Leptin and the GA genotype of rs2167270 of the LEP gene increase the risk of prediabetes

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Abstract. Prediabetes is a precursor stage that frequently develops to definitive type 2 diabetes mellitus (T2DM). Therefore, identifying individuals with prediabetes can allow for early intervention measures that delay or prevent disease progression to T2DM. Several biochemical changes appear to be associated with prediabetes, including an increase in the serum levels of leptin. In Jordan, this association has not been previously investigated. In the present study, the serum levels of leptin were measured in 122 prediabetes subjects and 122 controls. Furthermore, the genotypes of three single nucleotide polymorphisms in the LEP gene (rs7999039, rs2167270 and rs791620) were investigated for their association with prediabetes using PCR-restriction fragment length polymorphism. The results revealed a significant increase in serum leptin levels in the prediabetes group. It was also shown that the GA genotype and the A allele of rs2167270 were significantly associated with an increased risk of prediabetes (P<0.05). These findings were shown to be independent of body mass index, waist circumference and serum glucose levels. To the best of our knowledge, the present study is the first in Jordan to have reported an association between serum leptin levels and the GA genotype of rs2167270 with an increased risk of prediabetes, identified both in the univariate and multivariate models.

Introduction

Type 2 diabetes mellitus (T2DM) is one of the most prevalent and challenging chronic illnesses of the 21st century (1). It is characterized by chronic hyperglycemia and impaired metabolism of carbohydrates, fats and protein (2). T2DM is primarily caused by β-cell dysfunction accompanied by increased insulin resistance in the target tissue (3). In terms of the short- and long-term effects of T2DM, it is ranked as the 7th major cause of mortality worldwide according to the World Health Organization (4). Globally, the International Diabetes Federation (IDF) have reported that ~10% of the world’s population have T2DM. Indeed, 415 million individuals were reported to have T2DM in 2015, a number predicted to reach 642 million by 2040 (5). A sedentary lifestyle, together with increased consumption of unhealthy diets, are major triggers for the development of T2DM (1).

Previous estimates of the prevalence of T2DM in the Middle East and North Africa (MENA) region ranks it as the second highest worldwide. If current trends continue, the number of individuals with T2DM is expected to increase by 96.2% by 2035 (6). Statistics from the IDF indicate that Jordan, a country in the MENA region, ranks 26th in the prevalence of T2DM (5). A study of T2DM trends in Jordan over a 23-year period reported a 10.7% increase in the prevalence of T2DM between 1994 and 2017 (7,8).

Our understanding of the progression of T2DM highlights the presence of a transitional stage between normal blood glucose levels in healthy individuals and the characteristic hyperglycemia of T2DM. During this stage, commonly referred to as intermediate hyperglycemia or prediabetes, individuals develop insulin resistance, which results in an elevated level of blood glucose, albeit still lower than the reference values of T2DM (9).

The American Diabetes Association estimates that 70% of all individuals with prediabetes will eventually transition into T2DM (10). However, a growing body of evidence accumulated over the last few decades has indicated that lifestyle changes, such as a healthier diet and exercise, may decelerate or even halt this progression (11,12). Evidence also suggests that pharmacological intervention using therapeutics that modify insulin resistance may also supplement/replace the need for...
the above non-pharmacological interventions, and may also
delay or prevent progression to T2DM (13).

Given the above, it is imperative to diagnose individuals
with prediabetes, and to introduce the above intervention strat-
egies, whether pharmacological or non-pharmacological, at an
early stage before progression into T2DM. One approach to
help in the diagnosis of prediabetic individuals is to investigate
the biochemical changes that are associated with an increased
risk of prediabetes. The identification of the above changes
would not only help with improved diagnosis, but it may also
provide an improved understanding of the pathogenesis of the
disease and aid the monitoring of disease progression.

Leptin is an adipokine hormone secreted primarily by
adipocytes (14). Leptin regulates body fat through the suppres-
sion of appetite, induction of energy expenditure and regulation
of glucose homeostasis (15,16). Inactivating mutations in the
gene that encodes leptin (LEP) were found to be associated
obesity in animal models, and LEP was initially identi-
fied as the ‘obese gene’ (17). Counterintuitively, an elevation in
the levels of serum leptin in obese individuals was observed
in several cohorts (18-22). This led to the proposition that
resistance to leptin, rather than its absolute levels, is a major
characteristic of obesity in humans (23,24). This is supported
by evidence showing that insulin, levels of which are often
increased in obese individuals, stimulates leptin secretion (16).

Individuals with prediabetes are commonly obese, and have
elevated levels of serum insulin to compensate for resistance to
insulin action. Not surprisingly, data from several cohorts have
demonstrated an elevation in serum leptin levels in these indi-
viduals (24,25). This observation however, was not consistent
across all the different study cohorts, and was not tested in indi-
viduals from Jordan (26). The risk of developing prediabetes
is multifactorial; in addition to the role exerted by environ-
mental factors, it may be affected by genetic variations (9,18).
Interestingly, LEP variants were reported to be strongly
associated with obesity and insulin resistance (19,27-29). In
the present study, the association between serum leptin and the
following single nucleotide polymorphisms (SNPs), rs7799039,
rs2167270 and rs791620, were examined in LEP with respect to
assessing the risk of prediabetes in patients in Jordan.

Materials and methods

Patients. The present study was a case-controlled study
involving 122 individuals with prediabetes and 122 healthy
controls. In the prediabetes group, 67 of the recruited partici-
pants were females, with an age range of 34-66 years and a
median age of 49 years, and 55 males, with an age range of
40-68 years and a median age of 51 years. In the control group,
67 of the recruited participants were females with an age range
of 32-76 years and a median age of 49, as well as 55 males
with an age range of 36-72 years and a median age of 54 years.
Prior to subject recruitment, the sample size required to show
statistically significant differences in serum leptin in a case
control design was calculated using EpiTool (epitools.ausvet.
.com.au/samplesize). It was determined that a sample size of
98 subjects in each group was sufficient to conduct a study
that has 80% statistical power, 5% margin of error, 95% confi-
dence interval (CI), and an assumed odds ratio (OR) of 4.
The study was approved by the Institutional Review Board

of Jordan University of Science and Technology and its affili-
tated teaching hospital [King Abdullah University Hospital
(KAUH); approval no. 90/118/2018]. Subjects were recruited
from the Family Medicine clinics of KAUH. The demographic
data, anthropometric measurements [height, weight and waist
circumference (WC)] and medical history, along with patients’
written consents and signatures, were collected from all
subjects upon an interview with a clinical research coordi-
nator. Healthy controls and prediabetes subjects were matched
according to their sex and age.

Collection of blood and serum samples. From each patient,
two blood samples (5 ml each) were collected following a 15 h
overnight fast. One sample was collected in an EDTA tube
(AFco-Jordan) and stored at 4˚C for use in DNA extraction;
the other sample was collected in a plain tube with gel clot
activator (AFco-Jordan) and used to obtain serum following
centrifugation at room temperature for 5 min at 4,000 x g.

The collected serum was subsequently used to assess the
levels of leptin, fasting glucose, total cholesterol and triglyc-
erides (TGs). Subjects with fasting serum glucose levels of
100-125 mg/dl were requested to repeat the test in the following
month, and were considered to have prediabetes if their fasting
serum glucose levels remained within this range. Subjects
with fasting serum glucose levels <100 mg/dl were assigned
to the control group. All individuals with serum glucose levels
≥126 mg/dl were excluded from the study, and were referred
to the Endocrinology clinic at KAUH to confirm a tentative
diagnosis of T2DM.

Biochemical measurements. The levels of serum glucose, total
cholesterol and TG were measured using a Roche automated
clinical analyzer system (Roche Diagnostics GmbH). A sand-
wich ELISA was used to assess serum leptin levels using a
human ELISA kit (cat. no. MBS020274; MyBioSource, Inc.).
The minimum detection level was 10 pg/ml, and the protocol
used is described by Saadeh et al (30).

DNA extraction and genotyping. Genomic DNA was extracted
from the collected blood in EDTA tubes using a QIAamp DNA
Blood Mini kit (Qiagen GmbH) according to the protocol
described by Alfaqih et al (31). The DNA concentration was
measured spectrophotometrically at 260 nm using an ND-2000
Nanodrop spectrophotometer (Thermo Fisher Scientific, Inc.).
DNA purity was assessed using the same spectrophotometer
by calculating the 260/280 nm ratio.

The genotypes of the three SNPs of the LEP gene
(rs7799039, rs2167270 and rs791620) were examined using the
PCR-restriction fragment length polymorphism (PCR-RFLP)
technique. SNP information was obtained from the NCBI
dbSNP database (ncbi.nlm.nih.gov/snp/rs7799039, ncbi.nlm.
.nih.gov/snp/rs2167270 and ncbi.nlm.nih.gov/snp/rs791620).
Each PCR reaction was composed of GoTaq® Green MasterMix
(Promega Corporation), 0.4 µM primers (forward and reverse)
and 5 ng sample DNA, bringing the total reaction volume
to 25 µl. The PCR thermocycling conditions, as well as
the sequences of the forward and reverse primers of each SNP
are shown in Table I.

The PCR-RFLP assay details, including the location of the
SNPs on the LEP gene, and the size of the PCR amplicon,
Table I. SNP information of the *LEP* gene.

| SNP ID<sup>a</sup> | Location and base change<sup>a</sup> | Forward primer, 5'-3' | Reverse primer, 5'-3' | PCR program | PCR product size, bp | Restriction enzyme | RFLP products, bp |
|-------------------|----------------------------------|----------------------|----------------------|--------------|-------------------|------------------|------------------|
| rs7799039         | Promoter: 2KB Upstream variant region (G/A) | GGGCTGGGAACTTTTCTCTAAAG | CCTGACTTCCTGCAACATCT | 95° C for 3 min; followed by 35 cycles of 30 sec at 95°C, 30 sec at 58.8°C and 1 min at 72°C | 276 | *Bts*I<sub>MuI</sub> | GG: 276; GA: 276, 222, 54; AA: 222, 54 |
| rs2167270         | Exon 1: 5' UTR variant (G/A) | CTGGAGGGACATCAAGGATT | AAGAAAGACCAGCAGAGAAGG | 95°C for 3 min; followed by 35 cycles of 30 sec at 95°C, 30 sec at 58.8°C, and 1 min at 72°C | 348 | *HPYCH*<sub>IVIII</sub> | GG: 348; GA: 348, 292, 56; AA: 292, 56 |
| rs791620          | 2KB Upstream variant (C/A) | CTGGAGGGACATCAAGGATT | AAGAAAGACCAGCAGAGAAGG | 95°C for 3 min; followed by 35 cycles of 30 sec at 95°C, 30 sec at 63°C, and 1 min at 72°C | 348 | *Asc*I | CC: 262,86; CA: 348, 262, 86; AA: 348 |

<sup>a</sup>SNP information was obtained from the NCBI dbSNP database; SNP, single nucleotide polymorphism; RFLP, restriction fragment length polymorphism; UTR, untranslated region.
are summarized in Table I. The PCR product of each SNP was later digested using the appropriate restriction enzymes. The restriction enzymes used for genotyping, and the size of the products of each genotype following digestion with the corresponding restriction enzyme are listed in Table I. The undigested PCR products and the DNA fragments resulting from the restriction enzyme digestion were separated on a 3% agarose gel stained with 0.5 µg/ml ethidium bromide and subsequently visualized under ultraviolet light. The genotype and allele call rates of all the investigated SNPs were 100%.

**Statistical analysis.** Statistical analysis was performed using SPSS version 23 (IBM Corp.). The statistical differences between the prediabetes and control groups in terms of the levels of serum glucose, total cholesterol, TGs, leptin, body mass index (BMI), sex, age and WC were assessed using a Student’s t-test. A Pearson’s χ² test was used to assess the differences in sex distribution, whereas a Fischer’s exact test was used to examine the association between genotype or allele categories with the risk of prediabetes. The above test was also used to test whether the three SNPs were conformant with the Hardy-Weinberg equilibrium (HWE). Haplotype association analysis was performed using the SHEsis online platform (analysis.bio-x.cn/myAnalysis.php).

Multivariate logistic regression analysis was used to determine whether age, sex, serum leptin, rs7799039, rs2167270 or rs791620 were statistically associated with prediabetes following adjustments for serum glucose, BMI and WC. The Forward Wald statistics methods was used for variable entry. P<0.05 and the 95% confidence interval (CI) were considered to indicate a statistically significant difference.

**Results**

**Patient characteristics and biochemical profile.** A total of 122 healthy subjects and 122 subjects with prediabetes were recruited for the present study. The subjects were matched for sex and age. Females comprised 55% of the total subjects in each group (Table II). Individuals with prediabetes had significantly higher BMI (P=0.02) and WC (P<0.0001) values compared with the control group. Biochemical analysis of the subjects in each group showed that the subjects with prediabetes had significantly higher levels of serum glucose and leptin, and a greater leptin/BMI ratio (P<0.0001; Table II). Total serum cholesterol or serum TG levels were not significantly different between the two groups (Table II).

**LEP genotyping.** Subjects in the control and prediabetes groups were genotyped for three SNPs in the *LEP* gene (rs7799039, rs2167270 and rs791620). The genotyping results of all three SNPs did not deviate from the HWE. The genotype and allele frequencies of the above SNPs are shown in Tables III and IV, respectively. This analysis revealed significant differences in the genotype and allele frequencies of rs2167270. For this variant, the prediabetes group had a significantly higher frequency of the heterozygous GA genotype compared with the control group (37 cf. 27%; P<0.0001). The frequency of the A allele of rs2167270 was significantly higher in subjects with prediabetes compared with the control group (63 cf. 35%; Table III). Having the GA genotype of rs2167270 increased the risk of prediabetes by ~3-fold [odds ratio (OR)=3.1; CI=1.8-5.6; P<0.0001]. The frequency of the A allele of rs2167270 was significantly higher in subjects with prediabetes compared with the control group (37 cf. 27%; P=0.03; Table IV).

In order to identify a chromosomal block in the *LEP* gene associated with the risk of prediabetes, the associations of different haplotypes resulting from genotyping all three SNPs of the *LEP* gene were tested. The results of the above analysis are shown in Table V. The GGC haplotype of rs2167270, rs7799039 and rs791620, which contains the major allele of each SNP, had a lower frequency in the prediabetes group compared with controls, and was associated with a significantly lower risk of prediabetes (OR=0.47, CI=0.335-0.655; P<0.0001). Moreover, the AGC haplotype, which contains the high-risk A allele of rs2167270, was associated with a significantly increased risk of prediabetes (OR=3.1, CI=1.8-5.6; P<0.0001).

**Multivariate analysis.** Considering that the prediabetes and the control groups were significantly different with respect to

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**Table II. Baseline variable of the subjects.**

| Variable              | Control, n=122 | Prediabetes, n=122 | P-value |
|-----------------------|---------------|-------------------|---------|
| Sex                   |               |                   |         |
| Males                 | 55 (45%)      | 55 (45%)          | 1       |
| Females               | 67 (55%)      | 67 (55%)          |         |
| Age, years            |               |                   |         |
| 51.50±9.35            | 49.80±8.24    | <0.0001           |
| BMI, kg/m²            |               |                   |         |
| 30.70±6.00            | 32.40±6.19    | 0.02              |
| Waist circumference, cm|              |                   |         |
| 103.6±3.0             | 110.5±14.1    | <0.0001           |
| Glucose, mg/dl        |               |                   |         |
| 90.00±13.5            | 118.8±20.2    | <0.0001           |
| Cholesterol, mg/dl    |               |                   |         |
| 185.7±43.7            | 195.9±49.1    | 0.08              |
| Triglycerides, mg/dl  |               |                   |         |
| 165.2±124             | 164.4±93.1    | 0.95              |
| Leptin, ng/dl         |               |                   |         |
| 27.50±22.2            | 49.60±54.9    | <0.0001           |
| Leptin/BMI            | 0.867±0.620   | 1.487±1.58        | <0.0001 |

*Data are presented as the mean ± standard deviation, or n (%). BMI, body mass index.*

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| Variable | Control, n=122 | Prediabetes, n=122 | P-value |
|----------|----------------|-------------------|---------|
| Females  | 67 (55%)       | 67 (55%)          |         |
| Males    | 55 (45%)       | 55 (45%)          |         |
| Age, years | 51.50±9.35   | 49.80±8.24        | <0.0001 |
| BMI, kg/m² | 30.70±6.00   | 32.40±6.19        | 0.02    |
| Waist circumference, cm | 103.6±3.0   | 110.5±14.1        | <0.0001 |
| Glucose, mg/dl | 90.00±13.5 | 118.8±20.2        | <0.0001 |
| Cholesterol, mg/dl | 185.7±43.7 | 195.9±49.1        | 0.08    |
| Triglycerides, mg/dl | 165.2±124  | 164.4±93.1        | 0.95    |
| Leptin, ng/dl | 27.50±22.2 | 49.60±54.9        | <0.0001 |
| Leptin/BMI | 0.867±0.620 | 1.487±1.58        | <0.0001 |

*Data are presented as the mean ± standard deviation, or n (%). BMI, body mass index.*
their BMI, WC and serum glucose measurements, multiple logistic regression analysis was subsequently performed following adjustments for BMI, WC and glucose. The results of this analysis are shown in Table VI. The serum leptin levels remained a significant predictor of an increased risk of prediabetes (OR=1.022, 95% CI=1.002‑1.042; P=0.029). Furthermore, similar to the findings of the univariate analysis, the GA genotype of rs2167270 was associated with a significantly increased risk of prediabetes compared with the GG genotype (OR=3.826, 95% CI=1.543‑9.546; P=0.004). None of the other SNPs in LEP were significantly associated with prediabetes in this model.

Discussion

Leptin, a hormone secreted primarily by adipocytes, have been positively associated with body fat as well as adipocyte number and size (14). Several studies have examined the association between leptin levels and obesity, insulin resistance, metabolic syndrome and diabetes (24,32). In addition, several studies have explored the association between leptin levels in different populations with prediabetes, where certain studies identified an association between them, and others did not (24,26).

In Jordan, a small number of studies have investigated correlations between serum leptin levels with obesity and the metabolic syndrome (23,33). However, to the best of our knowledge, the association between serum leptin and the risk of prediabetes has not been explored before in Jordan. The results of the univariate and multivariate analyses presented in the current study, in addition to findings from other populations, indicate an association between serum leptin and an increased risk of prediabetes.

The above findings lend support to the tentative utility of serum leptin for the identification of individuals at a higher risk of prediabetes. They also highlight a potential role for leptin in mediating the pathophysiology of the disease. In addition to the aforementioned results describing the association between leptin protein and prediabetes, the present study also identified an association between prediabetes and the SNP rs2167270 in the LEP gene, which encodes the leptin protein (28). This finding further strengthens the association between leptin protein and prediabetes described above. Furthermore, it also provides evidence that the risk of developing prediabetes is multifactorial, involving lifestyle, environmental and genetic factors (11,25).

Leptin is a hormone that normally inhibits appetite and increases energy expenditure (15). The exact mechanism(s) by which leptin induces these effects have yet to be fully delineated, although they appear to be modulated through binding of leptin to its receptors in the hypothalamus, which acts as the central orchestrator of hunger and satiety signals (34,35). It therefore appears counterintuitive that serum levels of leptin are actually elevated in prediabetic individuals who are commonly obese and/or suffer from insulin resistance (16,22). However, the observations regarding the levels of leptin in prediabetes are in agreement with previous reports demonstrating elevated levels of leptin in obese subjects, and in individuals with metabolic syndrome (32,33).

The uniformity of these observations in multiple diseases that share common features indicate that resistance to leptin activity, rather than its absolute levels in the serum, is a common process involved in the pathophysiology of obesity, metabolic syndrome and T2DM (21,23). However, despite the plethora of evidence linking leptin resistance (LR) to a number of different metabolic disorders, this field suffers from the absence of a method for the accurate and reproducible
measurement of LR. The derivation of such a method may aid in monitoring the progression of several metabolic disorders, including the response of patients to the different regimens applied for the treatment of these diseases.

In addition to the effect leptin has on energy metabolism through binding to its hypothalamic receptors, it may also regulate energy expenditure through indirect effects on insulin activity. Denroeche et al (15) suggested that increased leptin levels in the serum may predispose individuals to insulin resistance via the uncoupling of insulin binding to its receptor from downstream signaling pathways, an effect mediated through inhibition of insulin receptor autophosphorylation by leptin protein.

It is interesting to note that Mazahreh et al (23) recently reported that laparoscopic sleeve gastrectomy (LSG), a bariatric surgical procedure, in morbidly obese individuals reduces serum leptin levels as well as the BMI (23). Given the above observation and the findings of the present study, it would be interesting to assess whether LSG reverses prediabetes in morbidly obese patients, possibly through a mechanism that involves a reduction in serum leptin/LR.

Another major finding of the present study was the association of SNP rs2167270 in the LEP gene with prediabetes. Specifically, in the univariate and multivariate analyses, the GA heterozygous genotype of rs2167270 was associated with an increased risk of prediabetes. Furthermore, the results obtained indicated that the minor A allele of rs2167270 was more frequently observed in patients with prediabetes. Along the same lines, a haplotype of all three SNPs examined in the present study that included the A allele of rs2167270 was found to increase the risk of prediabetes, whereas another haplotype that contained the major G allele was protective against the disease. Taken together, these data have indicated that the minor A allele of rs2167270 is a high-risk allele that may be involved in the pathophysiology of prediabetes.

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**Table V. Haplotype frequency of rs2167270, rs7799039, and rs791620 SNPs in control and prediabetic patients.**

| SNP         | Controls frequency | Prediabetes frequency | Odds ratio | 95% confidence interval | P-value |
|-------------|--------------------|-----------------------|------------|-------------------------|---------|
| rs2167270   |                    |                       |            |                         |         |
| A           | 0.043              | 0.062                 | 1.45       | 0.643 - 3.252           | 0.37    |
| G           | 0.225              | 0.311                 | 1.53       | 1.022 - 2.299           | 0.03    |
| rs7799039   |                    |                       |            |                         |         |
| A           | 0.043              | 0.389                 | 1.28       | 0.884 - 1.861           | 0.19    |
| G           | 0.328              | 0.230                 | 0.47       | 0.315 - 0.696           | <0.001  |
| rs791620    |                    |                       |            |                         |         |
| A           | 0.043              | 0.383                 | 1.28       | 0.884 - 1.861           | 0.19    |
| G           | 0.328              | 0.230                 | 0.47       | 0.315 - 0.696           | <0.001  |

**Table VI. Multivariate analysis of leptin and LEP single nucleotide polymorphisms with the risk of prediabetes.**

| Variable   | Odds ratio | Confidence interval | P-value |
|------------|------------|---------------------|---------|
| Leptin     | 1.022      | 1.002- 1.042        | 0.029   |
| rs2167270  |            |                     |         |
| GG         | 3.826      | 1.543- 9.546        | 0.004   |
| AA         | 1.543      | 0.380- 6.268        | 0.544   |

Variables in the model include age, sex, leptin levels, rs7799039, rs2167270, and rs791620. The model was adjusted for glucose, body mass index and waist circumference. Method of variables entry in the model: Forward Wald Statistics.
Availability of data and materials

The datasets generated and/or analyzed during the present study are available from the corresponding author on reasonable request.

Authors' contributions

MaAA, MuAA and FAM conceived the study. MuAA, MaAA, and MK designed the study. MaAA and LE supervised the study. MK, LE and ZOA contributed to data curation and validated the study. MaAA, MK and RS performed the analysis and experiments. MuAA and MaAA provided the resources and fund acquisition. MK and FAM collected the data. MuAA, MaAA and MK wrote the manuscript. MaAA, ZOA and LE reviewed and edited the manuscript. All authors have read and approved the final manuscript. MK, LE and ZOA confirm the authenticity of all the raw data.

Ethics approval and consent to participate

All procedures performed in the present study involving human participants were approved by the Jordan University of Science and Technology and King Abdullah University Hospital institutional review board (approval no. 90/118/2018), and in accordance with the 1964 Helsinki Declaration and its later amendments, or comparable ethical standards. Informed consent was obtained from all individual participants included in the study.

Patient consent for publication

Written informed consent was obtained from all individual participants included in the study.

Competing interests

The authors declare that they have no competing interests.

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