Adipose Tissue: A Metabolic Regulator. Potential Implications for the Metabolic Outcome of Subjects Born Small for Gestational Age (SGA)

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Abstract
Adipose tissue is involved in the regulation of glucose and lipid metabolism, energy balance, inflammation and immune response. Abdominal obesity plays a key role in the development of insulin resistance because of the high lipolytic rate of visceral adipose tissue and its secretion of adipocytokines. Low birth weight subjects are prone to central redistribution of adipose tissue and are at high risk of developing metabolic syndrome, type 2 diabetes and cardiovascular disease. Intrauterine adipogenesis may play a key role in the fetal origin of the pathogenesis of metabolic syndrome, type 2 diabetes and cardiovascular disease. Therefore, knowledge of the behavior of visceral adipose tissue-derived stem cells could provide a greater understanding of the metabolic risk related to intrauterine growth retardation, with potential clinical implications for the prevention of long-term metabolic alterations.

Keywords: diabetes · SGA · adipose tissue · glucose metabolism · lipids · insulin resistance · low birth weight

Adipose tissue and insulin resistance
Pathophysiology of visceral adipose tissue: the role of free fatty acids

Adipocytes are highly specialized cells that maintain whole body energy homeostasis by regulating glucose and lipid metabolism. For a long time, adipocytes have been considered to be an energy depot that stores and mobilizes triglycerides [1]. Recently, adipocytes have also been recognized as an endocrine tissue because of the discovery of several adipocyte-derived molecules, including lipid metabolites and adipocytokines [2]. Adipose tissue contains functionally distinct cellular subtypes, the white adipocyte, devoted to energy storage, and the brown adipocyte, which dissipates energy through thermogenesis. In the rat, brown adipose tissue is the major site of heat production. Brown fat also plays a major role in heat production in the neonates of many mammalian species. Its quantitative contribution to energy metabolism at maturity in large mammals, including humans, is uncertain. The storage of triglycerides and fatty acids in white adipose tissue occurs through the ability of insulin to stimulate significantly both glucose uptake and lipogenesis. Defects in fuel partitioning into adipocytes either because of increased adipose mass or increased circulating free fatty acids, results in dyslipidemia, obesity, insulin resistance and type 2 diabetes [3]. The association between type 2 diabetes and obesity is well established. Several studies have docu-
both obesity and insulin resistance are risk factors for [18, 19] (Figure 1). Furthermore, depots of fatty acids (FFA) into the portal (causing hepatic insulin resistance) and systemic (causing muscle insulin resistance) insulin-resistant, hyperinsulinemic and dyslipidemic individuals with preferential upper body fat accumulation (android) are more than people with a preponderance of lower body fat (gynecoid) [10, 11].

Increased visceral fat has been shown to be specifically related to insulin resistance. This association has been attributed to the enhanced lipolytic activity of visceral fat cells, with increased delivery of free fatty acids (FFA) into the portal (causing hepatic insulin resistance) and systemic (causing muscle insulin resistance) circulation [12, 13]. Patients with type 2 diabetes are characterized by day-long elevation in plasma FFA concentration, which is not suppressed after meals [14] or in response to insulin [15]. Chronically elevated plasma FFA concentrations cause insulin resistance in muscle and liver [15-17] and impair insulin secretion [18, 19] (Figure 1). Furthermore, depots of fatty acids stored in the form of triglycerides have been found in the muscle [20, 21] and liver [22, 23] of type 2 diabetic patients. The adipocytes of subjects with type 2 diabetes are enlarged cells with diminished capacity to store fat. When adipocyte storage capacity is exceeded, lipids ‘overflow’ into muscle and liver and possibly into the β-cells of the pancreas [8]. This ectopic fat deposition in muscle and liver has been referred to as one element of lipotoxicity [18, 24-26].

Muscle insulin resistance results in decreased glucose uptake [27] and consequently in impaired glucose oxidation and glycogen synthesis [8, 28]. In the liver, insulin resistance results in the impaired ability of insulin to suppress hepatic glucose production (HGP) [27-29] (Figure 2).

Increased intramyocellular triglyceride content is associated with impaired glucose tolerance and type 2 diabetes and is a better predictor of impaired insulin action than visceral adiposity [30]. Ectopic fat deposition leads to insulin resistance, as the intracellular metabolites of triglyceride metabolism interfere with insulin signaling, glucose transport and glycogen synthesis in muscle, and augment hepatic gluconeogenesis. In cases of dysfunctional adipose tissue, which is insulin resistant with a limited ability to store the energy excess, the triglyceride surplus is deposited in liver, skeletal muscle, heart and visceral adipose tissue [7].

Subjects born small for gestational age (SGA) are prone to central redistribution of adipose tissue and are at high risk of developing insulin resistance, type 2 diabetes, metabolic syndrome and cardiovascular disease [31].

The role of adipocytokines

Adipose tissue produces a wide variety of signaling molecules involved in inflammation, food intake and insulin sensitivity, which are known as adipocytokines. In type 2 diabetes, this adipocyte function is defective: fat cells, particularly from visceral adipose tissue, produce excessive amounts of proinflammatory, insulin resistance-provoking molecules and undersecrete insulin-sensitizing cytokines [30, 32, 33].

There is increasing evidence to suggest that chronic inflammation, insulin resistance, type 2 diabetes and atherosclerosis represent different stages of the same process. Release of TNF-α, IL-8 and IL-10 by adipose tissue from individuals with a BMI of 45 kg/m² is greater than in subjects with a BMI of 32 kg/m² [34]. The discovery of high circulating levels of several acute-phase proteins and inflammatory cytokines has led to the view that obese individuals are characterized
by a state of low-grade inflammation which links obesity to insulin resistance and the metabolic syndrome [3].

Twenty different adipocytokines have been identified so far and are classified into three groups: 1) cytokines produced mainly in white adipose tissue (e.g. leptin, resistin); 2) cytokines produced exclusively by adipocytes of white adipose tissue (e.g. adiponectin) and 3) cytokines produced primarily in other tissues or organs with simultaneous adipose tissue production (e.g. TNF-α) [35]. Adipocytokines may be even classified according to their putative physiological role into two groups: ‘insulin resistance-inducing factors’ such as resistin, TNF-α, IL-6, PAI-1, angiotensinogen, adipin, acylation-stimulating protein (ASP) and retinol binding protein-4 (RBP-4) and ‘insulin-sensitizing factors’ such as adiponectin, leptin [35], visfatin [36] and omentin [37] (Table 1).

The metabolic effects of the adipocytokines are probably mediated by a common pathway involving the activation of 5’AMP-activated protein kinase (AMPK) that represents a sensing mechanism of the energy status of the cells. The activation of AMPK increases β-oxidation and decreases fatty acids esterification to triglycerides reducing accumulation of lipids in skeletal muscle, liver and other tissues [3].

**Adipocytokines in children born small for gestational age**

Low birth weight has been associated with increased risk of developing insulin resistance, type 2 diabetes and cardiovascular diseases in adulthood. The thrifty phenotype hypothesis [38] suggests that the fetus adapts to an adverse intrauterine environment by diverting limited nutrients to favor the survival and development of vital organs, such as the brain, at the expense of growth. Important metabolic pathways would be permanently programmed during fetal life, leading to metabolic disturbances in adulthood [31, 39]. There is evidence suggesting that the degree of weight gain would be related to the degree of subsequent development of insulin resistance and diabetes.

**Figure 2.** FFA action on liver (A), muscle (B) and β-cells (C). A: In the liver, FFAs increase lipid oxidation and accumulation of acetyl CoA. Acetyl CoA stimulates the rate-limiting enzymes for gluconeogenesis eventually leading to increased glucose output. Finally, elevated plasma FFAs inhibit the insulin signal transduction system [24, 113, 114]. B: In muscle, FFAs reduce glucose oxidation by affecting the redox potential of myocytes and inhibiting key glycolytic enzymes. Furthermore, FFAs increase IRS-1 serine phosphorylation, through activation of protein kinase C, thus inhibiting insulin signaling. Finally, ceramide accumulation interferes with glucose transport and inhibits glycogen synthesis via inhibition of protein kinase B [24, 115-117]. C: In the pancreas, lipotoxicity is an important cause of β-cell dysfunction [18, 24, 118]. If short-term elevation (e.g. after a meal) of plasma FFAs enhances insulin secretion [119], long term exposure to FFAs (>48 hours) impairs insulin secretion and eventually leads to β-cells apoptosis [120, 121]. Increased formation of ceramides from accumulated acetyl CoA augments the nitric oxide formation that causes apoptosis of β-cells [118]. This has been demonstrated in *vitro* in human β-cells incubated with FFAs [122], and in *vivo* in rodents [123]. FFA: free fatty acids. IR: insulin receptor. PEPCK: phosphoenolpyruvate carboxylase. G6PD: glucose-6-phosphatase. NO: nitric oxide. Acetyl CoA: acetyl coenzyme A. PKB/Akt: protein kinase B. IRS-1: insulin receptor substrate-1. MMP: mitochondrial membrane potential.
and catch-up growth in BMI in postnatal life correlate with insulin resistance [40-43].

**Leptin**

Leptin, the ob gene product, is primarily produced and secreted by mature adipocytes and binds to its receptors in the hypothalamus. Leptin serves as a major ‘adipostat’ by repressing food intake and promoting energy expenditure. Leptin secretion correlates with adipose tissue mass and nutritional status, and is greater from subcutaneous than visceral adipose tissue [3]. High leptin levels in obese individuals are thought to be a consequence of leptin resistance. Leptin effects, particularly on energy intake and expenditure, are mediated via hypothalamic pathways, but leptin also exerts a direct action on peripheral tissues including muscle and endocrine pancreas [3] (Figure 3).

The existence of an ‘adipo-insular axis’, describing the insulin promotion of leptin secretion through activation of ob gene transcription has recently been proposed. Leptin, in turn, is able to inhibit insulin release (Figure 4) through central and direct action on β-cell insulin synthesis [44, 45] (Figure 3). Consistent with this model, ablation of leptin receptor from β-cells results in enhanced basal insulin secretion and fasting hypoglycemia [46].

In SGA children, increased leptin levels have been reported in cord blood [47] and in the first year of life, independently of BMI [48]. High serum leptin values with a loss of the regulatory effect of BMI and gender, suggest that SGA children develop an adaptative leptin resistance beneficial for their catch-up growth [48]. Nonetheless, Martinez-Cordero et al. found lower cord blood leptin levels in SGA than adequate for gestational age (AGA) infants [49]. Furthermore, in the Hague-nau study, leptin levels were found to be decreased in young adults

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**Legend:** * Stromal vascular fraction: pre-adipocytes, fibroblasts, endothelial cells, smooth muscle cells, pericytes, monocytes and macrophages.
born SGA, even after correction for gender, BMI and hyperinsulinemia [31]. This could be due to a greater adiposity in adults born SGA.

Adiponectin

Unlike the other adipocytokines, adiponectin levels correlate inversely with body mass [50, 51]. Recent studies have shown that insulin reduces levels of adiponectin mRNA in a dose- and time-dependent way [52]. Also β-adrenergic agonists [53] and glucocorticoids inhibit adiponectin gene expression and secretion, suggesting that decreased adiponectin production could play a role in catecholamine- and glucocorticoid-induced insulin resistance. In contrast to most adipocytokines, adiponectin expression and serum concentrations are not increased but reduced in a variety of obese and insulin resistant states. In obese rats, a reduction of adiponectin mRNA is present only in the visceral tissue [54]. A reduction in body weight achieved by food restriction is capable of increasing adiponectin mRNA levels in visceral adipose tissue [54]. Human adiponectin gene expression is lower in
Adipose Tissue in SGA Subjects

The adipo-insular axis. The effect of leptin on insulin levels is due to the inhibition of proinsulin synthesis by both central actions and direct actions on β-cells [45]. In turn, insulin plays a crucial role in the regulation of leptin gene expression in white adipose tissue. A candidate transcription factor, adipocyte determination- and differentiation-dependent factor 1/sterol regulatory element binding protein 1 (ADD1/SREBP1), links changes in insulin levels to ob gene expression in mice [131]. ADD1/SREBP1 expression increases after treatment with insulin and transactivates the leptin gene. Conversely, as fat stores increase, rising plasma leptin concentrations would reduce insulin levels, diminishing the formation of adipose tissue.

Several studies have examined human adiponectin gene expression in the adipose tissue of obese subjects, but the results have been inconsistent. Some reports found a reduction in mRNA adiponectin in subcutaneous adipose tissue [57, 58], or in both subcutaneous and visceral adipose tissue depots [55]. Nonetheless, there is an inverse correlation between serum adiponectin and BMI, and individuals with high adiponectin concentrations are at lower risk of developing type 2 diabetes [59].

The adiponectin gene is located on chromosome 3, very close to the diabetes susceptibility locus, and plays a role in the development of type 2 diabetes [60]. Adiponectin levels inversely correlate with a risk of type 2 diabetes. Administration of adiponectin causes glucose-lowering effects and ameliorates insulin resistance in mice [61, 62]. In addition, adiponectin has anti-atherogenic properties, inhibiting monocyte adhesion to endothelial cells and macrophage transformation into foam cells in vitro [63].

We previously reported significantly reduced adiponectin levels in SGA children [60]. Adiponectin was inversely related to height, corrected stature, weight and BMI and directly related to birth weight [60]. In subsequent studies, adiponectin has been reported to be reduced [31, 64, 65], unchanged [49, 66, 67] or increased [67, 68] in SGA subjects.

Resistin

Resistin is a protein expressed in preadipocytes undergoing differentiation [69]. In patients with type 2 diabetes or obesity, both resistin levels and resistin expression in fat cells are increased [66, 70], correlating with hepatic, but not muscle, insulin resistance [71]. In humans, the major source of resistin is the immune cells rather than the adipocytes [68, 72], resistin being a potent inflammatory agent [73]. Insulin inhibits resistin expression in adipocytes [74, 75]. Therefore, the elevated basal plasma resistin levels found in patients with type 2 diabetes [76, 77], despite increased insulin concentrations, may be the result of adipocyte insulin resistance. Resistin inhibits the phosphorylation of hepatic AMPK, decreasing β oxidation and increasing fatty acid esterification in triglycerides, and eventually leading to lipid accumulation [78]. Resistin levels have been reported to be reduced in short SGA children [79].

Tumor necrosis factor-α

TNF-α is implicated in insulin resistance as follows. TNF-α is overexpressed in adipose tissue in obesity and affects insulin signaling by modulating insulin receptor substrate-1 (IRS-1) function via serine phosphorylation [80]. It also affects GLUT4 expression [81], and reduces adiponectin expression in adipose tissue [82]. Finally, it stimulates lipolysis and activates the inflammatory pathways [83]. TNF-α knockout mice do not undergo the development of insulin resistance induced by a high-fat diet, suggesting a role for
this cytokine in mediating FFA-induced insulin resistance [84].

In SGA subjects, Jaquet et al. demonstrated an association between higher fasting insulin-to-glucose ratios and polymorphism in TNF-α/-308A [85]. Results for fasting insulin concentration and insulin excursion under OGTT were comparable [85]. These results were subsequently confirmed [86], suggesting that adipose tissue plays a key role in the interaction between intrauterine environment and genetic predisposition in the development of insulin resistance.

In conclusion, data on the adipocytokines in SGA subjects are still contradictory and inconclusive (Table 2).

**Fat partitioning and lipolysis**

Obese patients with an excess of visceral adipose tissue have elevated plasma C-reactive protein concentrations associated with elevated IL-6 and TNF-α levels and reduced adiponectin concentrations [7]. Expanded visceral adipose depot not only leads to altered NEFA metabolism but also to a proinflammatory profile that might contribute to the insulin resistance and altered glucose homeostasis in viscerally obese patients.

In addition, the excess of intra-abdominal fat may represent a marker of the relative inability of subcutaneous adipose tissue to act as an 'energy sink' in a caloric surplus state because of excess energy intake and/or reduced energy expenditure. This would result in ectopic fat deposition in liver, skeletal muscle, heart, β-cells and even visceral adipose tissue [7].

Transgenic fatless mice show liver and muscle insulin resistance and eventually develop diabetes [87]. Surgical implantation of adipose tissue in these mice improves liver and muscle insulin sensitivity [88]. Mice with implantation of subcutaneous adipose tissue in the intra-abdominal cavity show reduced weight, improved insulin sensitivity, reduced body fat percentage, reduced fat mass, reduced adiponectin and leptin [89].

In humans, the severe insulin resistance found in patients with lipodystrophic conditions [90] is also consistent with the role of subcutaneous adipose tissue as a depot buffering the energy excess [91]. Therefore, visceral obesity may also be a marker of defective fat partitioning between adipose tissue, skeletal muscle, liver and heart. There are some differences in the mechanism of accumulation and/or metabolism between visceral and subcutaneous adipose tissue [92].

In db/db mice, four weeks of beta 3-adrenoceptor agonist administration decreased body weight gain and reduced white fat [93]. The Iwao study, using the microdialysis technique in Wistar rats, showed that the lipolysis induced by isoproterenol (a β-adrenergic agonist) is higher in mesenteric than in abdominal subcutaneous adipose tissue at all

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isoproterenol concentrations, while basal lipolysis was identical in the two depots [94].

Omental fat has been reported to be relatively resistant to insulin suppression of lipolysis in vitro and sensitive to β3-adrenergic stimulation of lipolysis [95]. In vivo studies confirmed that omental adipose tissue is insulin-resistant, even if it extracts one fourth of the insulin passing through. The non-suppressible omental lipolysis in the postprandial state could explain why abdominal obesity is strongly associated with hepatic insulin resistance, since elevated plasma FFA are able to reach the liver [96].

SGA and visceral adiposity

Reduced fetal growth is associated with increased risk of developing insulin resistance, metabolic syndrome or one of its components (hypertension, dyslipidemia, impaired glucose tolerance and type 2 diabetes) and cardiovascular disease in adulthood [97-100].

Insulin resistance has also been detected in young adults and children born SGA [101-105], even in early life [106]. Metabolic syndrome has been found in young adults born SGA: in the Haguenau cohort, at 22 years of age 2.3% of individuals born SGA were affected by the metabolic syndrome compared with only 0.3% in the AGA group [31].

Recent observations emphasize that not only fetal growth but also early postnatal life is critical for the development of insulin resistance and metabolic syndrome. SGA children who experience catch-up growth in childhood are at risk of metabolic consequences. A longitudinal study of a Finnish cohort reported that the highest death rate from coronary heart disease occurred in boys who were thin at birth but whose weight caught up so that they had an average or above average body mass from the age of 7 years [107].

The Hertfordshire study group has recently demonstrated in a case-control study of 32 men of 64-72 years old with a low or high birth weight using dual-energy X-ray absorptiometry (DXA) that, after adjustment for weight and height, the low birth weight group had a higher percentage body fat and fat mass, but lower fat-free soft tissue, muscle mass and muscle-to-fat ratio. Lifelong differences in body composition and fat distribution between the low and high birth weight groups are consistent with programming in early life [40].

Other surveys have shown that catch-up growth in BMI is associated with higher fasting plasma insulin concentration, insulin resistance, and increased total and LDL cholesterol in childhood [41], and correlates with adiposity [43]. SGA children who experienced catch-up growth have a redistribution of fat tissue. Ong and colleagues found that SGA children who showed catch-up growth between zero and two years were fatter and had more central fat distribution at five years than SGA children without catch-up growth [108].

By using DXA, Ibanez et al. showed that SGA children exhibit greater accumulation of total body and abdominal fat than AGA children between the ages of 2 and 4 years, despite having already completed their catch-up growth between birth and 2 years of age [109].

In the Haguenau cohort [31], BMI catch-up growth
Intrauterine regulation of adipogenesis may be an important mechanism involved in the fetal origins of diabetes and cardiovascular diseases. Studying the differentiation of visceral adipose tissue in SGA children would help to unravel whether a fetal programming of adipogenesis is responsible for the high risk of developing metabolic syndrome in adulthood. Adipocytic mesenchymal stem cells retain the capacity to differentiate into fat cells that maintain human-specific adipocyte characteristics (Figure 5).

Adipose-derived stem cells (ADSC) could be more prone in SGA subjects to differentiate into a functionally different visceral adipose tissue after birth. The study of the differentiation capacity of visceral fat could help to understand the mechanisms involved in the pathogenesis of metabolic syndrome. Interventions aimed at normalizing fat partitioning in childhood could prevent insulin resistance and metabolic syndrome in subjects born small for gestational age.

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