Intense electroacupuncture normalizes insulin sensitivity, increases muscle GLUT4 content, and improves lipid profile in a rat model of polycystic ovary syndrome

Julia Johansson, Yi Feng, Ruijin Shao, Malin Lönn, Håkan Billig, and Elisabet Stener-Victorin

1Institute of Neuroscience and Physiology, Department of Physiology, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden; 2Department of Neurobiology and Integrative Medicine, Shanghai Medical College of Fudan University, Shanghai, China; 3Department of Clinical Chemistry and Transfusion Medicine, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden; and 4Department of Obstetrics and Gynecology, First Affiliated Hospital, Heilongjiang University of Chinese Medicine, Harbin, China

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HYPERANDROGENEMIA IS THE MOST PROMINENT endocrine phenotype in women with polycystic ovary syndrome (PCOS) (56) in addition to ovulatory dysfunction and polycystic ovary morphology (3). The main metabolic phenotype is hyperinsulinemia and insulin resistance, which are independent of body weight (19, 40). Other metabolic abnormalities associated with insulin resistance are obesity, dyslipidemia, and increased risk for type 2 diabetes.

The mechanisms for the association between endocrine and metabolic abnormalities in PCOS are unclear (13, 18). PCOS is characterized by clinical and/or biochemical hyperandrogenism. In female rats and humans, exogenous exposure to testosterone or dihydrotestosterone (DHT) leads to insulin resistance and obesity (4, 14, 17, 22, 50, 58). The insulin resistance in women with PCOS is associated with a dyslipidemia characterized by low levels of high-density lipoprotein (HDL) cholesterol and high levels of low-density lipoprotein (LDL) and triglycerides (TG) (49).

Women with PCOS display both insulin resistance and reduced insulin responsiveness (11). The insulin resistance has been attributed to defects in insulin signaling in adipocytes and skeletal muscle (11, 12, 20, 21). In female rats, testosterone exposure results not only in obesity and insulin resistance but also in changes in muscle morphology, including a reduction in type 1 fibers, an increase in type 2 fibers, and decreased capillary density (30, 31). After testosterone exposure, insulin-mediated glucose uptake is reduced, most likely because of impairments in glycogen synthase expression and plasma membrane translocation of glucose transporter 4 (GLUT4) in skeletal muscle (58). Indeed, women with PCOS have reduced GLUT4 content in both whole cell lysates and membrane preparations of adipose tissue (60, 62). Furthermore, GLUT4 translocation stimulated by insulin or contractions in skeletal muscle is dependent on phosphorylation of the Akt substrate of 160 kDa (AS160) (38, 39, 61). Recent findings suggest that insulin resistance in women with PCOS reflects impaired phosphorylation of Akt and AS160 in skeletal muscle (11, 32). Thus, hyperandrogenism and PCOS are associated with molecular alterations in skeletal muscle and adipose tissue that may explain, at least in part, the decreased insulin sensitivity.

Treatment of PCOS is symptom oriented, however unsatisfactory in a wider perspective. Physical exercise and diet are the first-line options for treating and preventing metabolic dysfunction both generally and in women with PCOS (55). In a rat model of DHT-induced PCOS that exhibits both ovarian and metabolic characteristics of the syndrome (50), low-frequency (2 Hz) electroacupuncture (EA) and physical exercise, both of which induce muscle contraction, increase insulin sensitivity and modulate gene expression in adipose tissue.
Unlike exercise, EA does not reduce adipose tissue mass (51, 52). Consistent with these results, in Goto-Kakizaki rats, a genetic model of type 2 diabetes, EA improves hyperglycemia and restores impaired glucose tolerance by enhancing insulin sensitivity (33). Furthermore, in mice with diet-induced hypercholesterolemia, EA had a cholesterol-lowering effect similar to that of simvastatin (35, 41).

The mechanism for the beneficial effects of 4–5 wk of low-frequency EA given 3 days/wk is unknown (51, 52). Most likely, it involves a direct influence on skeletal muscle signal- ing mechanisms and secondary actions in adipose tissue. Muscle contraction during low-frequency EA may stimulate glucose uptake via an insulin-independent pathway and may be mediated, at least in part, by signaling pathways in skeletal muscle similar to those activated by chronic exercise (16, 25). The signaling mechanisms in skeletal muscle after muscle contraction have been studied extensively (59). Few such studies have been conducted on low-frequency EA. In male rats acutely exposed to prednisolone to induce an insulin-resistant state, low-frequency EA for 60 min during anesthesia restored protein expression of insulin receptor substrate-1 and GLUT4 in skeletal muscle (45). The mechanism by which low-frequency EA improves insulin sensitivity in rats with DHT-induced PCOS remains to be elucidated. Furthermore, it is not known whether low-frequency EA can restore normal insulin sensitivity, as exercise does, when EA is given more frequently in rats with DHT-induced PCOS.

In this study, we tested the hypothesis that low-frequency EA, given 5 days/wk for 4–5 wk at an intensity high enough to evoke muscle twitches, would normalize insulin sensitivity by restoring signaling mechanisms in skeletal muscle and improve the lipid profile of DHT-induced PCOS rats. We measured whole body insulin sensitivity by euglycemic hyperinsulinemic clamp test, body composition by dual-emission X-ray absorptiometry (DEXA), the lipid profile by ELISA, and skeletal muscle protein expression and activation of GLUT4, Akt, and AS160 by Western blot and GLUT4 location by immunofluorescence staining.

MATERIALS AND METHODS

Animals. Four Wistar dams, each with eight or nine female pups, were purchased from Charles River Laboratories (Sulzfeld, Germany). Pups were raised with a lactating dam until 21 days of age and housed four to five per cage under controlled conditions (21–22°C, 55–65% humidity, 12:12-h light-dark cycle). Rats were purchased from Charles River Laboratories (Sulzfeld, Germany) with an identification number was inserted in the neck along with the pellets. EA treatments started at 70 day of age, 7 wk after the start of DHT exposure. The study was concluded after 12 wk of DHT exposure, including 4–5 wk of treatment with low-frequency EA.

Treatment. Low-frequency EA was given to conscious rats daily, Monday to Friday, for 4–5 wk (20–25 treatments in total). The treatment duration was 15 min in week 1, 20 min in weeks 2 and 3, and 25 min thereafter. Acupuncture needles were inserted in the rectus abdominis and in the soluses and gastrocnemius muscles forming the triceps surae muscles bilaterally in the somatic segments corresponding to innervation of the ovaries (i.e., from spinal levels T10 to L2 and at the sacral level). The needles (HEGU Svenska, Landsbro, Sweden) were inserted into a depth of 0.5–0.8 cm, attached to an electric stimulator (CEFAR ACU II; Cefar-Compex Scandinav, Malmo, Sweden), and stimulated with at 2 Hz with 0.1-s, 80-Hz burst pulses (51, 53, 69–71). The intensity varied from 0.8–1.4 mA during stimulation and was adjusted to produce local muscle contractions. Owing to receptor adaptation, the amplitude was adjusted when muscle contractions became invisible. Usually, the amplitude was adjusted after 5 min of stimulation, and most rats tolerated higher amplitudes at the end of the each treatment. All rats tolerated the full treatment for 4–5 wk.

Before handling or needle insertion, all rats were lightly anesthetized with isoflurane (2% in 1:1 mixture of oxygen and air, Isoba Vet; Schering-Plough, Stockholm, Sweden) for 2–3 min. One investigator inserted all needles. During EA treatment, rats were placed in a fabric harness and suspended above the desk. All rats were conscious during handling and treatment. Rats in the control and PCOS groups were anesthetized, suspended in a harness, and handled in the same way as rats in the PCOS EA group except for needle insertion and electrical stimulation. No treatment was performed 24 h before examinations and blood sampling.

Vaginal smears. The stage of cyclicity was determined by microscopic analysis of the predominant cell type in vaginal smears obtained daily from the onset of EA treatment at 70 days of age to the end of the experiment (54).

Blood sampling and body composition. At 14 wk of age (4 wk of treatment, 10 wk after pellet implantation), tail blood was obtained to assess the lipid profile. Plasma samples were stored at ~80°C until analyses. Body composition was also assessed at 14 wk. Rats were lightly anesthetized by inhalation of isoflurane (2% in 1:1 mixture of oxygen and air; Abbott Scandinavia, Solna, Sweden) and analyzed with a whole body DEXA instrument (QDR-1000/W; Hologic, Waltham, MA). Total body fat, lean body mass, and bone mineral content were determined for each rat.

Euglycemic hyperinsulinemic clamp and sample collection. At 15–16 wk of age (5 wk of treatment, 11–12 wk after pellet implantation), rats were subjected to a euglycemic hyperinsulinemic clamp (27) during the estrous phase if cycling. PCOS rats without treatment displayed chronic pseudoestrus. Rats were anesthetized with thiobutabarbital sodium (130 mg/kg ip, Inactin; Sigma-Aldrich, St. Louis, MO), and body temperature was maintained at 37°C with a heating pad throughout the clamp. Catheters were inserted into the left carotid artery for blood sampling and into the right jugular vein for glucose and insulin infusions; to facilitate breathing, a tracheotomy was performed. Insulin (100 U/ml Actrapid; Novo Nordisk, Bagsvaerd, Denmark), together with 0.2 ml of albumin and 10 ml of physiological saline, was infused at 24, 16, and 12 μU·min⁻¹·kg⁻¹ for 1, 2, and 3 min, respectively, followed by 8 μU·min⁻¹·kg⁻¹ for the rest of the clamp. Blood glucose was analyzed (10 μl) with a B-glucose analyzer (HemoCue, Dronfield, Derbyshire, UK); 20% glucose in saline solution was administered continuously to maintain plasma glucose at a constant euglycemic level (6.0 mM). The glucose infusion rate (GIR) was guided by glucose concentration measurements every 5 min. At steady state (after 50–70 min), mean GIR was normalized to body weight, and blood samples were taken to determine plasma insulin concentrations.

After the experiment the rats were decapitated, and hindlimb muscles (soleus, gastrocnemius, and extensor digitorum longus) and...
fat depots (parametrial, retroperitoneal, inguinal, and mesenteric) were dissected and weighed. Soleus muscle was stabilized in RNA later (Qiagen, Hilden, Germany) for 12 h and stored at −80°C until protein analyses.

Biochemical analyses. Plasma concentrations of total cholesterol (product ref. no. 981813), HDL (product ref. no. 981655) and LDL (product ref. no. 981656) cholesterol, and TG (product ref. no. 981786) were determined enzymatically; HDL was determined after precipitation of apolipoprotein B-containing lipoproteins with magnesium sulfate and dextran sulfate (Thermo Fisher Scientific, Vantaa, Finland). All analyses were performed on a Konelab 20 autoanalyzer (Thermo Fisher Scientific); the interassay coefficients of variation were <3%. All lipid analyses were carried out at an accredited laboratory at the Wallenberg Laboratory, Sahlgrenska University Hospital, Gothenburg, Sweden. Basal insulin and human insulin, given during the clamp, were measured in duplicate with ELISA kits (product ref. nos. 10-1124-01 and 10-1113-01, respectively; Merckodia, Uppsala, Sweden).

Homogenization. Frozen tissue was placed in ice-cold RIPA buffer (150 mM NaCl, 1% IGEPAL CA-630, 0.5% sodium deoxycholate, 0.1% SDS, 50 mM Tris, pH 8.0; Sigma-Aldrich) containing 1× complete protease inhibitor cocktail and phosphatase inhibitor cocktail (PhosSTOP; Roche Diagnostics, Basel, Switzerland) and homogenized twice for 3 min each with a tissueLyser (Qiagen) at 25 Hz. Homogenate samples were rotated on ice for 45 min and centrifuged (16,300 g) for 20 min at 4°C. Supernatants were collected, and protein concentration was determined with a BCA protein assay kit (Pierce Biotechnology, Rockford, IL) according to the manufacturer’s protocol. The rest was stored at −80°C until further analyses.

Immunoblotting. Total protein (~30 or 50 µg) was separated by SDS-PAGE and transferred to nitrocellulose or PVDF. Membranes were rinsed in Tris-buffered saline with 0.1% Tween-20 (TBS-T), blocked in 5% nonfat dry milk in TBS-T for 1 h at room temperature, and incubated in primary antibody overnight at 4°C. The following day, blots were washed in TBS-T, incubated in secondary antibody for 1 h at room temperature, and washed again in TBS-T. Protein bands were developed with SuperSignal West Dura Extended Duration Substrate (Pierce Biotechnology) and photographed with an LAS-1000 camera system (Fujifilm, Tokyo, Japan). The intensity of protein signals was quantified with Multigauge software, normalized to gel Coomassie blue staining, and expressed as a ratio to gain arbitrary densitometric units of relative abundance.

Antibodies against GLUT4, Akt, and p-Akt Ser473 for Western blot were from Cell Signaling Technology (catalog nos. 2299, 4691, and 9271; Cell Signaling Technology, Danvers, MA). Antibodies against AS160 and p-AS160 Thr642 were from Millipore (catalog nos. 07-741 and 07-802; Millipore, Billerica, MA), and horseradish peroxidase-conjugated anti-rabbit IgGs were from Sigma-Aldrich (A0545).

Immunofluorescence staining. The location of GLUT4 was determined by immunofluorescence staining of paraffin-embedded muscle sections with GLUT4 antibody (catalog no. ab33780; Abcam) as described (63). Slides were viewed on an Axiovert 200 confocal microscope (Zeiss, Jena, Germany) equipped with a laser-scanning confocal imaging LSM 510 META system (Carl Zeiss) and photomicrographed. Background settings were adjusted from examination of negative control specimens. Images of positive staining were adjusted to make optimal use of the dynamic range of detection. Control sections were stained with hematoxylin and eosin to illustrate the nucleus of muscle cells.

Statistical analysis. Data are reported as means ± SE. Body weight gain at each time point was analyzed with a mixed between-within-subjects ANOVA followed by t-test. Remaining analyses were tested with the Mann-Whitney U-test, where primary comparisons were between the PCOS and PCOS EA groups, and secondary comparisons were between controls and the PCOS groups. All statistical evaluations were performed with SPSS software (version 17.0; SPSS, Chicago, IL). P < 0.05 was considered significant.

RESULTS

After 4–5 wk of low-frequency EA treatment, 11 of 12 rats (91.7%) in the PCOS EA group exhibited epithelial keratinocytes, the main cell type during estrus, indicating estrous cycle changes (23).

EA does not affect body composition. Rats with DHT-induced PCOS gained significantly more weight than controls, and they weighed more from 49 days of age (i.e., after 4 wk of DHT exposure) and remained heavier throughout the study (Table 1). After 4 wk of treatment (11 wk of DHT exposure), the PCOS group had a higher percentage of fat mass along with a lower percentage of lean body mass, resulting in a higher ratio between body fat and lean body mass. They also had lower bone mineral content than controls (Table 2). Low-frequency EA did not affect body weight (Table 1) or body composition (Table 2).

The inguinal and parametrical adipose tissue depots were heavier in the PCOS group than in controls; the weights of retroperitoneal and mesenteric depots did not differ between the groups (Table 3). In relation to total body weight, the inguinal fat depot weighed more and the mesenteric depot

<table>
<thead>
<tr>
<th>Table 1. Weight development during the study</th>
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<tbody>
<tr>
<td>Age, days</td>
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<tr>
<td>21</td>
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<td>28</td>
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<td>35</td>
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<td>42</td>
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<td>49</td>
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<td>56</td>
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<td>63</td>
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<tr>
<td>70</td>
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<tr>
<td>77</td>
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<tr>
<td>84</td>
</tr>
<tr>
<td>91</td>
</tr>
<tr>
<td>End of experiment</td>
</tr>
</tbody>
</table>

Values are means ± SE; n = 12. PCOS, polycystic ovary syndrome; EA, electroacupuncture; NS, not significant. Mixed between-within subjects ANOVA was significant (P < 0.05). Differences between groups at each time point were determined by t-test.
Statistical significance was determined with the Mann-Whitney U-test.

Low-frequency EA increased retroperitoneal fat depots in both absolute and relative terms compared with PCOS rats with no treatment (Table 3). The extensor digitorum longus, soleus, tibialis, and gastrocnemius muscles weighed more in the PCOS EA group than in untreated PCOS rats. However, after 4–5 wk of low-frequency EA treatment, GLUT4 expression in the PCOS EA group was confirmed by immunofluorescence staining. In controls, GLUT4 was localized predominantly in the cytosol, but GLUT4 expression in the plasma membrane and cytosol were increased by low-frequency EA (Fig. 3, A1–A3 and B1–B3). In muscle cells from rats with DHT-induced PCOS, GLUT4 expression was less intense than in controls (Fig. 3, B1–B3), but GLUT4 expression in the plasma membrane and cytosol were increased by low-frequency EA (Fig. 3, C1–C3).

Continuous DHT exposure or intensive low-frequency EA did not affect the p-Akt/Akt (Fig. 2C), or expression of Akt, p-Akt, AS160, or p-AS160 (data not shown).

**DISCUSSION**

This study demonstrates that intensive low-frequency EA, given 5 days/wk for 4–5 wk, restores normal insulin sensitivity, as measured by euglycemic hyperinsulinemic clamp, in rats with DHT-induced PCOS. EA also increased expression of total GLUT4 in different compartments of soleus muscle cells and partly improved the lipid profile in PCOS rats, which may explain,

<table>
<thead>
<tr>
<th>Variable</th>
<th>Control (n = 11)</th>
<th>PCOS (n = 11)</th>
<th>PCOS-EA (n = 12)</th>
<th>PCOS vs. Control</th>
<th>PCOS vs. PCOS-EA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fat depots, g</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Inguinal</td>
<td>1.18 ± 0.07</td>
<td>2.23 ± 0.13</td>
<td>2.22 ± 0.17</td>
<td>P &lt; 0.001</td>
<td>NS</td>
</tr>
<tr>
<td>Parametral</td>
<td>3.75 ± 0.38</td>
<td>6.93 ± 0.37</td>
<td>5.08 ± 0.77</td>
<td>P &lt; 0.05</td>
<td>NS</td>
</tr>
<tr>
<td>Retropertioneal</td>
<td>2.17 ± 0.11</td>
<td>2.31 ± 0.09</td>
<td>2.48 ± 0.11</td>
<td>NS</td>
<td>P &lt; 0.05</td>
</tr>
<tr>
<td>Mesenteric</td>
<td>2.68 ± 0.19</td>
<td>2.94 ± 0.19</td>
<td>2.61 ± 0.18</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Fat depots, g/kg BW</td>
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<td></td>
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<td></td>
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</tr>
<tr>
<td>Inguinal</td>
<td>4.47 ± 0.21</td>
<td>6.93 ± 0.37</td>
<td>6.63 ± 0.42</td>
<td>P &lt; 0.001</td>
<td>NS</td>
</tr>
<tr>
<td>Parametral</td>
<td>14.20 ± 1.21</td>
<td>16.22 ± 1.23</td>
<td>15.17 ± 2.15</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Retropertioneal</td>
<td>8.83 ± 0.64</td>
<td>8.14 ± 0.54</td>
<td>10.81 ± 0.81</td>
<td>NS</td>
<td>P &lt; 0.05</td>
</tr>
<tr>
<td>Mesenteric</td>
<td>8.26 ± 0.29</td>
<td>7.10 ± 0.28</td>
<td>7.43 ± 0.32</td>
<td>P &lt; 0.01</td>
<td>NS</td>
</tr>
<tr>
<td>Muscles, g</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDL</td>
<td>0.12 ± 0.004</td>
<td>0.28 ± 0.01</td>
<td>0.28 ± 0.01</td>
<td>P &lt; 0.001</td>
<td>NS</td>
</tr>
<tr>
<td>Soleus</td>
<td>0.13 ± 0.003</td>
<td>0.14 ± 0.05</td>
<td>0.14 ± 0.003</td>
<td>P &lt; 0.05</td>
<td>NS</td>
</tr>
<tr>
<td>Tibialis</td>
<td>0.54 ± 0.01</td>
<td>0.63 ± 0.01</td>
<td>0.64 ± 0.02</td>
<td>P &lt; 0.001</td>
<td>NS</td>
</tr>
<tr>
<td>Gastrocnemius</td>
<td>4.92 ± 0.15</td>
<td>5.22 ± 0.12</td>
<td>4.91 ± 0.17</td>
<td>P &lt; 0.001</td>
<td>NS</td>
</tr>
<tr>
<td>Muscles, g/kg BW</td>
<td></td>
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<tr>
<td>EDL</td>
<td>0.47 ± 0.02</td>
<td>0.47 ± 0.01</td>
<td>0.47 ± 0.016</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Soleus</td>
<td>0.50 ± 0.01</td>
<td>0.44 ± 0.01</td>
<td>0.44 ± 0.01</td>
<td>P &lt; 0.01</td>
<td>NS</td>
</tr>
<tr>
<td>Tibialis</td>
<td>2.05 ± 0.04</td>
<td>1.99 ± 0.04</td>
<td>1.92 ± 0.05</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Gastrocnemius</td>
<td>4.92 ± 0.15</td>
<td>5.21 ± 0.12</td>
<td>4.91 ± 0.17</td>
<td>NS</td>
<td>NS</td>
</tr>
</tbody>
</table>

Values are means ± SE. DHT, dihydrotestosterone; EDL, extensor digitorum longus. Statistical significance was determined with the Mann-Whitney U-test.
Acupuncture, GLUT4 Muscle Content, and Lipid Profile

Table 4. Fasting serum concentrations of total cholesterol, triglycerides, HDL, and LDL in DHT-induced PCOS compared with controls and effect of intensive low-frequency EA treatment

<table>
<thead>
<tr>
<th>Variable</th>
<th>Control</th>
<th>PCOS</th>
<th>PCOS EA</th>
<th>PCOS vs. Control</th>
<th>PCOS vs. PCOS-EA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cholesterol</td>
<td>2.49 ± 0.11</td>
<td>2.37 ± 0.11</td>
<td>2.11 ± 0.07</td>
<td>NS</td>
<td>P &lt; 0.05</td>
</tr>
<tr>
<td>Triglycerides</td>
<td>0.82 ± 0.08</td>
<td>1.19 ± 0.08</td>
<td>1.05 ± 0.06</td>
<td>P &lt; 0.01</td>
<td>NS</td>
</tr>
<tr>
<td>HDL</td>
<td>2.05 ± 0.10</td>
<td>1.96 ± 0.10</td>
<td>1.71 ± 0.08</td>
<td>NS</td>
<td>P &lt; 0.05</td>
</tr>
<tr>
<td>LDL</td>
<td>0.36 ± 0.03</td>
<td>0.43 ± 0.03</td>
<td>0.36 ± 0.02</td>
<td>P &lt; 0.01</td>
<td>P &lt; 0.05</td>
</tr>
</tbody>
</table>

Values are means ± SE; n = 12. Statistical significance was determined with the Mann-Whitney U-test.
shift in the distribution of GLUT4 to the plasma membrane suggests a potential increase in transport capacity. Thus we speculate that the increased expression of GLUT4 may increase its translocation capability from other intracellular compartments to the plasma membrane, which may help explain the improved insulin sensitivity in PCOS rats. However, we cannot conclude from the immunofluorescence data alone that GLUT4 translocation increases after EA treatment.

This result indicates that low-frequency EA, given five times/wk, activates signaling pathways similar to those activated by muscle contraction during exercise. It also indicates a dose-response relationship between the number of EA treatments and improvement in insulin sensitivity compared with our previous trial (51, 52). Our results are in line with the acute effects of low-frequency EA in rats with prednisolone-induced insulin resistance, demonstrating increased skeletal muscle protein expression of insulin receptor substrate-1 and GLUT4 (45). Moreover, in the present study, the beneficial effects were at least semichronic, since no treatment was performed 24 h before assessment of insulin sensitivity and tissue collection.

The euglycemic hyperinsulinemic clamp with high insulin input may induce insulin-dependent signaling beyond the molecular events caused by low-frequency EA. However, insulin stimulation and muscle contraction have a combined effect that is larger than the net effect of either alone (46, 57). Thus contractions and insulin stimulation induce translocation of GLUT4 vesicles through diverse intracellular mechanisms.

In skeletal muscle and adipocytes, GLUT4 translocation induced by insulin or muscle contractions is at least partly dependent on phosphorylation of AS160 (38, 39, 61). However, the exact mechanism is unclear. Insulin-stimulated phosphorylation of AS160 is mediated by Akt, whereas contraction-stimulated phosphorylation is mediated by AMP-activated protein kinase possibly together with Akt and other kinases (38). Although both Akt and AS160 seem to be involved in GLUT4 translocation, neither was affected by low-frequency EA. The reason for this may be that the experiment ended with euglycemic hyperinsulinemic clamp with high insulin input, which may induce Akt phosphorylation, as in women with PCOS (11, 32), or the effect of EA may involve other insulin-independent signaling mechanisms. Further studies of Akt phosphorylation in skeletal muscle and adipose tissue, using lower insulin levels, are required to elucidate its role in DHT-induced PCOS.

Partly normalized lipid profile after low-frequency EA. Low-frequency EA for 4–5 wk reduced total and LDL cholesterol in rats with DHT-induced PCOS. Interestingly, we found a decrease in HDL cholesterol. This result might seem conflicting with an otherwise improved lipid profile. However, mice and rats, compared with humans, carry most of their serum cholesterol in the HDL fraction instead of in the LDL fraction (27). Hence, it is not surprising that the demonstrated decrease in total cholesterol is reflective of changes in HDL cholesterol. EA also reduces total and LDL cholesterol in obese patients with hypercholesterolemia (7, 72) and in a rat model of hyperlipidemia (42). In comprehensive gene expression profile analyses, the cholesterol-lowering effect of EA in the liver of hypercholesterolemic mice was attributed to improved lipid metabolism and suppression of inflammation (35,
In line with these observations, we demonstrated that low-frequency EA decreases mRNA expression of inflammatory markers in mesenteric adipose tissue of rats with DHT-induced PCOS (52). In studies not related to PCOS, daily low-frequency EA treatment for 4 wk in rats and humans reduced food intake and weight (6, 37). EA treatment has also been shown to improve lipid profile in mice (41) and humans (7). However, low-frequency EA administered 3 or 5 days/wk in rats with DHT-induced PCOS does not affect body weight (52) and thus may not explain the improved lipid profile in the present experiment. Our studies have shown that EA improves ovarian morphology and restores altered adipose tissue gene expression related to insulin resistance, obesity, inflammation, and high sympathetic activity (51, 52). Thus EA seems to disrupt the vicious circle of androgen excess, insulin resistance, and ovarian dysfunction despite continuous administration of androgens.

No change in body composition. As in our previous study (52), EA did not alter body composition measured by DEXA. Furthermore, the weight of soleus was lower in relation to body weight in PCOS rats; however, it was not affected by EA despite the more frequent treatment (52). This implies that the normalization of insulin sensitivity in the present study is more likely due to molecular effects than to altered body composition or an increased glucose demand due to larger muscle mass.

The discrepancy in muscle weight could simply reflect differences related to tissue dissection. Surprisingly though, EA increased the weight of the retroperitoneal fat depot, something not seen in the earlier study (52). The implications of this finding in relation to the increased insulin sensitivity are unclear.

Conclusion. Low-frequency EA given 5 days/wk for 4–5 wk restores normal insulin sensitivity, increases skeletal muscle protein expression of GLUT4 in different compartments of soleus muscle cells, and improves the lipid profile in rats with DHT-induced PCOS. Thus, low-frequency EA treatment has systemic and local effects involving intracellular signaling pathways in muscle that may account for the improved insulin sensitivity.

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Fig. 3. Expression of GLUT4 in muscle cells in controls, rats with DHT-induced PCOS, and PCOS-EA rats. Although the immunoreactivity of GLUT4 is less intense in DHT-induced PCOS rat muscle cells (B1–B3) than in controls, GLUT4 is localized predominantly around the nucleus of the muscle cells (A1– A3). EA treatment (C1–C3) increases GLUT4 expression in the plasma membrane and in the cytosol of muscle cells. D: muscle GLUT4 immunoreactivity was absent in the adjacent section when the primary antibody was omitted. Staining was repeated in 4 rats/group with similar results. The immunofluorescence findings shown are representative of those in randomly selected sections from multiple animals. E: hematoxylin-eosin staining in control rats illustrates nucleus of muscle cells. All photographs were taken with a ×20 objective; the exact scale is given in the figure.
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DISCLOSURES

The authors confirm that there are no conflicts of interest.

REFERENCES


