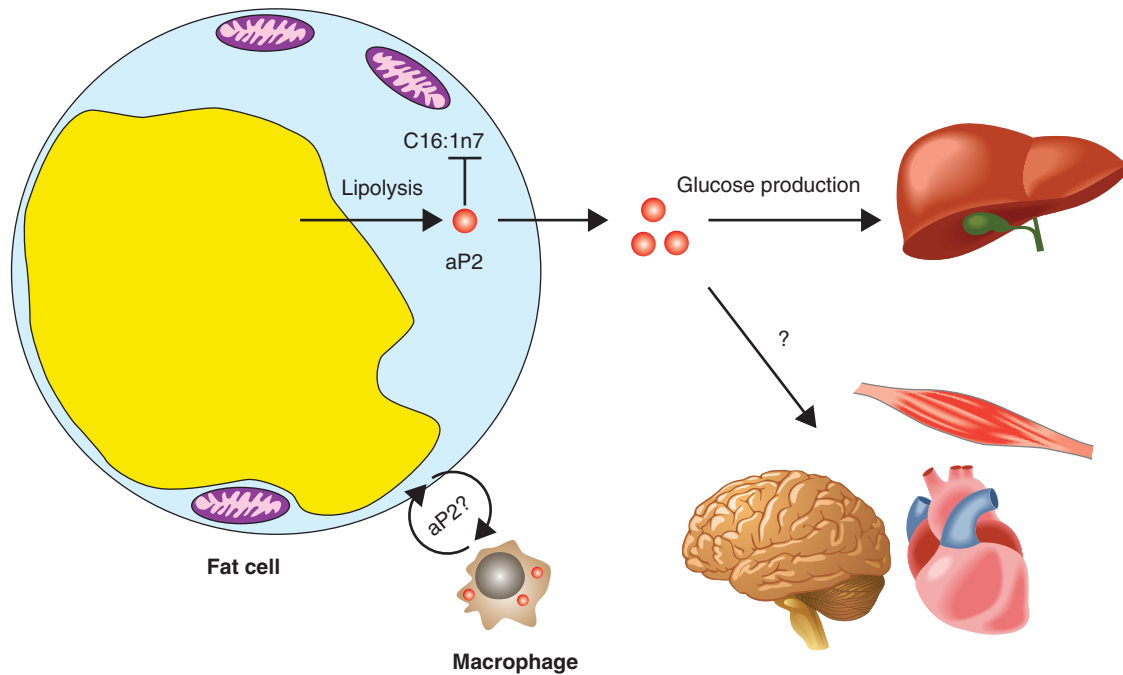
network in adipose tissue could also help to explain the autocrine/paracrine mechanism of metabolic inflammation, which is still poorly understood.

### aP2, a lipid-activated adipocytokine

The identification of aP2 as a lipid-activated adipokine is a surprising and exciting finding considering it has been extensively studied for over two decades as an essential intracellular regulator of lipid metabolism and inflammation in metabolic disease. AP2 is a member of fatty acid-binding protein (FABP) family and was initially thought to be exclusively expressed in adipocytes. In fact, the aP2 promoter has been widely used to specially drive transgene expression in adipose tissue. AP2-deficient mice have normal adiposity and gain more weight than controls when fed with high-fat diet, but they were partially protected from obesity-induced insulin resistance (Hotamisligil *et al.* 1996). The mild effect of aP2 deficiency could be due to the upregulation of mal1, a related FABP (Maeda *et al.* 2005). Therefore, mice deficient in both FABPs were produced to study the full impact of adipose FABP deficiency. The double-knockout mice have reduced adiposity, enhanced insulin sensitivity, and reduced hepatosteatosis (Maeda *et al.* 2005). It appears that some of the beneficial effects of FABP deficiency are mediated by robust upregulation of the fatty acid species, palmitoleate (C16:1n7), in the adipose tissue and its secretion into circulation (Fig. 2). Palmitoleate enhances insulin action in the muscle and suppresses *de novo* lipogenesis in the liver (Cao *et al.* 2008).

Yet the molecular mechanism for the pronounced reduction in gluconeogenesis in FABP-deficient mice remained elusive until it was found that aP2 is in fact actively secreted from adipocytes to control liver glucose metabolism (Cao *et al.* 2013; Fig. 2). Secretion of aP2 from adipocytes is regulated by lipolysis, which might be the reason that circulating aP2 levels are markedly elevated in obesity. Recombinant aP2 stimulates hepatic glucose production whereas neutralization of secreted aP2 reduces glucose production and corrects the diabetic phenotype of obese mice (Cao *et al.* 2013).

aP2 is the first adipokine whose secretion is strongly regulated by lipolysis-released fatty acids, suggesting that aP2 might function as a lipid sensor in adipocytes and might also carry specific lipids in plasma to specific organs or cells. Therefore, like other well-studied adipocytokines, it is conceivable that secreted aP2 could potentially act on other key organs such as the CNS or heart to regulate other aspects of metabolic homeostasis (Fig. 2) and these

**Figure 2**

aP2 as a lipid-activated adipokine. aP2 is secreted from adipocytes through a process that is regulated by fasting and lipolysis. Circulating aP2 acts on liver tissue to stimulate the gluconeogenic program and enhance hepatic

glucose production. Other potential functions of aP2 in local adipose–macrophage interaction and on other metabolic organs warrant further investigation.

questions need to be addressed in future studies. Another interesting question is whether secreted aP2 is also involved in metabolic inflammation. Despite long having been considered an adipocyte-specific protein, aP2 was found to be expressed in the macrophages (Makowski *et al.* 2001) and can be quickly induced by endotoxin (Kazemi *et al.* 2005). Mice with aP2 deficiency in macrophages are protected from atherosclerosis partly because of activated PPAR $\gamma$  and reduced inflammatory responses (Makowski *et al.* 2005). The proinflammatory action of aP2 was also demonstrated in an asthma mouse model, in which aP2 deficiency protects mice from airway inflammation (Shum *et al.* 2006). It will be interesting to investigate whether aP2 is also secreted from macrophages and whether secreted aP2 regulates inflammatory responses in metabolic diseases (Fig. 2).

Accumulating evidence suggests that circulating aP2 is implicated in human metabolic syndrome. Plasma aP2 levels are closely associated with obesity and metabolic syndrome in cohorts of multiple ethnicities (Stejskal & Karpisek 2006, Xu *et al.* 2006, Simon *et al.* 2009). In addition, circulating aP2 has also been linked to carotid atherosclerosis in humans (Yeung *et al.* 2007) and non-alcoholic fatty liver disease (NAFLD; Koh *et al.* 2009). In NAFLD patients, elevated plasma aP2 levels independently

predict inflammation and fibrosis (Milner *et al.* 2009). Neutralizing secreted aP2 robustly improves glucose metabolism (Cao *et al.* 2013), indicating that plasma aP2 could constitute a potential therapeutic target for diabetes, NAFLD, and cardiovascular disease.

### Conclusion and future perspective

There is overwhelming evidence that adipocytokines play a pivotal role in metabolic homeostasis of healthy subjects, and that deficiencies in these factors, caused by excess adiposity and adipocyte dysfunction, are a central component in the pathogenesis of the constellation of diseases surrounding obesity. Therefore, it will be fruitful to fully define the secretome of adipose tissue; novel adipocytokines identified in this process will, no doubt, provide critical insights into the functions of adipose tissue as an essential metabolic regulator. Identifying receptors for existing adipocytokines and mapping their downstream signaling pathways, especially in the context of metabolic disorders, is another area of research that could generate fresh therapeutic targets for managing adipocytokines to treat metabolic diseases. Due to the intertwined nature of metabolic and immune cells in major metabolic organs, further mechanistic



investigations are required to understand how adipocytokines integrate metabolic and inflammatory responses in each site and the pathological significance of these responses in metabolic disorders. It is particularly important to differentiate the detrimental effects of metabolic inflammation inflicted by nutritional stress and those beneficial ones underlying the physiological tissue expansion when designing anti-inflammation therapies for metabolic disorders (Ye & McGuinness 2013). Following the example of adipocytokines, numerous muscle- and hepatocyte-secreted hormones (myokine and hepatokine) have been identified as essential metabolic regulators. Therefore, it is very likely that a comprehensive endocrine network of organ communications in nutrient sensing and metabolic homeostasis could be established in the foreseeable future. Such a blueprint of organ crosstalk would have far-reaching impact on the development of effective therapies against obesity and metabolic disease.

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The author declares that there is no conflict of interest that could be perceived as prejudicing the impartiality of the review.

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