Interaction of fish oil and a glucocorticoid on metabolic responses to an oral glucose load in healthy human subjects

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Compared with saturated fat, n-3 long-chain PUFA-rich fish oil improves insulin sensitivity in rats. We studied whether n-3 long-chain PUFA could prevent insulin resistance induced by dexamethasone (a glucocorticoid) in healthy human volunteers. A group of eight subjects was studied twice after a 2 d dexamethasone treatment, before and after a 3-week supplementation with fish oil (providing daily doses of 1·1 g 20 : 5n-3 and 0·7 g 22 : 6n-3). The subjects were studied during the basal state and over the 6 h following an oral glucose load (1 g/kg). Plasma glucose fluxes were traced with [6,6-2H2]glucose and [13C]glucose (naturally 13C-enriched corn glucose). Substrate oxidation was obtained from indirect calorimetry.

**Eicosapentaenoic acid: Docosahexaenoic acid: Polyunsaturated fatty acids: Stable isotopes: Insulin resistance**

In rats, fish oil substitution in a high-fat or a high-sucrose diet prevents insulin resistance induced by these diets (Storlien et al. 1987, 1991; Podolin et al. 1998; Taouis et al. 2002). In man, contrasting effects of dietary fish oil supplementation have been reported. In healthy subjects, fish oil supplementation (6 g/d over 3 weeks, providing daily doses of 1·1 g EPA (20 : 5n-3) and 0·7 g DHA (22 : 6n-3)) decreased the insulinemic response to an oral glucose load by 40% while plasma glucose response remained unaffected (Delarue et al. 1996). This suggested a sensitizing effect of fish oil on insulin action, since insulin secretion has been shown to be related to insulin sensitivity (Kahn et al. 2003). However, in patients with type 2 diabetes, fish oil does not reverse insulin resistance (Borkman et al. 1989; Puhakainen et al. 1995; Rivellese et al. 1996) and does not improve plasma glucose control (Montori et al. 2000). Taken together, these studies demonstrate that fish oil is able to prevent insulin resistance in rat models of dietary-induced insulin resistance and to improve glucose metabolism in healthy subjects, but for unclear reasons is probably unable to reverse insulin resistance once it is established (review in Delarue et al. 2004).

Short-term dexamethasone treatment (2 d) induces a reversible well-characterized insulin resistance in healthy subjects. Dexamethasone is a synthetic glucocorticoid used mainly for treatment of chronic inflammatory diseases and for exploration of the hypophyso–adrenal axis. Insulin resistance induced by dexamethasone translates into decreased insulin-mediated plasma glucose utilization during a euglycaemic hyperinsulinaemic clamp (Tappy et al. 1994; Willi et al. 2002) and by a larger increase in plasma insulin and glucose responses to an oral glucose load (Wajngot et al. 1992; Schneider & Tappy, 1998; Willi et al. 2002). Dexamethasone decreases phosphatidylinositol 3-kinase activity (Saad et al. 1993) and the translocation of GLUT4 glucose transporters in rat muscle (Dimitriadis et al. 1997; Weinstein et al. 1998), both abnormalities also present in muscle of patients with type 2 diabetes (Cusi et al. 2000; Ryder et al. 2000). Troglitazone, a pharmacological ligand of PPARγ, has been demonstrated to antagonize the metabolic effects of dexamethasone in healthy human subjects. This translates into both a marked reduction of the excessive plasma insulin responses to oral glucose and an increase in plasma glucose utilization during a euglycaemic hyperinsulinaemic clamp (Willi et al. 2002). Because 20 : 5n-3 is a natural ligand of PPAR and because fish oil prevents the decrease in phosphatidylinositol 3'-kinase and GLUT 4 content in muscle of rats fed a diet high in n-6 PUFA (Taouis et al. 2002), dietary fish oil supplementation could antagonize the metabolic effects of dexamethasone in healthy human subjects.

To verify this hypothesis, the aim of the present work was to determine whether a 3-week dietary fish oil supplementation (6 g/d, providing 1·1 g 20 : 5n-3 and 0·7 g 22 : 6n-3)
daily) was able to prevent, at least in part, the metabolic alterations induced by a 2 d treatment with dexamethasone in healthy subjects following an oral glucose load (1 g/kg).

**Subjects and methods**

**Subjects**

Eight healthy subjects (six males, two females; mean age 25.4 (SE 0.2) years, mean weight 61.5 (SE 3.2) kg and mean BMI 20.7 (SE 1.2) kg/m²) were studied. The subjects were in good health, non-smokers and were not taking any drugs. None had a personal or family history of diabetes or hypertension. The subjects did not regularly take part in any strenuous physical activity and had no history of endurance training. Female subjects were studied during the follicular phase of their menstrual cycle. The experimental protocol was approved by the Ethical Committee of Tours. Before participating in the study, each subject gave informed written consent.

**Materials**

The fish oil was kindly provided by Roche (Ropufa 30; Roche, Basel, Switzerland). Oral glucose from corn was purchased from Sigma-Aldrich Chimie (Lyon, France). Its isotopic enrichment in $^{13}$C was 1.0974 at%. $[6,6-2H_2]$Glucose (99 mol% excess) was purchased from Cambridge Isotopes (Bergmeyer et al. 1977). Plasma insulin (INS-IRMA; Biosource Europe SA, Nivelles, Belgium) and C-peptide (Riaanost; Hoechst Behring, Marburg, Germany) concentrations were measured by RIA. The urinary N concentration was determined using the Beckman glucose analyser 2 (Beckman Instruments, Fullerton, CA, USA). NEFA concentrations were measured by an enzymatic colorimetric method with the use of a commercial kit (NEFA C; Wako Chemicals, Freiburg, Germany). Lactate concentrations were determined using standard enzymatic methods (Proietto et al. 1987) and validated by Tissot et al. (1990). Endogenous glucose production was calculated as RaT minus RaE. Metabolic clearance rate of plasma glucose was calculated from VCO$_2$, VO$_2$ and urinary N excretion using the equations of Livesey & Elia (1988).

**Sampling and analytical procedures**

Blood samples were immediately spun at 4°C. The plasma was separated into aliquots and frozen at −80°C until time of assay. Urine samples were frozen at −80°C for later determination of total urinary N. Plasma glucose concentrations were measured by the glucose oxidase method using a Beckman glucose analyser 2 (Beckman Instruments, Fullerton, CA, USA). NEFA concentrations were measured by an enzymatic colorimetric method with the use of a commercial kit (NEFA C; Wako Chemicals, Freiburg, Germany). Lactate concentrations were determined using standard enzymatic methods (Proietto et al. 1987) and validated by Tissot et al. (1990). Endogenous glucose production was calculated as RaT minus RaE. Metabolic clearance rate of plasma glucose was calculated from VCO$_2$, VO$_2$ and urinary N excretion using the equations of Livesey & Elia (1988).

**Computations**

Absolute area under the curve was calculated using basal values of plasma glucose or insulin as baseline. The total rates of appearance (RaT) and disappearance (RdT) of plasma glucose were calculated in non-steady state using the equation of Steele et al. (1956) as modified by De Bodo et al. (1963). Plasma rate of appearance of exogenous glucose (RaE) was calculated by transposition of the Steele equation as proposed by Proietto et al. (1987) and validated by Tissot et al. (1990). Endogenous glucose production was calculated as RaT minus RaE. Metabolic clearance rate of plasma glucose was calculated as RdT/glycaemia. Total carbohydrate and fat oxidations were calculated from VCO$_2$, VO$_2$ and urinary N excretion using the equations of Livesey & Elia (1988).

**Statistical analyses**

All data are expressed as means with their standard errors. Comparison of values between the two periods used
two-way ANOVA with a post hoc test (paired t test). Statistical calculations were performed in Statview™ II (Abacus Concepts Inc., Berkeley, CA, USA) running on a Powerbook G4 (Apple, Cupertino, CA, USA).

**Results**

**Metabolites and insulin**

Basal plasma metabolites and insulin concentrations are reported in Table 1. There was no effect of fish oil on plasma glucose concentrations (Fig. 1(a)) and area under the curve of glucose (439 (SE 17) v. 440 (SE 11) pmol/ml per 6h, without v. with fish oil, respectively). Insulinaemia during oral load was significantly lower with fish oil supplementation than without fish oil supplementation (ANOVA, P<0·05; Fig. 1(b)). Area under the curve of insulin was decreased by 17 % with fish oil v. without fish oil (15 220 (SE 1200) v. 18 280 (SE 1210) pmol/ml per 6h, respectively; P<0·05). There was no effect of fish oil on plasma C-peptide (Fig. 1(c)), lactate and NEFA concentrations during the oral glucose load (Fig. 2(a and b)).

**Plasma glucose fluxes**

Basal RaT glucose was not different with and without fish oil supplementation (2·04 (SE 0·12) v. 2·14 (SE 0·12) mg/kg per min, respectively). Plasma glucose RaT, RdT and metabolic clearance rate (Fig. 3(a–c)) were not different with and without fish oil supplementation. RaE (Fig. 4(a)) and endogenous glucose production (Fig. 4(b)) were not different without and with fish oil.

**Substrate oxidation**

Basal carbohydrate oxidation was not different with and without fish oil supplementation (1·03 (SE 0·16) v. 1·24 (SE 0·1) mg/kg per min, respectively). Basal lipid oxidation was not different with and without fish oil supplementation (1·17 (SE 0·1) v. 1·10 (SE 0·07) mg/kg per min, respectively). Carbohydrate and lipid oxidations during oral glucose were not different without and with fish oil supplementation. (Fig. 5(a and b)).

**Discussion**

We have assessed the interaction between fish oil and glucocorticoids on the metabolic responses to oral glucose in healthy human subjects. Dexamethasone was chosen because it induces insulin resistance (Wajngot et al. 1992; Tappy et al. 1994; Schneiter & Tappy, 1998; Willi et al. 2002; Nicod et al. 2003).

Fish oil supplementation induced a modest but significant 17% decrease in plasma insulin response without altering

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<th>Table 1. Basal plasma metabolites after 2 d treatment with dexamethasone, with and without chronic fish oil (FO) supplementation (Mean values and their standard errors)</th>
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**Fig. 1.** Time course of plasma glucose (a), insulin (b) and C-peptide (c) in eight healthy subjects, pretreated with dexamethasone, without (□) or with (■) 3-week fish oil supplementation. Values are means with their standard errors shown by vertical bars. Fish oil supplementation had no statistically significant effect on glucose or C-peptide concentrations, but reduced insulin concentrations significantly compared with non-supplemented values (P<0·05, ANOVA).
other metabolic parameters. The maintenance of plasma glucose disappearance and of substrate oxidation despite the significant decrease in plasma insulin response suggests an insulin-sensitizing effect of fish oil. The lack of effect of fish oil on plasma C-peptide response and on the molar ratio of plasma C-peptide : insulin argues against an effect on insulin secretion or insulin clearance. We have previously reported a 40% decrease in plasma insulin response after the same amount of fish oil supplementation in healthy subjects not pretreated with dexamethasone (Delarue et al. 1996). This larger effect of fish oil without dexamethasone can be explained mainly by the potent negative impact of dexamethasone on insulin sensitivity, preventing fish oil from exerting its full positive effect. Willi et al. (2002) have previously reported that the insulin-sensitizer troglitazone totally prevented the deleterious effect of dexamethasone on insulin sensitivity. In comparison, fish oil in the present study decreased postprandial insulin response, suggesting that it indeed prevented some of the metabolic effects of dexamethasone. However, the lowering of insulin concentration was less than with fish oil alone (Delarue et al. 1996), suggesting that fish oil did not completely prevent the effects of dexamethasone. Careful analysis of the data reported by Willi et al. (2002) similarly suggests that troglitazone only partially corrected the effect of dexamethasone, since the postprandial insulin responses remained higher after dexamethasone + troglitazone than after troglitazone alone.
The lack of randomization of fish oil intake in our study is an unlikely explanation for its effect on plasma insulin response. A cross-over study would have been an ideal design, but incorporation of 20:5n-3 and 22:6n-3 into membranes has been reported to take as long as 18 weeks (Endres et al. 1989), so that the two experiments should have been performed at least 18 weeks apart. During such a long period other confounding factors could appear. Subjects had very similar basal plasma metabolites and insulin concentrations, as well as basal plasma glucose fluxes and substrate oxidations, on the day of each of the two experiments, which demonstrates a similar metabolic state. Moreover, we have previously checked (data not shown), in a group of healthy subjects, that mean plasma glucose and insulin responses to an oral load of 1 g glucose/kg were similar over a 3-week interval.

In conclusion, the present study shows that a 3-week fish oil supplementation (1.8 g 20:5n-3 + 22:6n-3 daily) given prior to induction of insulin resistance by a 2 d dexamethasone treatment did not alter plasma glucose utilization and substrate oxidation despite a significant decrease (−17%) in plasma insulin response to an oral glucose load. This suggests an insulin-sensitizing effect of fish oil, which could be of potential interest in subjects predisposed to insulin resistance.

Acknowledgements

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