Acute elevation of plasma lipids does not affect ATP synthesis in human skeletal muscle

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Acute elevation of plasma lipids does not affect ATP synthesis in human skeletal muscle. Am J Physiol Endocrinol Metab 299: E33–E38, 2010. First published May 4, 2010; doi:10.1152/ajpendo.00756.2009.—Prolonged elevation of plasma triglycerides and free fatty acids (FFA) reduces insulin-stimulated glucose disposal and myocellular flux through ATP synthase (fATPase). However, the early effects of lipids per se on fATPase are as yet unclear. Thus, this study examined glucose disposal and fATPase during 3 h of FFA elevation in the presence of low plasma insulinemia. Euglycemic pancreatic clamps with low-dose insulin supplementation (6 mU·m body surface area−2·min−1) were performed in eight healthy men with (LIP) or without (CON) lipid infusion to measure whole body glucose disposal. 31P/1H magnetic resonance spectroscopy of calf muscle was applied to quantify fATPase and concentrations of glucose 6-phosphate (G6P), inorganic phosphate (Pi), phosphocreatine (PCr), ADP, pH, and IMCL before and during the clamps. Lipid infusion increased plasma FFA approximately twofold and decreased glucose disposal by ~50% (110–180 min: LIP 0.87 ± 0.45 vs. CON 1.75 ± 0.42 mg·kg−1·min−1, P = 0.002; means ± SD). Intramyocellular G6P tended to rise only under control conditions, whereas PCr, ADP, pH, and IMCL remained unchanged from fasting in LIP and CON. Although P concentrations increased by ~18%, fATPase remained unchanged from fasting during the clamps (LIP 10.2 ± 2.2 vs. CON 10.5 ± 2.6 μmol·g muscle−1·min−1, P = not significant). We conclude that 3 h of lipid elevation fail to affect ATP synthesis despite marked reduction of whole body glucose uptake. This suggests that lipid-induced insulin resistance results primarily from mechanisms decreasing glucose uptake rather than from direct interference of fatty acid metabolites with mitochondrial function.

In healthy humans, plasma FFA elevation by lipid infusion mimics this mechanism of muscular insulin resistance via sequential inhibition of insulin-stimulated glucose transport/phosphorylation and glycogen synthesis (8, 17, 34, 35), in which alterations are typically observed in skeletal muscle of humans with obesity or T2DM (31, 37). Insulin-resistant individuals also frequently show reduced skeletal muscle oxidative capacity and mitochondrial flux through ATP synthase (fATPase) in parallel with increased IMCL (16, 19, 25, 28, 38, 41). This has been explained by altered mitochondrial fatty acid oxidation favoring accumulation of fatty acid metabolites and IMCL ultimately leading to insulin resistance (24). Elevated FFA might further interfere with the regulation of mitochondrial function or biogenesis, as demonstrated by reduced expression of nuclear-encoded mitochondrial genes and peroxisome proliferator-activated receptor (PPAR)γ coactivator-1 (PGC-1) during 48 h of lipid infusion in humans (33). On the other hand, high-fat diet was shown to increase fatty acid oxidation and mitochondrial biogenesis via PPARδ (14) and PGC-1α (11), whereas development of FFA-mediated insulin resistance might require incomplete fatty oxidation and generation of mitochondrial stress (20).

Aside from its intermediate and long-term action on energy metabolism, FFA elevation may cause rapid effects on mitochondrial respiration and ATP production. We have previously shown that 6 h of lipid infusion suffices to inhibit both insulin-stimulated increase of skeletal muscle fATPase and glucose disposal in healthy humans (8). Likewise, physiological concentrations of the fatty acid metabolites palmitoyl carnitine and palmitoyl-CoA were shown to inhibit ex vivo ATP production in mitochondria isolated from human and murine muscle (1). Recently, 6 h of lipid infusion resulted in decreased ex vivo mitochondrial membrane potential in young healthy humans, whereas mitochondrial content, gene expression, and ATP content remained unaffected (10). Taken together, these studies raised the issue of the sequence of events leading to FFA-induced insulin resistance and whether FFA directly through and independently of stimulation by insulin affects in vivo mitochondrial fATPase in skeletal muscle. To this end, we assessed the acute effect (within 3 h) of lipid infusion in the presence of fasting insulin levels observed in insulin-resistant states (19, 25, 29, 31, 41) on glucose disposal, transport/phosphorylation, and fATPase in calf muscle of healthy humans. Intramyocellular fATPase, glucose 6-phosphate (G6P), inorganic phosphate (Pi), adenosine 5′-diphosphate (ADP), phosphocreatine (PCr), pH, and IMCL were monitored by combined 31P and 1H magnetic resonance spec-
tective continuous wave irradiation of the
ational reduction of Pi magnetization (Mo
calculated by multiplying the constant
ensity and
were measured from the ratio of the integrated respective peak
of a study that tested the effect of lipid infusion on insulin-
strometry (MRS) during euglycemic pancreatic clamps with
ose infusion (LIP) or saline (CON) infusions. These experiments were part
participants were on intensive physical exercise. They had medium
women, Germany), using a 10-cm circular double resonant 1H/31P
magnetic resonance spectrometer (Medspec S300-DBX; Bruker, Et-
alysis were performed using GraphPad Prism version 4.00 for Windows (Graph-
 Student t-tests. Changes in sequential data within experiments were evaluated
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Table 1. Steady-state concentrations of hormones and
metabolites during euglycemic pancreatic clamp tests with
low-dose insulin supplementation (6 mU·m body surface
area-1·min-1) on CON and LIP days in 8 healthy males

<table>
<thead>
<tr>
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<th>CON</th>
<th>LIP</th>
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<tbody>
<tr>
<td>Insulin, pmol/l</td>
<td>93 ± 13</td>
<td>90 ± 11</td>
</tr>
<tr>
<td>C-peptide, mmol/l</td>
<td>0.1 ± 0.0</td>
<td>0.1 ± 0.0</td>
</tr>
<tr>
<td>Glucagon, pmol/l</td>
<td>48 ± 14</td>
<td>49 ± 12</td>
</tr>
<tr>
<td>Glucose, mmol/l</td>
<td>5.5 ± 0.1</td>
<td>5.5 ± 0.1</td>
</tr>
<tr>
<td>FFA, mmol/l</td>
<td>0.05 ± 0.03</td>
<td>1.12 ± 0.22</td>
</tr>
<tr>
<td>Triglycerides, mg/dl</td>
<td>48 ± 14</td>
<td>643 ± 163</td>
</tr>
<tr>
<td>Lactate, mmol/l</td>
<td>0.91 ± 0.17</td>
<td>0.64 ± 0.11</td>
</tr>
<tr>
<td>β-Hydroxybutyrate, µmol/l</td>
<td>96 ± 0</td>
<td>460 ± 290</td>
</tr>
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Values are means ± SD. CON, control; LIP, lipid infusion. *p < 0.05, †p < 0.005, and ‡p < 0.001 for the comparison between CON and LIP.
rate (GIR) required to maintain euglycemia did not differ between LIP and CON (Fig. 1, A and B). Between 110 and 180 min, GIR was ~50% lower during LIP than during CON (0.87 ± 0.45 vs. 1.75 ± 0.42 mg·kg⁻¹·min⁻¹, \( P = 0.002 \)). During the pancreatic clamps, intramyocellular concentrations of G6P remained unchanged from baseline in LIP but tended to increase in CON (repeated-measures ANOVA \( P = 0.059 \)), albeit without significant difference from LIP (Fig. 1C).

**Intramyocellular fATPase.** Baseline fATPase did not differ between both LIP and CON study days (11 ± 3 vs. 10 ± 4 μmol·g muscle⁻¹·min⁻¹, \( P = \text{NS} \)). During the pancreatic clamp, fATPase remained unchanged at 10.2 ± 2.0 and 10.5 ± 2.6 μmol·g muscle⁻¹·min⁻¹, without differences between LIP and CON (Fig. 2A). Correlation analysis revealed no significant relationship between metabolic parameters of lipid (FFA, TG, IMCL) or glucose metabolism (glucose, insulin, GIR, G6P) and fATPase at baseline or during the low-insulin clamp.

**Intramuscular phosphorus metabolites.** Intramyocellular P₇ was similarly increased under both conditions by ~8 and ~12% (\( P < 0.05 \) vs. baseline for LIP and CON), without difference between LIP and CON (Table 2). Intramyocellular ADP, PCr, and pH were not affected by the clamp during LIP and CON (Table 2).

**IMCL.** IMCL in soleus muscle was unchanged at the end of the low-insulin clamp and not different between LIP and CON (Fig. 2B).

**DISCUSSION**

This study shows that modest plasma FFA concentrations for up to 3 h reduce whole body glucose disposal but do not affect myocellular fATPase in healthy humans.

Excessive plasma FFA elevation for up to 6 h leads to skeletal muscle insulin resistance associated with reduced glucose transport/phosphorylation, glycogen synthesis, and glucose oxidation (6, 10, 35). These effects are currently attributed to a rise in intramyocellular concentrations of fatty acid metabolites and subsequent interference with various steps of insulin signaling (17, 34). Alternatively, overload of the tricarboxylic acid cycle by β-oxidation of FFA could lead to incomplete fat oxidation along with impaired mitochondrial function (36). This mechanism would be particularly relevant during low-grade insulinemia, when glucose metabolism is not maximally stimulated. Of note, lipid infusion stimulates insulin secretion and decreases fasting glycemia (5) and causes marked hyperglycemia under classical basal insulin (~35 pmol/l) pancreatic clamp conditions (36). To prevent such differences in plasma insulin or glucose concentrations between the lipid and control studies, we chose a pancreatic clamp test with low-dose insulin supplementation (6 mU · m body surface area⁻²·min⁻¹) on saline (CON; filled bars and LIP; open bars) and lipid infusion days (LIP; filled bars and open bars) in 8 healthy males. Data are means ± SE. *\( P = 0.001 \) for LIP vs. CON.

Fig. 1. Plasma glucose (A), glucose infusion rates for 20-min intervals (B), and change from baseline of intramyocellular glucose 6-phosphate concentration (ΔG6P; C) during the euglycemic pancreatic clamp test with low-dose insulin supplementation (6 mU · m body surface area⁻²·min⁻¹) on saline (CON; ● and filled bars) and lipid infusion days (LIP; ○ and open bars) in 8 healthy males. Data are means ± SE. *\( P = 0.001 \) for LIP vs. CON.

Fig. 2. Intramyocellular flux through ATP synthase (fATPase; A) and intramyocellular lipid content (IMCL; B) during the euglycemic pancreatic clamp test with low-dose insulin supplementation (6 mU · m body surface area⁻²·min⁻¹) on saline (CON; filled bars) and lipid infusion days (LIP; open bars) in 8 healthy males. Data are means ± SE.
Table 2. Intramyocellular concentrations of \( P_i \), ADP, PCR, and pH as determined noninvasively by \(^{31}P\)-MRS before (baseline) and during the euglycemic pancreatic clamp tests with low-dose insulin substitution (6 mU·m body surface area\(^{-2} \cdot \text{min}^{-1}\)) with CON or LIP in 8 healthy males

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>90–120</th>
<th>150–170</th>
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<tbody>
<tr>
<td>( P_i ), mmol/l muscle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CON</td>
<td>2.63 ± 0.38</td>
<td>3.20 ± 0.40*</td>
<td>2.96 ± 0.30*</td>
</tr>
<tr>
<td>LIP</td>
<td>2.95 ± 0.62</td>
<td>3.30 ± 0.80*</td>
<td>3.15 ± 0.72</td>
</tr>
<tr>
<td>ADP, ( \mu \text{mol/l muscle} )</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CON</td>
<td>59 ± 8</td>
<td>61 ± 10</td>
<td>59 ± 10</td>
</tr>
<tr>
<td>LIP</td>
<td>56 ± 6</td>
<td>57 ± 4</td>
<td>58 ± 7</td>
</tr>
<tr>
<td>PCR, mmol/l muscle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CON</td>
<td>21 ± 2</td>
<td>21 ± 3</td>
<td>21 ± 3</td>
</tr>
<tr>
<td>LIP</td>
<td>22 ± 2</td>
<td>22 ± 2</td>
<td>21 ± 3</td>
</tr>
<tr>
<td>pH</td>
<td>7.09 ± 0.02</td>
<td>7.10 ± 0.02</td>
<td>7.09 ± 0.02</td>
</tr>
<tr>
<td>LIP</td>
<td>7.08 ± 0.01</td>
<td>7.09 ± 0.02</td>
<td>7.09 ± 0.02</td>
</tr>
</tbody>
</table>

Values are means ± SD. PCR, phosphocreatine; MRS, magnetic resonance spectroscopy. *\( P < 0.05 \) for the within-group comparison between low-insulin period and baseline.

clamping design with slightly higher than “basal” insulin supplementation. This approach yielded identical conditions of insulinemia and glyceremia, but we are aware that even these low-dose insulin infusion rates resulted in higher plasma insulin concentrations compared with baseline levels (~54 pmol/l). The observed plasma insulin concentrations of ~92 pmol/l were less than 20% of those seen in common hyperinsulinemic clamps and reflect basal portal vein insulinemia in insulin-sensitive humans and basal peripheral insulinemia in insulin-resistant individuals (19, 25, 29, 41). This will lead to suppression of adipocyte lipolysis but will only slightly stimulate muscular glucose metabolism, since steady-state GIR was ~15% of the GIR obtained under common hyperinsulinemic clamp conditions (8, 41). The plasma concentrations of ~1 mmol/l FFA and ~640 mg/dl TGs are also within the range reported for severely insulin-resistant humans (34). We found that lipid infusion decreased GIR by ~50% from 110 min onward, which is comparable with previous findings obtained at euglycemia and at ~2.6 mmol/l plasma FFA and ~50 pmol/l plasma insulin (21). In this previous study, the lipid-induced reduction of GIRs resulted from both decreased whole body glucose uptake and increased endogenous glucose production. Given the greater plasma FFA and lower plasma insulin levels, the reduction in GIRs was unlikely to have resulted from increased glucose production. This is further supported by the lower rise of intramyocellular G6P, an indicator of muscle glucose transport/phosphorylation at the end of the lipid infusion. The failure to observe a more marked difference of changes in G6P most likely resulted from the lower number of MRS scans, which decrease the sensitivity of the G6P measurement. This protocol was required to allow for longer duration of the fATPase measurements and thereby improved sensitivity of the assessment of mitochondrial function.

This study shows that 2–3 h of lipid infusion combined with a small rise in plasma insulin within the pathophysiological range do not affect fATPase. Previous studies using in vivo and ex vivo measurements of mitochondrial oxidative phosphorylation demonstrated a regulatory effect of insulin on skeletal muscle ATP production, mitochondrial protein synthesis, and enzyme activities (2, 8, 18, 30, 40, 41). In healthy humans, postprandial-like plasma insulin concentrations stimulate ATP production and protein synthesis (2, 8, 30, 40, 41). Most recently, lipid infusion for 6 h without inhibition of endogenous insulin secretion decreased the ex vivo-measured muscle inner mitochondrial membrane potential but did not affect citrate synthase activity, ATP content, or mitochondrial content or gene expression (10). Short-term insulin deprivation, on the other hand, decreases ATP production in mitochondria isolated from skeletal muscle of type 1 diabetic patients (18). In agreement with the present study, small increases in plasma insulin did not alter ATP production by mitochondria isolated from skeletal muscle of healthy humans (2).

In the present study, myocellular \( P_i \) concentration was similarly increased by ~8 and 12% during LIP and CON, respectively, which is in accordance with our previous finding that FFAs do not affect the insulin-stimulated rise in \( P_i \) (35). Of note, the insulin-mediated increase in \( P_i \) was found to be reduced in insulin-resistant first-degree relatives of patients with T2DM and in the presence of increased plasma FFA during concomitant hyperglycemia (21, 30). Moreover, myocellular ADP, PCR, and pH were comparable during LIP and CON conditions, rendering allosteric effects of these metabolites on mitochondrial ATP synthase flux or glucose transport/phosphorylation unlikely.

Because fasting plasma FFA concentrations were identified as the strongest predictor of basal myocellular fATPase in nondiabetic and T2DM patients (41), one might suspect a pathophysiological relationship between increased plasma FFA and oxidative phosphorylation in skeletal muscle. Nevertheless, fasting plasma FFAs were not increased in the insulin-resistant participants of this study despite impaired insulin-stimulated fATPase. Likewise, studies on the long-term effects of increased FFA availability revealed conflicting results regarding mitochondrial function and biogenesis in rodents. Mice on high-fat diets developed abnormalities of biogenesis, structure, and function of skeletal muscle mitochondria associated with diabetes (7). Interestingly, impairment of biogenesis of muscle mitochondria did not develop prior to the onset of overt diabetes but clearly after the development of insulin resistance (7). On the other hand, Zucker diabetic fatty rats serving as a model of T2DM exhibit normal mitochondrial function despite elevated plasma FFA (12). In high-fat-fed rats, both mitochondrial biogenesis and enzymes of the fatty acid oxidation pathway and citrate cycle were even upregulated by activation of the PPAR\( \alpha \) pathway (14, 15). Furthermore, mice overexpressing PGC-1\( \alpha \) show increased myocellular mitochondrial density and fATPase but are more prone to fat-induced insulin resistance (11). These findings rather support the concept of incomplete \( \beta \)-oxidation, which proposes that fat-induced insulin resistance occurs despite increased transport of fatty acids into mitochondria (20).

In healthy humans, consumption of a high-fat diet for 3 days not only increased plasma FFA but resulted in coordinated downregulation of genes involved in oxidative phosphorylation and mitochondrial biogenesis (39). An even shorter time period of plasma FFA elevation induced by lipid infusion for 48 h decreased the expression of PGC-1 and nuclear-encoded mitochondrial genes in skeletal muscle (33). Thus, the duration...
of FFA exposure seems to be critical for the analysis of FFA effects on skeletal muscle mitochondria. In the present study, we assessed rapid effects of increased FFA occurring within 3 h on skeletal muscle mitochondrial fATPase, which rules out relevant alterations of enzyme expression. A recent ex vivo study found that low concentrations of FFA metabolites such as palmitoyl carnitine and palmitoyl-CoA stimulate, whereas higher concentrations inhibit, ATP production in mitochondria of human and murine muscle (1). The inhibitory effects were explained mainly by inhibition of the electron chain transport activity. In contrast, 6 h of plasma FFA elevation decreased only the inner mitochondrial membrane potential in skeletal muscle (10). These measurements were performed under ex vivo conditions and in the absence of inhibition of insulin secretion by somatostatin (10). Using the in vivo dynamic approach and matched plasma glucose and insulin concentrations, we found no acute (within 3 h) alterations of mitochondrial fATPase in skeletal muscle during lipid infusion. This suggests that direct effects of FFA on mitochondrial ATP production do not likely contribute to FFA-induced peripheral insulin resistance. Differences between our in vivo and the above-mentioned ex vivo studies could be due to differences in the composition of the lipid infusion containing a high percentage of unsaturated FFAs and in the effective FFA metabolite concentrations in the myocellular cytoplasm and the shorter duration of increased FFA exposure in the present study. Of note, we also detected no changes in IMCL in soleus muscle, which is in accordance with previous data also obtained at low plasma insulin levels (21).

This study has some limitations. The setting of an acute increase in plasma FFAs does not allow us to extrapolate the findings to long-term effects of increased lipid availability, particularly resulting from high-fat feeding of rodents. Furthermore, no biopsies were taken, so alterations of the insulin-signaling cascade or intramyocellular fatty acid metabolites are not available. In addition, only males were studied here, so possible sex-associated differences in the susceptibility to fatty acid-induced insulin resistance cannot be ruled out (13, 27).

In conclusion, acute lipid elevation for 2–3 h already reduces whole body glucose uptake but fails to affect fATPase within this time frame. These data complete the finding that prolonged lipid availability for 6 h reduces insulin-stimulated fATPase in parallel, but not prior to impairment of glucose transport/lipid availability for 6 h reduces insulin-stimulated fATPase in this time frame. These data complete the finding that prolonged acid-induced insulin resistance cannot be ruled out (13, 27).

REFERENCES


LIPIDS AND MUSCULAR ATP SYNTHESIS


