Human physiology needs to be well adapted to cope with major discontinuities in both the supply of and demand for energy. This adaptability requires ‘a clear capacity to utilize lipid and carbohydrate fuels and to transition between them’ (Kelley et al. 2002b). Such capacities characterize the healthy state and can be termed ‘metabolic flexibility’. However, increasing evidence points to metabolic inflexibility as a key dysfunction of the cluster of disease states encompassed by the term ‘metabolic syndrome’. In obese and diabetic individuals this inflexibility is manifest in a range of metabolic pathways and tissues including: (1) failure of cephalic-phase insulin secretion (impaired early-phase prandial insulin secretion concomitant with failure to suppress hepatic glucose production and NEFA efflux from adipose tissue); (2) failure of skeletal muscle to appropriately move between use of lipid in the fasting state and use of carbohydrate in the insulin-stimulated prandial state; (3) impaired transition from fatty acid efflux to storage in response to a meal. Finally, it is increasingly clear that reduced capacity for fuel usage in, for example, skeletal muscle, as indicated by reduced mitochondrial size and density, is characteristic of the metabolic syndrome state and a fundamental component of metabolic inflexibility. Key questions that remain are how metabolic flexibility is lost in obese and diabetic individuals and by what means it may be regained.

Cephalic-phase insulin release

It may be Woody Allen’s second favourite organ, but a good deal of metabolism is pretty sensible if put in the perspective of the brain’s pre-eminence in the drive for a closely regulated supply of glucose for energy. Efficient storage of incoming meal-associated nutrients, minimizing glucose levels after a meal (area under the curve), is a hallmark of healthy carbohydrate and lipid metabolism. This outcome involves coordinated regulation of the major organs of carbohydrate and lipid flux: pancreas; liver; skeletal muscle; adipose. The desired effect is rapid and appropriate insulin secretion from pancreatic β-cells, effective suppression of lipid mobilization and utilization, and activation of diverse metabolic pathways of tissue energy uptake and storage. An early metabolic event that initiates major elements of this coordinated pattern, and begins to occur even before the meal-related nutrient load has impacted on the gastrointestinal tract and bloodstream, is nervous system-driven or cephalic-phase insulin release.
As Fig. 1 shows, the pattern of prandial insulin secretion involves an initial ‘blip’ of insulin, the early or cephalic phase, followed by a more sustained release driven by rising blood glucose. There is good evidence from rodent studies that this initial insulin rise is nervous system driven. In these studies animals are conditioned to expect a meal. On the experimental day only the conditioning stimuli are presented but the meal does not appear. Despite the lack of any nutrient intake results clearly show a pronounced insulin rise, which can only be nervous system driven and closely linked to hypothalamic monoamine activation (Holmes et al. 1989).

In human subjects at a stage of the metabolic syndrome characterized by insulin resistance and glucose intolerance bordering on frank diabetes, but where there is still considerable β-cell capacity, a clear characteristic is the absence of this initial critical peak of insulin secretion (see Bruce et al. 1988). Associated with this factor are pronounced glucose levels after a meal (area under the curve) and failure to inhibit plasma NEFA levels. This condition is indicated by a marked blunting of the normal rapid decline in plasma NEFA in the early prandial period. ‘Restoration’ of this early insulin peak, by exogenous infusion of only 1·8 U insulin with the appropriate temporal profile, has a major effect of reducing glucose levels after a meal (area under the curve) by approximately 50% of the excess, despite the major insulin resistance of the subjects and no net increase in total prandial insulin area under the curve (Fig. 2). Equally, this small insulin infusion is remarkably effective in restoring the appropriately steep curve of NEFA decline (Bruce et al. 1988). Similar insulin infusions either delayed by 30 min or as a continuous infusion over the prandial period are essentially ineffective in restoring either better glycaemic or lipaemic control.

The decline in plasma NEFA may be a particularly important index of ‘flexibility’ at the early prandial phase. The blood level will reflect a combination of inhibition of lipolysis and an increase in lipid uptake. The inhibition of lipolysis will be discussed later in relation to both skeletal muscle and adipose tissue. In relation to lipid uptake, there are data from Zucker fatty rats that very effectively show that the cephalic phase of insulin secretion is capable of eliciting a marked increase in lipoprotein lipase activity in adipose tissue and a decrease in skeletal muscle (Picard et al. 1999). This finding illustrates the coordinate metabolic patterning that is necessary to achieve optimal fuel handling.

Finally, it is worth noting here that the derangement of the cephalic phase is progressive. It is even likely that cephalic-phase insulin secretion is elevated early in simple obesity, when insulin levels are extremely high, with pancreatic β-cell capacity still sufficient for the maintenance of those levels. Insulin resistance at the organ level is, however, very likely to be already blunting insulin’s physiological effectiveness, regardless of how it is driven. It is in the later phase, when the β-cell is metabolically in extremis and incapable of being driven further by nervous system input, that the full impact of this failure of metabolic flexibility becomes truly apparent. Whether it is too late by then to reverse back down this troublesome road by, for example, major weight loss, is not clear. Recent work by Polyzogopoulou and colleagues has shown that major weight loss following bariatric surgery is capable of restoring the early phase of insulin secretion by type 2 diabetics, suggesting this aspect of metabolic inflexibility can be ameliorated (Polyzogopoulou et al. 2003).

**Skeletal muscle and metabolic inflexibility**

There are two elements of skeletal muscle metabolism on which to focus in relation to metabolic flexibility. The first
et al (Kelley 1999, 2002ab; Kelley & Mandarino, 2000) has been informative in characterizing muscle fuel dynamics in normal healthy subjects and in obese and diabetic individuals. However, the present review will focus on one comprehensive set of studies (Kelley et al. 1999) of both lean and obese individuals under basal fasting and insulin-stimulated (hyperinsulinaemic euglycaemic clamp) conditions, with measurement of leg fuel balance. The leg represents a part of the body with a large muscle mass and comparatively little other metabolically-active tissue, and its total blood inflow and outflow can be sampled to allow balance studies to be performed. Equally, skeletal muscle is a major player in energy balance, it contributes >20% of the total energy expenditure, is the major tissue of insulin-stimulated glucose uptake and of glucose storage (≤4-fold the glycogen content of liver) and strongly influences metabolism via modulation of lipid flux (both circulating and stored). Thus, leg balance studies are particularly relevant to the characterization of whole-body metabolic flexibility. The main findings of this set of studies are that under basal fasting conditions glucose uptake and oxidation are normal or even increased in obese subjects compared with lean subjects. Fatty acid uptake is also normal, but fatty acid oxidation is lower and its storage elevated. In the meal or ‘re-fed’ situation, achieved using a hyperinsulinaemic euglycaemic clamp to deliver higher insulin and sufficient glucose to maintain glucose levels, the changes in fuel utilization are strikingly different for lean and obese individuals. In the lean subjects glucose uptake increases 10-fold, with both oxidation and storage contributing strongly, while fatty acid uptake decreases equally dramatically, again with changes in oxidation and storage contributing. In the obese subject the changes in leg metabolism in response to clamp insulin elevation are severely blunted. Glucose uptake, oxidation and storage are much reduced. Of equal importance, while fatty acid uptake is comparable with that of the lean controls, oxidation is three times as high and there is evidence that fatty acids, instead of being stored, are still being mobilized for energy. This overall pattern was confirmed by leg RQ measurements (see Fig. 3). RQ in the lean subject shifts from approximately 0.82, indicating a substantial reliance on fat for fuel, to approximately 1.00, indicating that glucose is virtually the only energy source. In contrast, in the obese the RQ of 0.9 in the fasting state does not shift at all in response to the clamp (total metabolic inflexibility).

A very useful additional feature of the study reported by Kelley et al. (1999) is that the authors also attempted to answer the question of whether flexibility could be restored by substantial weight loss (very-low-energy diet-induced loss of approximately 15 kg over 12 weeks with a further 4 weeks of maintained weight stability). As Fig. 3 shows, the answer would appear to be a very qualified maybe! There is some evidence of a shift to carbohydrate use during the clamp, but substantial inflexibility remains. In this regard perhaps hope is more engendered by drug intervention in an animal model of the metabolic syndrome, the Zucker ‘fatty’ rat. This rat shows, compared with its lean siblings, an equally marked metabolic inflexibility.

![Fig. 3. Illustration of the metabolic response in the leg (largely indicative of skeletal muscle response) to elevation of insulin levels at euglycaemia in lean (○) and obese (■) subjects. The results show the complete metabolic inflexibility of the obese individual compared with lean healthy individuals, which is only very partially restored by weight loss. (Redrawn, with permission from the American Physiological Society, from Kelley et al. 1999.)](https://www.cambridge.org/core/terms)

Insulin-stimulated glucose uptake into skeletal muscle is badly impaired as is insulin suppression of plasma NEFA. Interestingly, treatment with a novel PPARα/δ agonist, tesaglitazar, has been reported to restore both factors, effectively almost normalizing the metabolic flexibility in these rodents (Oakes et al. 2002). Perhaps there is a way forward here.

**Adipose tissue as a key player in the flexibility of lipid supply**

Adipose tissue has a major role to play in the flexibility of metabolism. In this context Frayn (2002) has proposed ‘that adipose tissue plays a crucial role in buffering the flux of fatty acids in the circulation in the postprandial period, just as the liver and, to a lesser extent, skeletal muscle buffer postprandial glucose fluxes’. This buffering role is illustrated by the data (from Frayn, 2002) presented in Fig. 4. In both the obesity and insulin-resistance states the function of the adipose tissue is disturbed (for review, see Frayn, 2002). These abnormalities include the relative failure of insulin to down regulate hormone-sensitive lipase and up regulate lipoprotein lipase (Coppack et al. 1992), and hence to suppress NEFA release and facilitate triacylglycerol clearance, and to increase adipose tissue blood flow prandially (Summers et al. 1996). This adipose tissue inflexibility is also seen in the blunting of the adrenergic control of the nervous system regulation of lipolysis in obese individuals (for a comprehensive review, see Dott et al. 2003).

The abnormalities of the adipose tissue response to insulin may also extend to secretion of adipokines, particularly adiponectin. Adiponectin is now seen to be a major factor in the control of insulin sensitivity (Kern et al. 2003). Adiponectin levels are certainly low in obesity and diabetes, and most investigators may have been assumed
that this factor reflects a chronic dysregulation. Interestingly, and contrary to what might be expected from the ‘inflexible obese’ profile, there is no change in circulating adiponectin levels in response to meals in lean individuals but there is a 4-fold rise in obese individuals (English et al. 2003). It would be interesting to know if this result relates to fully-processed and biologically-active adiponectin, what drives its release in response to meals in the obese and whether its release is accompanied by increased mRNA levels.

**Capacity for fuel usage as a critical element of metabolic flexibility**

As well as the ability to make the transition between carbohydrates and lipids for fuel, which has been the focus of the present paper thus far, the Kelley et al. (2002b) definition emphasizes the capacity to utilize these fuels. Given its sheer size as an organ, skeletal muscle is again critical in relation to the issue of capacity. Most major muscle groups in man are composed of a mixture of fibre types with very different metabolic characteristics (the most salient of which are summarized in Fig. 5). Given these metabolic characteristics, it is perhaps not surprising that a number of cross-sectional studies have shown relationships between muscle fibre type, and markers of metabolic capacity, and both obesity and insulin action (for references, see Kelley et al. 2002a). Consistently in these studies increased proportion of type I fibres and increased oxidative enzyme expression are associated with leanness and good insulin sensitivity, with the converse true for type Iib fibres. It is notable that the subject populations in most of these studies ranged from lean to obese, but were otherwise normal, and most sampled muscle was derived from the vastus lateralis, the large thigh muscle. What is striking is that there is a tremendous variation in the relative proportions of these muscle fibre types across individuals, which may reflect both genetic and environmental influences.

Together with enzyme measurements of oxidative capacity, recent work has investigated mitochondrial morphology in lean and obese individuals and individuals with type 2 diabetes. Obese individuals and obese individuals with type 2 diabetes have been shown to have markedly reduced mitochondrial size, even when corrected for fibre type distribution (Kelley et al. 2002b). This finding, together with the other data presented by Kelley et al. (2002b), strongly suggests impaired skeletal-muscle mitochondrial bioenergetic capacity in obese individuals. Furthermore, mitochondrial area has been shown to correlate well with insulin-stimulated glucose disposal. Interestingly, it is not only in obesity and diabetes that this reduced capacity has been observed. The same phenomenon of reduced mitochondrial oxidative and phosphorylation activity is associated with normal aging, and has recently been demonstrated in a non-invasive in vivo study using NMR spectroscopy (Petersen et al. 2003).

So, is there a way forward here to restoring tissue metabolic capacity? New work would suggest that the answer is quite possibly yes, and considerable excitement is being generated. PPARγ co-activator (PGC) 1α is a transcriptional co-activator that interacts with a number of nuclear receptors as well as with other transcription factors (nuclear respiratory factor 1, myocyte-enhancing factor 2). It is expressed in many tissues, but most highly in metabolically-active tissues such as skeletal muscle, brown fat, kidney, heart, brain and liver. PGC-1α expression is induced in skeletal muscle and brown adipose tissue; it can be induced in muscle by exercise (Goto et al. 2000) and in liver by fasting (Yoon et al. 2001). Retrovirus-mediated expression of PGC-1α in C2C12 myotubes increases O2 consumption and mitochondrial content, as well as the expression of uncoupling protein 2 and the transcription factor nuclear respiratory factor 1, which is important for mitochondrial biogenesis, and myocyte-enhancing factor 2, which is important for type I myofibre genesis. PGC-1α also serves as a target for calcineurin signalling, which has been implicated in type I myofibre expression (Wu et al. 1999, 2000). PGC-1α is mainly located in the type I muscle fibre, which, as described earlier, is rich in mitochondria, has an excellent capacity to utilize fatty acids as fuel and equally is very insulin responsive in terms of glucose...
metabolism. Very importantly, transgenic mice over-expressing PGC-1α under the control of muscle creatine kinase promoter, which directs expression to type II fibres, show conversion of type II to type I muscle fibres and increased endurance to electrical stimulation of some of these muscle groups (Lin et al. 2002). Equally, adenoviral-mediated overexpression of PGC-1α in cultured human white adipocytes induces the classic uncoupling protein 1, thereby giving these adipocytes a ‘brown’ heat-generating–energy-dissipating phenotype (Tiraby et al. 2003). Interestingly two recent papers have shown a coordinated down-regulation, in insulin-resistant and diabetic individuals, of a set of genes that are involved in oxidative phosphorylation and activated by PGC-1α (Mootha et al. 2003; Patti et al. 2003). In addition, a PGC-1 isoform, PGC-1β, has also been shown to be important in mitochondrial biogenesis and cellular fuel utilization capacity (Meirhaeghe et al. 2003). It is tempting to speculate that activation of PGC might be a way of restoring also capacity of cells to utilize lipid and carbohydrate fuels, and hence provide the basis for improving the flexibility to switch effectively between these fuel sources. However, PGC-1 is only one example, and work needs to be done to demonstrate that elevating its activity can actually improve metabolic flexibility. Also, there are undoubtedly other metabolic targets that will provide alternative modes for restoration of metabolic flexibility.

Summary

The intention here has been to give some flavour of the overall concept of metabolic flexibility, by looking at some of the elements involved and discussing what it is and what it does. Currently, the questions of why is it lost and can it be regained are more important. Lipid overload, insulin resistance, leptin resistance and insulin resistance, leptin resistance and adiponectin levels can be regained are more important. Lipid overload, insulin resistance, leptin resistance and

References


