Effects of nicotinic acid on fatty acid kinetics, fuel selection, and pathways of glucose production in women

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We conclude that chronic effects of NA on FFA metabolism are complex (acute suppression followed by overshoot of Ra FFA and [FFA] on top of a trend toward basal elevations), that responses after NA are consistent with operation of a glucose-fatty acid cycle in peripheral tissues, and that secondary effects on EGP were through changes in glycogenolysis, not gluconeogenesis.

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recent studies (4, 16) have shown that lowering of FFA concentrations with NA can reduce pancreatic insulin secretion, which could outweigh direct insulin sensitizing effects on tissues.

Our objectives in this study were to establish the effects of NA on FFA availability, whole body fuel selection, and pathways of endogenous glucose production (EGP) in healthy women. Specifically, we addressed the following questions. 1) Do changes in whole body fuel selection parallel changes in serum FFA concentrations in normal NA-treated overnight-fasted humans? 2) Does acute lowering of serum FFA concentrations by NA result in lower or higher rates of EGP? 3) If EGP is altered by administration of NA, is this mediated by changes in gluconeogenesis or glycogenolysis?

METHODS

Human subjects. Five volunteers were recruited by advertisement. Protocols received previous approval from both the University of California at San Francisco and the University of California at Berkeley Committees on Human Research. Subjects gave written informed consent before enrollment. This study was part of a larger study of lipid metabolism in women; because body fat distribution and lipolysis may differ between men and women, enrollment was restricted to females. Subjects had no history of medical illnesses, showed no abnormalities on screening physical examination and laboratory testing, had body mass indexes (BMI) between 20 and 25 kg/m² and stable weights over the preceding 6 mo, and had normal serum glucose and lipid concentrations. Smokers, heavy coffee drinkers (>3 cups of coffee/day), and users of oral contraceptives were excluded. The age of the subjects was 26.6 ± 1.4 yr, weight was 57.5 ± 3.0 kg, and BMI was 21.1 ± 0.5 kg/m² (means ± SE). Characteristics of the subjects are shown in Table 1.

Study design. The design consisted of two study periods, each lasting 4 wk. Subjects participated in two separate 4-day inpatient metabolic ward studies in the General Clinical Research Center (GCRC) of San Francisco General Hospital. The two GCRC admissions were separated by exactly 1 mo; both were performed in the luteal phase of the menstrual cycle (based on subjects’ histories). The first GCRC admission was under basal (control) conditions. Before this first GCRC infusion study, two subjects received placebo calcium lactate tablets 4 times/day for 1 mo, whereas three subjects received an intravenous infusion of [U-13C6]glucose (0.02 mg · kg⁻¹ · min⁻¹) from 0300 to 1400, plus sodium [2-13C]glycerol (18 mg · kg lean body mass⁻¹ · h⁻¹) and [1,2,3,4-13C₄]palmitate (7 μg · kg⁻¹ · min⁻¹) from 0400 to 1400. All labeled substrates were >98% enriched and were sterile and pyrogen free. Indirect calorimetry was performed by use of a Delta-trac Metabolic Cart (Sensor Medix, Yorba Linda, CA) in the hospital and at home. Two 30-min measurements were performed in the morning before NA administration (0700–0800), two 30-min measurement periods were shortly after NA administration (0900–1000), and two 30-min measurement periods were in the early afternoon (1300–1400). NA (500 mg) or a placebo was administered at 0800 on day 4 (Fig. 1).

Subjects remained fasted (other than noncaloric, non-cafeine-containing fluids) from 2200 of the preceding evening (day 3 of GCRC admission) until the end of the infusion study (1400 of day 4). A baseline blood draw was taken the previous evening, and repeat samples were taken from an indwelling blood-drawing line at several time points (Fig. 1).

Clinical laboratory measurements. Serum lipids were measured by standard methods (Clinical Laboratories, San Francisco General Hospital). Serum insulin was measured by RIA and serum glucose by autoanalyzer.

Body composition measurements. Body fat mass and fat free mass (FFM) were measured by bioelectrical impedance analysis (Xitron, model 1990B, Valhalla Scientific, San Diego, CA).

Isolation of metabolites and mass spectrometry. Gas chromatography-mass spectrometry (GC-MS) (model 5971; Hewlett-Packard, Palo Alto, CA) was used for analysis of isotopic enrichments of serum glucose, glyceroi, and FFA. FFAs were extracted from plasma as described previously (24, 39) and separated from cholesterol and phospholipids on silica gel G thin-layer chromatography plates (Anatech, Newark, DE). Derivatization to fatty acid methyl esters (FAME) was as described elsewhere (24). FAME were analyzed by GC-MS with a 12.0-m DB1 fused silica column under selected-ion monitoring with electron impact ionization. Abundances of ions at mass-to-charge ratio (m/z) 270–274, representing the M₀-M₄ isotopomers, were quantified, and enrichments [molar excess (ME)] were calculated by comparison with standard curves of [1,2,3,4-13C₄]palmitate. Concentrations of individual fatty acids were determined simulta-

Table 1. Subject characteristics

<table>
<thead>
<tr>
<th>Age, yr</th>
<th>Weight, kg</th>
<th>%Body Fat</th>
<th>Fat Mass, kg</th>
<th>LBM, kg</th>
<th>BMI, kg/m²</th>
</tr>
</thead>
<tbody>
<tr>
<td>26.6 ± 1.4</td>
<td>57.5 ± 3.0</td>
<td>27.3 ± 2.6</td>
<td>15.9 ± 1.9</td>
<td>41.6 ± 2.2</td>
<td>21.1 ± 0.5</td>
</tr>
</tbody>
</table>

Values are means ± SE; n = 5. LBM, lean body mass; BMI, body mass index.
Glucose and glycerol were isolated from 350 µl of plasma and derivatized (24, 38) to glucose pentaacetate and glycerol triacetate, respectively. Samples were dried under N₂ at 60°C, and 800 µl of ethyl acetate were added. A 100-µl aliquot was used for GC-MS analysis of glucose pentaacetate. The remaining 700 µl was used for GC-MS analysis of glycerol triacetate.

A DB-17 fused silica column was used for GC-MS analysis of glucose pentaacetate. For [U-¹³C₆]glucose, the molecular ion minus acetate and its Mᵦ isotopomer (m/z 331 and 337, respectively) were monitored by means of selected-ion monitoring and chemical ionization (24). For calculations of gluconeogenesis by mass isotopomer distribution analysis (MIDA), m/z 332 and 333 were also monitored (27, 32). Glycerol triacetate was analyzed with a DB-225 column by chemical ionization (26, 40). Selected-ion monitoring was of m/z 159 and 160, representing mass Mᵦ and M₁, and enrichment were determined by comparison with standard curves of [2-¹³C₁]glycerol.

Calculations. Rates of appearance (Rₛ) of glucose, FFA, and glycerol were calculated by isotope dilution after subtracting the exogenous chemical infusion (24, 39).

Because FFA flux was not at a steady state for several hours after NA administration, we used non-steady-state equations (Steele’s equation) (44)

\[ Rₛ \text{ palmitate} = \frac{F - pV[(C₂ + C₃)/2][(E₂ - E₁)/(t₂ - t₁)]}{(E₂ + E₁)/2} - F' \]

where F = infusion rate of isotopically labeled material (µmol/min), F’ = chemical infusion rate of labeled material (µmol/min), pV = volume of distribution of metabolite (ml), C₂ and C₃ are the concentrations at time 2 and 1 (µmol/ml), E₂ and E₁ are the enrichments at time 2 and 1 (ME), and t₂ and t₁ are final and initial times (min)

\[ Rₛ \text{ FFA} = \frac{Rₛ \text{ palmitate}}{\% \text{ palmitate in total FFA}} \]

Gluconeogenesis was calculated by the MIDA technique, as described in detail elsewhere (25, 27, 32). In brief, the ratio of excess double-labeled to excess single-labeled species, or \( \Delta A₂/\Delta A₁ \), of glucose reveals the isotopic enrichment of the true precursor (p) for gluconeogenesis by application of probability principles based on the binomial expansion. The fractional contribution from gluconeogenesis to plasma glucose is then calculated from the precursor-product relationship (25, 26). Glycogenolysis was calculated as the nongluconeogenic contribution (i.e., 1.0 minus the fractional contribution from gluconeogenesis). Absolute fluxes into plasma glucose through gluconeogenesis and glycogenolysis were calculated from their fractional contributions to plasma glucose multiplied by EGP.

Nonprotein respiratory quotient (NPRQ), energy expenditure, and whole body oxidation of fat and carbohydrate were calculated by indirect calorimetry according to standard equations (18).

Statistical analyses. Effects of chronic NA treatment on baseline (t = 0) values between study periods were determined by paired t-test. Interaction between time and study period (i.e., acute effect of NA administration) was determined by paired t-test comparing the change from t = 0 to 1.5 h (phase 1) and t = 0 to 3.0 h (phase 2) between the two study periods. Significance was set at P < 0.05. Results are presented as means ± SE.

RESULTS

Subject characteristics. The 1-mo treatment with NA did not lead to changes in body weight or body fat content. The treatment with NA resulted in significant decreases in total cholesterol (mean, 26.9% reduction; r = 9.1–48.1%), LDL cholesterol (mean, 42.1% reduction; r = 26.6–65.5%) and TG (mean, 42.1% reduction; r = 19.0–59.3%). HDL cholesterol did not change significantly (Table 2).

Serum FFA concentrations and lipolytic fluxes. FFA concentrations are shown in response to chronic and acute NA in the treatment and in the control study periods (Fig. 2). FFA concentrations were relatively stable during the control study, with a nonsignificant increase as the fasting continued. After 1-mo treatment with NA, subjects had nonsignificantly elevated fasting FFA concentrations in the basal state (501.9 ± 91.1 vs. 361.4 ± 70.7 nmol/ml, P = 0.07). The acute effect of NA on FFA concentrations was biphasic (Fig. 2). After the acute dose of 500 mg NA at 0800 (hour 0 time point), FFA concentrations dropped to nadir values (151.9 ± 16.5 nmol/ml, P < 0.05 vs. time 0 and control study) at 1.5 h post-NA (phase 1). FFA concen-
trations then rebounded, increasing to 1,338.7 ± 310.4 nmol/ml (about two- to threefold increase, \( P < 0.05 \), vs. time 0 and control study) at 3 h post-NA (phase 2) and remained elevated above basal values until the end of the study.

Plasma Ra FFA showed parallel changes to FFA concentrations (Fig. 3). The nadir value at 1.5 h (phase 1) was 3.4 ± 0.6 \( \mu \text{mol} \cdot \text{kg}^{-1} \cdot \text{min}^{-1} \), significantly different from time 0 and from control study; the 3-h (phase 2) value was 14.8 ± 2.6 \( \mu \text{mol} \cdot \text{kg}^{-1} \cdot \text{min}^{-1} \), also significantly greater than time 0 and control study values.

Plasma Ra glycerol reflects absolute adipose lipolysis (24, 44), because glycerol released from intracellular hydrolysis of TG cannot be reesterified in the adipocyte. The rates of \([2^{-13}\text{C}]\)glycerol infusion required for gluconeogenesis measurement by MIDA represent a substantial nontracer exogenous glycerol load; plasma glycerol enrichments were in the range of 40–50%. Nevertheless, Ra glycerol was relatively constant during the control study (Fig. 4), and basal Ra glycerol was not significantly higher after 1 mo of NA treatment compared with the control study period (3.1 ± 0.3 vs. 2.2 ± 0.3 \( \mu \text{mol} \cdot \text{kg}^{-1} \cdot \text{min}^{-1} \)). Ra glycerol fell during phase 1 after NA (to 1.3 ± 0.5 \( \mu \text{mol} \cdot \text{kg}^{-1} \cdot \text{min}^{-1} \) at 2 h, \( P < 0.05 \), vs. time 0 and control study) and then rebounded in the same manner as Ra FFA values during phase 2 (maximum 7.8 ± 0.7 at 3 h post-NA, \( P < 0.05 \), vs. time 0 and control study) and remained significantly higher than pre-NA values through 4 h and nonsignificantly higher through 6 h.

Plasma glycerol concentrations paralleled changes in Ra glycerol. Acute administration of NA resulted in an initial fall (from 19.7 ± 1.3 to 14.0 ± 2.5 mg/dl (mean ± SE, \( n = 3 \) subjects) from baseline to 1.5 h post-NA), followed by an overshoot and return to baseline (27.0 ± 4.4 and 20.0 ± 2.9 mg/dl at 3 and 6 h post-NA, respectively). In contrast, plasma glycerol concentrations were unchanged over time in the placebo phase (19.3 ± 4.9, 19.0 ± 6.2, 17.3 ± 3.3, and 17.3 ± 3.4 mg/dl at baseline, 1.5, 3.0, and 6.0 h, respectively). The change in glycerol concentrations over time was significantly different between the two phases for baseline to 1.5 h and from 1.5 h to 3.0 h (\( P < 0.05 \)).

EGP, gluconeogenesis, and glycogenolysis. Figure 5 shows EGP before and after NA treatment. EGP values were relatively constant during the control study. Basal values of EGP were not different between NA and control phases. After acute NA administration, EGP increased during phase 1, reaching a peak (2.7 ± 0.2 mg \( \cdot \text{kg}^{-1} \cdot \text{min}^{-1} \), \( P < 0.05 \), vs. time 0 and control study) at 1.5 to 2 h post-NA. EGP then gradually declined to basal levels (1.9 ± 0.1 mg \( \cdot \text{kg}^{-1} \cdot \text{min}^{-1} \)) during hours 3–6 (not significant vs. time 0 or control study). Enrichments of plasma glucose (excess \( M_g \)) ranged from 0.75 ± 0.02% (mean ± SE) at 1.5 h to 0.84 ± 0.03% at +6.0 h (control study) and from 0.80 ±

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Table 2. Lipid measures

<table>
<thead>
<tr>
<th></th>
<th>Cholesterol</th>
<th>Triglyceride</th>
<th>HDL</th>
<th>VLDL</th>
<th>LDL</th>
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<tbody>
<tr>
<td>Pre-NA</td>
<td>153.4 ± 19.7</td>
<td>93.4 ± 31.4</td>
<td>51.4 ± 5.4</td>
<td>13.0 ± 1.2</td>
<td>87.2 ± 15.8</td>
</tr>
<tr>
<td>Post-NA</td>
<td>110.4 ± 14.0</td>
<td>48.4 ± 11.0</td>
<td>53.8 ± 6.5</td>
<td>10.2 ± 2.9</td>
<td>50.4 ± 11.1</td>
</tr>
<tr>
<td>%Change</td>
<td>-26.9 ± 6.3</td>
<td>-42.1 ± 7.5</td>
<td>+6.8 ± 12.6</td>
<td>-23.5 ± 17.0</td>
<td>-42.1 ± 6.4</td>
</tr>
</tbody>
</table>

Values are means ± SE in mg/dl. NA, nicotinic acid; HDL, high-density lipoprotein; VLDL, very low density lipoprotein; LDL, low-density lipoprotein. *\( P < 0.05 \) vs. pre-NA values.

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Fig. 2. Plasma free fatty acid (FFA) concentrations in response to chronic and acute nicotinic acid (NA) or control. *\( P < 0.05 \) vs. control. Arrow denotes time of NA administration.

Fig. 3. FFA rate of appearance (Ra FFA) in response to chronic and acute NA or control. *\( P < 0.05 \) vs. control. Arrow denotes time of NA administration.
0.01% at -2.0 h to 0.67 ± 0.05% at 1.5 h and to 0.88 ± 0.06% at 6.0 h (NA study).

The fractional contribution from gluconeogenesis to plasma glucose fell nonsignificantly during phase 1 after acute NA and then returned to values that were higher than but not significantly different from the control study (Fig. 6A). Basal gluconeogenesis was 35.2 ± 3.1% (NA) vs. 27.8 ± 2.5% (control), 28.7 ± 4.1% (NA) vs. 35.4 ± 3.3% (control) at 2 h, and 53.5 ± 3.3% (NA) vs. 41.4 ± 3.5% (control) at 6 h. Absolute gluconeogenesis values also did not change after NA treatment (Fig. 6B), although a nonsignificant decrease in absolute gluconeogenesis was observed between 1.5 and 3 h post-NA. The calculated precursor pool (hepatic triose phosphate) enrichments were not different after NA vs. control (Fig. 7). In the control study, enrichments of plasma glucose M₁ and M₂ mass isotopomers ranged from 4.56 ± 0.49% at -1.5 h to 6.58 ± 0.40% (mean ± SE) at 6.0 h for excess M₁ and 1.23 ± 0.20% at -2.0 h to 1.74 ± 0.13% at 6.0 h for excess M₂. In the NA study, excess M₁ enrichments ranged from 4.49 ± 0.99% at 1.5 h to 7.45 ± 0.24% at 6.0 h and excess M₂ enrichment ranged from 1.00 ± 0.26% at 1.5 h to 1.93 ± 0.12% at 6.0 h.

Glycogenolysis initially accounted for the major contribution (Fig. 6C): 1.5 ± 0.1 and 1.7 ± 0.1 mg·kg⁻¹·min⁻¹ (NA and control study periods, respectively). The contribution from glycogenolysis declined during progressive fasting in the control study to 1.2 ± 0.1 mg·kg⁻¹·min⁻¹ (58.6 ± 3.9% EGP) at 6 h. After acute NA, the glycogenolytic contribution increased significantly (P < 0.05 vs. time 0 and control study) to 1.9 ± 0.2 mg·kg⁻¹·min⁻¹ (71.3 ± 4.1%) concurrently with the decrease in FFA concentration during the first 2 h post-NA (Fig. 6C) and then fell during hours 2–6 by 0.9 ± 0.1 mg·kg⁻¹·min⁻¹ (to 46.5 ± 3.3%). After 3 h, the changes were not statistically significant vs. time 0 or the control study.

Serum glucose and insulin concentrations. Basal serum glucose concentrations after overnight fasting in control and NA study periods were not different (88.4 ± 2.8 mg/dl and 88.7 ± 4.1 mg/dl, respectively). Glucose concentrations did not change significantly post-NA (not shown).

Plasma insulin concentrations were stable during the control study. Fasting insulin concentrations were not different between studies (6.4 ± 1.7 μU/ml in NA study and 5.2 ± 1.0 μU/ml in control study). Plasma insulin concentrations were not significantly different after control vs. NA administration, although there was a nonsignificant fall to 2.8 ± 0.1 μU/ml at 1.5 h and then a rise to 9.0 ± 2.5 μU/ml at 3.5 h after acute NA administration.

Plasma glucose clearance. The clearance of glucose from plasma (Ra glucose divided by plasma glucose concentration) was not significantly different at time 0 between study periods (0.026 ± 0.001 dl·kg⁻¹·min⁻¹ in the control study and 0.024 ± 0.000 dl·kg⁻¹·min⁻¹ in the NA study). Glucose clearance increased significantly during phase 1 after acute NA (0.026 ± 0.002 dl·kg⁻¹·min⁻¹ at 1.5 h in the control study vs. 0.029 ± 0.002 dl·kg⁻¹·min⁻¹ in the NA study, P < 0.05 between studies and from time 0 for NA study) and then returned to baseline values (0.023 ± 0.001 dl·kg⁻¹·min⁻¹ in control and 0.021 ± 0.000 dl·kg⁻¹·min⁻¹ in NA study) at 6 h.

Fuel selection and energy expenditure. Basal measurements of NPRQ (0.80 ± 0.01 vs. 0.76 ± 0.03), whole body fat oxidation, (3.79 ± 0.28 vs. 4.72 ± 0.45 μmol·kg⁻¹·min⁻¹), whole body glucose oxidation (1.37 ± 0.03 vs. 0.90 ± 0.38 mg·kg⁻¹·min⁻¹), and resting energy expenditure (1,467 ± 60 vs. 1,519 ± 38 kcal/24 h) were not significantly different at time 0 between NA and control study periods.

NPRQ increased significantly, to 0.90 ± 0.03 between 1 and 2 h post-NA and then decreased back to basal values (0.73 ± 0.01) during hours 5 and 6 of the
study in association with changes in serum FFA concentrations, R,a FFA, and EGP. In the control study, NPRQ fell nonsignificantly to 0.76 ± 0.01 at 5–6 h.

Whole body carbohydrate oxidation was significantly increased, and fat oxidation was significantly decreased (Fig. 8) at 1–2 h post-NA compared with the control study period. The values at 1–2 h post-NA were significantly different from those at 1–2 h in the control study and those at 5–6 h in the NA study. Total energy expenditure was not significantly different between NA and control study periods or at any time point after NA.

DISCUSSION

Chronic treatment followed by acute NA administration resulted in a complex pattern for serum FFA concentrations, R,a FFA, and EGP. In the control study, NPRQ fell nonsignificantly to 0.76 ± 0.01 at 5–6 h.

Whole body carbohydrate oxidation was significantly increased, and fat oxidation was significantly decreased (Fig. 8) at 1–2 h post-NA compared with the control study period. The values at 1–2 h post-NA were significantly different from those at 1–2 h in the control study and those at 5–6 h in the NA study. Total energy expenditure was not significantly different between NA and control study periods or at any time point after NA.

**DISCUSSION**

Chronic treatment followed by acute NA administration resulted in a complex pattern for serum FFA concentrations in the postabsorptive state; overnight fasting FFA concentrations and R,a FFA tended to be higher (but nonsignificantly so) after chronic NA compared with control periods and then showed a significant decrease after an acute dose that was followed by a significant rebound overshoot. Biphasic changes in serum FFA concentrations after acute NA have been reported previously (34). The consequences of these
complex changes in FFA availability on in vivo fuel selection and glucose metabolism were not, however, entirely predictable from studies performed in isolated tissue and cell systems (5, 6). Of particular interest was our demonstration for the first time that increases in glucose production, utilization, and glycogen-to-glucose flux clearly occur in glycogen-replete postabsorptive humans when systemic FFA availability is reduced. Also of interest was the observation of asymmetric effects of sub- vs. supraphysiological FFA availability on whole body fuel selection.

With regard to fuel selection, whole body oxidation of fat decreased by 60% (from 4.7 to 1.9 μmol · kg⁻¹ · min⁻¹) within 1–2 h after acute NA administration with a reciprocal threefold increase in carbohydrate oxidation (from 0.9 to 2.5 mg · kg⁻¹ · min⁻¹). This striking change in fuel selection, reflected by a change in NPRQ from 0.76 to 0.90, paralleled the reduced serum FFA concentrations and Ra FFA. Thus, the rate of delivery of circulating FFA to tissues, perhaps in combination with changes in serum hormone levels, appears to regulate fat oxidation in the range below the usual postabsorptive FFA values. In contrast, in the period of supranormal FFA concentrations and Rₜ FFA. Thus, the rate of delivery of circulating FFA to tissues, perhaps in combination with changes in serum hormone levels, appears to regulate fat oxidation in the range below the usual postabsorptive FFA values. In contrast, in the period of supranormal FFA concentrations and fluxes associated with NA administration (the phase 2 rebound hyperlipolytic period), whole body fat oxidation was not higher than normal. Basal rates of fat oxidation were restored but were not exceeded in the face of elevated serum FFA availability. Thus serum FFA concentrations and the rate of their delivery to tissues was no longer rate controlling for tissue oxidation in the range above the usual postabsorptive FFA levels, consistent with the previous conclusions (24, 28, 45) that serum FFA are present in excess of oxidative needs under normal postabsorptive conditions. Agents that increase FFA mobilization (e.g., nicotine, caffeine, and sympathomimetic agents) cannot, therefore, be expected to increase whole body fat oxidation by this mechanism alone; instead, higher rates of FFA reesterification and VLDL-TG production result (24).

What is the explanation for our clear and reproducible finding of increased glucose production, utilization, and glycogenolysis in phase 1 after NA (Figs. 5, 6, and 8)? The striking increase in EGP during the first 2 h after acute NA intake in the face of reduced FFA availability is not what would have been predicted from the direct operation of the Randle cycle on fasted liver in isolation. Instead, reduced FFA availability would have been expected to lower gluconeogenesis and reduce glucose production by the liver (6, 29).

These changes in glucose metabolism might best be explained by secondary changes in glucoregulatory hormones induced by the reduction in serum FFA. Lowering of serum FFA concentrations may reduce serum insulin concentrations by two mechanisms. First, serum FFA themselves are secretagogues for insulin release in the β-cell (4, 16), particularly in the postabsorptive state. Second, if lowering of serum FFA allows increased glucose oxidation and utilization by peripheral tissues, as we observed (Fig. 8), the effect will be to reduce plasma glucose concentrations and secondarily to reduce insulin secretion. Subtle changes in portal or systemic insulin and glucagon concentrations in animal models result in marked changes in hepatic glucose production, acting primarily through modulation of glycogenolysis (11, 13, 30). Although our study was not designed to detect subtle changes in portal concentrations of glucoregulatory hormones, we did observe a trend toward reduction in systemic insu-
lin concentrations. Changes in glucregulatory hormones might, therefore, explain our results.

The observation that plasma glucose clearance was elevated in phase 1 after NA administration in the absence of higher serum insulin concentrations rules out a primary effect of NA on the liver (e.g., stimulation of glycogenolysis). If NA itself acutely increased EGP, serum insulin concentrations should have been elevated after NA. Instead, we observed lower serum insulin concentrations, as have others (4, 16), after acute NA administration in the postabsorptive state.

Other observations also indirectly support the model that the observed changes in EGP were a secondary effect on liver (or kidney) mediated by glucregulatory hormones or other systemic signals, rather than a direct effect of FFA on the liver. EGP peaked at an almost identical value (2.40 mg·kg⁻¹·min⁻¹) as whole body carbohydrate oxidation between 1.5 and 2.0 h after NA, consistent with a compensatory increase in glucose production that was modulated to match the peripheral stimulation of glucose oxidation. Also, the increase in EGP being attributable to glycogenolysis rather than to gluconeogenesis is consistent with the acute actions of a variety of glucregulatory factors on hepatic glucose metabolism, including insulin, glucagon, diet, and exercise, as reported in previous studies in dogs (11, 13, 30). In contrast, most formulations regarding a direct glucose-fatty acid cycle in liver (36) invoke changes in gluconeogenesis.

It is of interest to compare these results with the recent report of Chen et al. (10). These workers studied the effect of a first administration of NA (1,100 mg given over 4 h) during the 16th to the 24th h of a fast, using ²H₂O incorporation to measure gluconeogenesis. They reported no change in EGP during the period of reduced plasma FFA concentrations, so that the increase in absolute glycogenolytic flux into glucose that they also observed was associated with a fall in absolute gluconeogenesis. Also, Chen et al. observed no change in whole body carbohydrate or fat oxidation and reported that fractional and absolute gluconeogenesis increased to suprabasal levels when FFA concentrations rebounded. They concluded that serum FFA have a primary effect on hepatic glycogenolysis after NA with reciprocal changes in glycogenolysis that serve to maintain constant EGP. Our results suggest a different model: a primary effect of FFA on glucose utilization by peripheral tissues with the hepatic effect being mainly a secondary alteration in glycogenolysis likely modulated by changes in hormone levels.

Reasons for the differences between these two studies are uncertain. The use of different techniques to measure gluconeogenesis does not explain the results, because the major differences between the studies were for EGP (initially increased after acute NA administration in our study but unchanged in theirs) and whole body fuel selection (altered after NA administration in our study but unchanged in theirs), whereas fractional gluconeogenesis was similar in the two studies (fall then rise). The subjects of Chen et al. differed from those in the present study in that they were studied after 20–24 h of fasting. The duration of previous fasting may affect glycogenolysis or dependence of pancreatic β-cell insulin secretion on serum FFA (16, 19). Also, our subjects were all women, whereas theirs were both men and women. These factors may alter tissue fuel selection or substrate metabolism. Finally, we gave NA chronically before studying its acute effects, to be more representative of the steady-state clinical situation, whereas the subjects in the Chen et al. study had not received previous treatment with NA. It is possible that counterregulatory responses to NA administration (10) are enhanced after chronic NA treatment and contribute to the increased EGP, as well as to the lack of a fall in gluconeogenesis that we observed. In the design of future studies, it will be important to consider these physiological and pharmacological factors.

Comparison with the studies of Fulcher et al. (20) further supports the importance of feeding state and duration of previous NA therapy for the glucose metabolic response to acute NA administration. These investigators reported that a single dose of acipimox, a long-acting NA analog, did not reduce fasting glucose production or concentrations acutely but did so after overnight administration in diabetic subjects. Their explanation for the delayed reduction in EGP was that compensatory increases in glycogenolysis initially overcame reduced rates of gluconeogenesis until glycogen stores were depleted. In rats, initial increases in glycogenolysis and EGP after NA are followed by glycogen depletion and the subsequent development of hypoglycemia (3). Because our subjects were studied between hours 10 and 16 of overnight fasting, hepatic glycogen stores had not been depleted. If our studies had been performed under conditions of prolonged fasting with depletion of liver glycogen stores, acute administration of NA might have had very different effects on EGP.

Debate continues regarding the source of EGP in postabsorptive humans (27, 29, 32, 37) and the validity of using MIDA to measure gluconeogenesis and glycogenolysis (14, 27, 32, 33, 35, 42). The results presented here are relevant to the latter question. The extremely stable values calculated for p, despite very large changes in serum glycerol concentrations, fluxes, and enrichments (Fig. 7), argues against the criticism postulated by Previs et al. (35) of the MIDA technique for measuring gluconeogenesis from labeled glycerol. These authors proposed that a gradient exists for glycerol across the hepatic lobule that is exacerbated by lower serum glycerol concentrations and results in uneven uptake of label, thereby distorting the combinatorial model (high enrichments in some hepatocytes at the beginning of the lobule and no label in others at the end of the lobule). The postulated consequence is an artifactual overestimation of p (and underestimation of fractional gluconeogenesis). These predictions are not consistent with observations in the present study, however. Both p and fractional gluconeogenesis were constant after acute administration of NA, despite initially reduced and then increased systemic concentrations and delivery of cold glycerol and the op-
posite effects on serum glycerol enrichments. If the glycerol gradient model applied, lowering the flux and concentration of plasma glycerol while increasing its enrichment (during phase 1 after acute NA administration) should have worsened the isotopic gradient across the liver and resulted in higher values of p (and lower values of fractional gluconeogenesis, all else being equal). The opposite effects should have been apparent during the rebound hyperlipolytic phase after NA: “flooding” the liver with glycerol would be predicted to result in higher fractional gluconeogenesis and lower values of p (35). There was no sign, however, of either of these changes during either phase after NA (Fig. 7). The ~2-h duration of perturbed glycerol metabolism (Fig. 7) is sufficient for changes to have become apparent in plasma glucose labeling (t1/2 of plasma glucose pool being ~30 min), if these in fact had occurred.

In contrast, if the postulated labeling gradient from glycerol does not exist, constant values of p would be expected. The rate of delivery of labeled glycerol to the liver should not change, regardless of dilution by endogenous glycerol, because the great majority of glycerol utilization is hepatic. Moreover, the contribution from endogenous plasma glycerol to gluconeogenesis and the triose phosphate precursor pool is relatively small (~10–15%), as we have observed here and previously (27, 32). Even a 50% reduction in endogenous glycerol flux would therefore not be expected to change significantly the substrate load into the gluconeogenic precursor pool. Accordingly, the reproducible observation of constant values for p, despite marked changes in endogenous glycerol flux (Fig. 7), is consistent with the postulated MIDA model rather than with the existence of a labeling gradient. Because of the potentially complex physiological changes involved after administration, these results do not provide conclusive evidence against a labeling gradient. It should be noted, however, that a labeling gradient from [13C]glycerol across the hepatic lobule (as contrasted with uptake across the organ) has never been shown experimentally but has been only postulated (35). Moreover, previous results from our laboratory, as well as those from other laboratories, have not been consistent with the existence of a significant labeling gradient. Fractional gluconeogenesis values have been appropriately high with the technique in fasted animals (32, 33), perfused livers from fasted animals (33), and fasted humans (14, 27, 42). The reason that Previs et al. (35) have observed discordantly low values of gluconeogenesis, unlike other investigators (14, 27, 32, 33, 42), remains uncertain.

Finally, do these findings advance our understanding of how NA can worsen glycemic control or bring out overt diabetes? We did not study diabetic or insulin-resistant subjects, so definitive statements cannot be made in this regard. It is difficult to propose a scenario by which the immediate effects observed post-NA (i.e., increased glucose oxidation and utilization by tissues with a compensatory increase in EGP and glycolysis) could worsen glycaemia. The phase 2 rebound (hours 2–6) post-NA or the trend toward overnight increases in lipolysis and FFA concentrations might result in impaired glucose utilization or increased EGP, however, in insulin-resistant or deficient states. Whereas the normal subjects studied here did not exhibit a parallel increase in fat oxidation or a decrease in glucose utilization, and glycolysis and EGP returned to basal levels, in the face of supraphysiological FFA concentrations, individuals with impaired glucose homeostasis might not be able to adapt as effectively to rapid changes in FFA availability. Another possibility is if pancreatic insulin secretion were more dependent on FFA concentrations in type II diabetic or insulin-resistant subjects than in normal subjects (4, 16), resulting in inadequate insulin secretion after NA to maintain normoglycemia. Future studies will need to examine in detail the metabolic response to the various phases associated with NA treatment in clinical settings of impaired glucose homeostasis.

In summary, a model of the consequences of altered FFA availability on glucose utilization and production in postabsorptive subjects can be proposed based on these results. Under postabsorptive conditions, acute administration of NA initially reduces FFA release into the circulation and affects tissue fuel utilization, with whole body fat oxidation falling and carbohydrate oxidation rising proportionately. In response to increased whole body glucose utilization, presumably mediated by changes in secretion of insulin or other hormones, EGP increases; this is due exclusively to increased glycolytic flux without changes in gluconeogenesis. A rebound hyperlipolytic phase then follows but without increases above basal for fat oxidation, EGP, or glycolysis; instead, basal rates are restored. We conclude that the glucose-fatty acid cycle occurs under physiological conditions in postabsorptive healthy women but is tissue specific (periphery dominating over liver) and asymmetric (operative in response to lower but not higher FFA concentrations) and that compensatory increases in EGP in this setting operate through stimulation of glycolysis, not gluconeogenesis.

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