3.5 Years of Insulin Therapy With Insulin Glargine Improves In Vivo Endothelial Function in Type 2 Diabetes

Satu Vehkavaara, Hannele Yki-Järvinen

Objective—To determine long-term effects of insulin glargine on vascular function in patients with type 2 diabetes.

Methods and Results—A total of 49 in vivo endothelial function tests, intrabrachial artery infusions of endothelium-dependent (acetylcholine [ACh]) and endothelium-independent (sodium nitroprusside [SNP]) vasoactive agents, were performed in 11 patients with type 2 diabetes (age: 59±2 years; BMI: 29.7±0.9 kg/m²; fasting plasma glucose: 226±14 mg/dL) and 16 matched normal subjects. The tests in the type 2 diabetic patients were performed before and after 6 months and 3.5 years of combination therapy with insulin glargine and metformin. A control group of type 2 diabetic patients not treated with insulin was studied twice at 6-month intervals. Before treatment, blood flow during infusions of low and high doses of ACh were significantly lower in the type 2 diabetic patients than in the normal subjects (P<0.021 for ANOVA). In the patients with type 2 diabetes, blood flow during infusion of the low dose of ACh averaged 7.1±0.8 mL/dL per minute at baseline, 8.8±1.0 mL/dL per minute at 6 months (NS), and then increased compared with baseline by 87±29% to 11.6±1.4 mL/dL per minute at 3.5 years (P<0.02 versus baseline). Blood flow during infusion of the high dose of ACh increased from 8.8±0.9 at baseline to 13.0±1.9 mL/dL per minute at 6 months (P<0.05) and by 86±25% to 14.7±1.6 mL/dL per minute at 3.5 years (P<0.01 versus baseline), which was not different from normal subjects. Blood flow during infusion of low (blood flow at 0 months: 7.7±0.5; at 6 months: 9.9±0.6; P<0.01 for 6 versus 0 months; and 3.5 years: 11.6±1.1 mL/dL per minute; P<0.02 for 3.5 years versus 0 months) and high (blood flow at 0 months: 10.7±0.9; 6 months: 13.4±1.0; P<0.05 for 6 versus 0 months; and 3.5 years: 16.6±1.5 mL/dL per minute; P<0.05 for 3.5 years versus 0 months) doses of SNP also increased significantly during insulin therapy.

Conclusions—We conclude that insulin glargine therapy improves endothelium-dependent and endothelium-independent vasodilatation. These data support the idea that long-term insulin therapy has beneficial rather than harmful effects on vascular function in type 2 diabetes. (Arterioscler Thromb Vasc Biol. 2004;24:325-330.)

Key Words: hyperglycemia circulation blood vessels insulin therapy

The two perhaps most important trials addressing effects of insulin therapy on cardiovascular outcome in type 2 diabetes are the United Kingdom Prospective Diabetes Study (UKPDS)1 and the Diabetes Mellitus, Insulin Glucose Infusion in Acute Myocardial Infarction (DIGAMI) study.2 The UKPDS showed an almost statistically significant (P=0.052) 16% reduction in the risk of myocardial infarction in patients allocated to receive intensive glucose control using either insulin or sulfonylurea compared with standard therapy. In the DIGAMI study, patients with an acute myocardial infarction, who received insulin acutely and chronically, had a 28% reduction in mortality rate compared with those of patients who continued their existing therapies.

Coronary endothelial dysfunction, defined as impaired vasodilatory response to intracoronary infusion of acetylcholine (ACh), is an independent predictor of vascular events even after adjustment for traditional cardiovascular risk factors.3,4 Recently, these findings were extended to measurements performed across the forearm vascular bed.5,6 Regarding insulin, acute studies have shown that a physiological increase in the circulating insulin concentration potentiates ACh-induced but not sodium nitroprusside (SNP)-induced vasodilatation.7,8 In studies addressing effects of long-term insulin therapy on endothelial function, we have previously shown that endothelium-dependent and endothelium-independent blood flow in forearm resistance vessels improves during 6 months of combination therapy with bedtime neutral protamine Hagedorn (NPH) insulin and metformin, while continuation of long-term metformin therapy had no effect on vascular function.9 In another study of patients with type 2 diabetes, 2 months of insulin therapy tended (P=0.09) to increase the blood flow response to ACh and restored the ability of insulin to acutely potentiate ACh-induced vasodilatation.9 There are no data on effects of insulin therapy on vascular function beyond 6 months.
Insulin glargine is a long-acting insulin analogue. Its vascular effects have not been studied. Compared with regular human insulin in vitro, insulin glargine was, in one study, reported to have a 6.5-fold higher affinity for insulin-like growth factor 1 (IGF-1) receptors in transfected baby hamster kidney cells. In contrast to these results, a recent study found equivalent binding of insulin glargine and regular human insulin to insulin and IGF-1 receptors in skeletal muscle cells. IGF-1 is a potent stimulator of blood flow. It human insulin to insulin and IGF-1 receptors in skeletal muscle cells. IGF-1 is a potent stimulator of blood flow. In vivo endothelial function tests were performed by the same investigator (S.V.) in 11 type 2 diabetic patients who were previously treated with metformin (1000 mg twice per day, n=10; 500 mg twice per day, n=1) before and after 6 months and 3.5 years of combination therapy with bedtime glimepiride insulin and metformin, and in 6 type 2 diabetic patients (age: 50±2 years; BMI: 28±1 kg/m²) who had been treated with long-term metformin (1000 mg twice per day). The latter group was as poorly controlled as the patients receiving insulin (glycosylated hemoglobin [HbA1c] 9.1% [reference range 4.0% to 6.0%]); (4) current BMI 0.4% [reference range 4.0% to 6.0%]); (4) current BMI <35 kg/m²; (5) duration of diabetes more than 3 years; and (6) no history of ketoacidosis. Exclusion criteria included: (1) clinically significant cardiovascular, hepatic, neurologic, endocrine, or other major systemic disease; (2) retinopathy requiring laser treatment; (3) an elevated serum creatinine concentration; (4) history of drug or alcohol abuse; and (5) mental illness rendering the subject unable to understand the nature, scope, and possible consequences of the study. Informed written consent was obtained after the purpose, nature, and potential risks were explained to the subjects. The study was performed in a blinded fashion by the same investigator. The study was approved by the Ethics Committee of the Helsinki University Central Hospital.

Methods

Study Design

Type 2 diabetic patients were recruited from diabetes outpatient clinics in the Helsinki area based on the following criteria: (1) age 40 to 70 years; (2) treatment with metformin alone; (3) HbA1c 8.5% (reference range 4.0% to 6.0%); (4) current BMI <35 kg/m²; (5) duration of diabetes more than 3 years; and (6) no history of ketoacidosis. Exclusion criteria included: (1) clinically significant cardiovascular, hepatic, neurologic, endocrine, or other major systemic disease; (2) retinopathy requiring laser treatment; (3) an elevated serum creatinine concentration; (4) history of drug or alcohol abuse; and (5) mental illness rendering the subject unable to understand the nature, scope, and possible consequences of the study. Informed written consent was obtained after the purpose, nature, and potential risks were explained to the subjects. The experimental protocol was designed and performed according to the principles of Helsinki Declaration and was approved by the Ethics Committee of the Helsinki University Central Hospital.

Inclusion and Exclusion Criteria

Type 2 diabetic patients were recruited from diabetes outpatient clinics in the Helsinki area based on the following criteria: (1) age 40 to 70 years; (2) treatment with metformin alone; (3) HbA1c 8.5% (reference range 4.0% to 6.0%); (4) current BMI <35 kg/m²; (5) duration of diabetes more than 3 years; and (6) no history of ketoacidosis. Exclusion criteria included: (1) clinically significant cardiovascular, hepatic, neurologic, endocrine, or other major systemic disease; (2) retinopathy requiring laser treatment; (3) an elevated serum creatinine concentration; (4) history of drug or alcohol abuse; and (5) mental illness rendering the subject unable to understand the nature, scope, and possible consequences of the study. Informed written consent was obtained after the purpose, nature, and potential risks were explained to the subjects. The experimental protocol was designed and performed according to the principles of Helsinki Declaration and was approved by the Ethics Committee of the Helsinki University Central Hospital.

Insulin Therapy

Patients considered eligible to participate in the study met with the doctor and diabetes nurse 4 weeks before start of insulin treatment. At this visit, the patients underwent a complete history and physical examination. The patients were instructed to measure their fasting blood glucose concentrations daily and to record any episodes of symptomatic hypoglycemia. The patients were taught self-adjustment of the insulin dose based on fasting plasma glucose measurements. The patients were asked to increase the dose by 2 IU per day if the fasting plasma glucose exceeded 6 mmol/L on 3 consecutive measurements. The patients were taught the doctor and diabetes nurse 4 weeks before start of insulin therapy and then at 3-month intervals. The second endothelial function test was performed after 3 months, and the third was performed after 3.5 years of treatment.

Measurements

In Vivo Endothelial Function Test

In vivo endothelial function was assessed by measuring forearm blood flow responses to intra-arterial infusions of endothelium-dependent (ACh) and endothelium-independent (SNP) vasodilators. The study was begun after a 10- to 12-hour fast at 7:30 AM. Venous blood samples were withdrawn for measurement of plasma glucose and serum free insulin, HbA1c, triglyceride, and HDL cholesterol concentrations. A 27-gauge unmounted steel cannula (Coopers Needle Works, Birmingham, UK), connected to an epidural catheter (Portex, Hythe, Kent, UK) was inserted into the left brachial artery. Drugs were infused at a constant rate of 1 mL/min with infusion pumps (Braun AG, Mesungen, Germany). Subjects rested supine in a quiet environment for 30 minutes after needle placement before blood flow measurements were begun. Normal saline was first infused for 18 minutes. Drugs were then infused in the following sequence: SNP (Nitropress, Abbott Laboratories), 3 μg/min (low dose) and 10 μg/min (high dose); and ACh (Miochol, ÖMJ Pharmaceuticals), 7.5 μg/min (low dose) and 15 μg/min (high dose). Each dose was infused for 6 minutes, and the infusion of each drug was separated by infusion of normal saline for 18 minutes, during which time blood flow returned to basal values. Forearm blood flow was recorded for 10 seconds at 15-second intervals during the last 3 minutes of each drug and saline infusion period with mercury-in-rubber strain-gauge venous occlusion plethysmography (EC 4 Strain Gauge Plethysmograph, Hokanson), which was connected to a rapid cuff inflator (E 20; Hokanson), an analog-to-digital converter (McLab/4e; AD Instruments Ltd), and a personal computer, as previously described. Blood flow measurements were performed simultaneously in the infused (experimental) and control arm. Means of the final 5 measurements of each recording period were used for analysis. All blood flow data were analyzed in a blinded fashion by the same investigator. Metformin was discontinued for 2 days before the endothelial function studies to avoid any acute effects on vascular function.

Other Measurements

Plasma glucose concentrations were measured in duplicate with the glucose oxidase method, using the Beckman Glucose Analyzer II (Beckman Instruments). HbA1c was measured by HPLC using the fully automated Glycosylated Hemoglobin Analyzer System (BioRad). Serum-free insulin concentrations were measured by radioimmunoassay (Phadebas Insulin RIA; Pharmacia & Upjohn Diagnostics) after precipitation with polyethylene glycol. Serum HDL cholesterol and triglyceride concentrations were measured with respective enzymatic kits from Roche Diagnostics, using an autoanalyzer (Roche Diagnostics Hitachi 917; Hitachi Ltd). Body-weight mass and fat-free mass were measured by a single-frequency bioelectrical impedance device (model BIA-101A; Bio-Electrical Impedance Analyzer System).

Statistical Analysis

Data between the type 2 diabetic patients and control subjects were compared using Student unpaired t test. Changes in endothelial function during insulin therapy were analyzed using ANOVA for repeated measures. Horizontal contrasts were thereafter calculated using the paired t test. Correlation analyses were performed using Spearman nonparametric correlation coefficient. All calculations were made using the Systat statistical package (Systat, Evanston, IL.). All probability values are two-tailed. A P<0.05 was considered statistically significant. Data are expressed as mean±SEM.

Results

Glycemic Control, Body Composition, and Lipids During insulin therapy, HbA1c decreased from 9.1%±0.4% to 7.5%±0.2% at 6 months and remained at this level...
(7.5% ± 0.2%) until 3.5 years (Table 1). The bedtime insulin dose averaged 40.5 ± 10 IU at 6 months (range: 12 to 60 IU) and increased to 60 ± 10 IU at 3.5 years (range: 14 to 120 IU). Body weight remained unchanged during insulin therapy (mean change versus baseline 1.2 ± 0.8 kg and 2.4 ± 1.4 kg at 6 months and 3.5 years, respectively; NS). Serum free insulin concentrations increased significantly (Table 1). The percent body fat tended to decreases slightly (29.8% ± 2.0%, 28.5% ± 2.1%, and 28.9% ± 1.9% at 0, 6 months, and 3.5 years; NS), whereas fat-free mass increased from 61.2% ± 2.5% at baseline to 63.2% ± 3.0% (*P < 0.01 versus baseline) at 6 months, and to 63.7% ± 3.1% at 3.5 years (*P < 0.05 versus baseline). Serum HDL cholesterol concentrations increased significantly and triglyceride concentrations decreased slightly but not significantly (Table 1).

**Endothelial Function**

**Reproducibility Study**

In the type 2 diabetic patients who were studied twice during metformin therapy, basal flows were comparable (2.2 ± 0.2 and 2.5 ± 0.3 mL/dL per minute; NS). Blood flow responses to the low (8.4 ± 1.2 and 7.7 ± 0.3 mL/dL per minute; NS) and high (10.8 ± 2.0 and 10.5 ± 2.7 mL/dL per minute; NS) doses of SNP also remained unchanged, as did those to the low (7.2 ± 1.0 and 7.3 ± 1.1 mL/dL per minute; NS) and high (8.9 ± 1.4 and 9.1 ± 1.0 mL/dL per minute; NS) doses of ACh. The coefficients of variation for the two repeated measurements in these patients were 10% ± 1%, 14% ± 3%, 13% ± 4%, 10% ± 2%, and 15% ± 4% for infusion of saline, low-dose SNP, high-dose SNP, low-dose ACh, and high-dose ACh, respectively.

**Insulin Therapy Study**

Basal blood flow in the experimental arm averaged 2.1 ± 0.3 mL/dL per minute at baseline and 2.0 ± 0.2 mL/dL per minute at 6 months (NS) and increased slightly to 2.5 ± 0.2 mL/dL per minute at 3.5 years (NS versus baseline and 6 months; Table 2). Basal blood flow was not different from that in the normal subjects (2.1 ± 0.2 mL/dL per minute) at any time point.

Blood flows in the control arm were similar to those in the experimental arm basally in patients with type 2 diabetes (2.1 ± 0.3 mL/dL per minute, 2.0 ± 0.2 mL/dL per minute, and 1.9 ± 0.1 mL/dL per minute at baseline, 6 months, and 3.5 years; Table 2) and normal subjects (2.0 ± 0.2 mL/dL per minute; NS) throughout the study.

Before treatment, blood flow during the low (7.1 ± 0.8 mL/dL per minute versus 9.8 ± 1.1 mL/dL per minute, insulin-treated versus normal group) and high (8.8 ± 0.9 mL/dL per minute versus 12.0 ± 1.1 mL/dL per minute, insulin-treated versus normal group) dose infusions of ACh were significantly lower in the patients with type 2 diabetes than in the normal subjects (*P = 0.021 for ANOVA; Figure 1). In patients with type 2 diabetes, blood flow during infusion of the low dose of ACh averaged 7.1 ± 0.8 mL/dL per minute at baseline, 8.8 ± 1.0 mL/dL per minute at 6 months (NS), and then increased compared with baseline by 87% ± 29% to 11.6 ± 1.4 mL/dL per minute at 3.5 years (*P < 0.02 versus baseline). Blood flow during infusion of the high dose of ACh increased from 8.8 ± 0.9 mL/dL per minute at baseline to 13.0 ± 1.9 mL/dL per minute at 6 months (*P < 0.05), and by 86% ± 25% to 14.7 ± 1.6 mL/dL per minute at 3.5 years (*P < 0.01 versus baseline). After 3.5 years of treatment, blood flow during the low (11.6 ± 1.4 mL/dL per minute versus 9.8 ± 1.1 mL/dL per minute, insulin-treated versus normal group) and high (14.7 ± 1.6 mL/dL per minute versus 12.0 ± 1.1 mL/dL per minute, respectively) dose infusions of ACh were not different between the groups.

In patients with type 2 diabetes, blood flow during infusion of the low dose of SNP increased from 7.7 ± 0.5 mL/dL per minute at baseline to 9.9 ± 0.6 mL/dL per minute at 6 months (*P < 0.01), and by 60% ± 22% to 11.6 ± 1.1 mL/dL per minute at 3.5 years (*P < 0.02 versus baseline). Blood flow during infusion of the high dose of SNP increased from 10.7 ± 0.9 mL/dL per minute at baseline to 13.4 ± 1.0 mL/dL per minute at 6 months (*P < 0.05), and by 72% ± 24% to 16.6 ± 1.5 mL/dL per minute at 3.5 years (*P < 0.05 versus baseline). Before treatment, blood flow during infusion of SNP was slightly (low-dose 7.7 ± 0.5 versus 9.2 ± 0.8 mL/dL per minute; high-

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**TABLE 1. Physical and Biochemical Characteristics Before and After 6 Months and 3.5 Years of Insulin Therapy in Patients With Type 2 Diabetes and in Normal Subjects**

<table>
<thead>
<tr>
<th></th>
<th>Before (n = 11)</th>
<th>6 Months (n = 11)</th>
<th>3.5 Years (n = 11)</th>
<th>Normal Subjects (n = 16)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex (F/M)</strong></td>
<td>2/9</td>
<td></td>
<td></td>
<td>4/12</td>
</tr>
<tr>
<td><strong>Age (y)</strong></td>
<td>59 ± 2</td>
<td></td>
<td></td>
<td>56 ± 1</td>
</tr>
<tr>
<td><strong>Weight (kg)</strong></td>
<td>87.5 ± 3.4</td>
<td>88.7 ± 3.8</td>
<td>89.7 ± 3.9</td>
<td>87.3 ± 2.5</td>
</tr>
<tr>
<td><strong>Fasting plasma glucose (mg/dL)</strong></td>
<td>226 ± 14‡</td>
<td>137 ± 9†</td>
<td>118 ± 10‡</td>
<td>102 ± 2</td>
</tr>
<tr>
<td><strong>HbA1c (%)</strong></td>
<td>9.1 ± 0.4‡</td>
<td>7.5 ± 0.2‡</td>
<td>7.5 ± 0.4‡</td>
<td>5.7 ± 0.1</td>
</tr>
<tr>
<td><strong>Fasting plasma free insulin (mU/L)</strong></td>
<td>17 ± 3†</td>
<td>21 ± 3§</td>
<td>21 ± 3</td>
<td>7 ± 1</td>
</tr>
<tr>
<td><strong>Insulin dose (UI)</strong></td>
<td>...</td>
<td>40 ± 5</td>
<td>60 ± 5</td>
<td>...</td>
</tr>
<tr>
<td><strong>Insulin dose (IU/kg)</strong></td>
<td>...</td>
<td>0.43 ± 0.05</td>
<td>0.63 ± 0.09#</td>
<td>...</td>
</tr>
<tr>
<td><strong>Serum triglycerides (mmol/L)</strong></td>
<td>2.0 ± 0.4</td>
<td>1.7 ± 0.2</td>
<td>1.8 ± 0.3</td>
<td>1.5 ± 0.2</td>
</tr>
<tr>
<td><strong>HDL cholesterol (mmol/L)</strong></td>
<td>1.10 ± 0.06*</td>
<td>1.16 ± 0.03</td>
<td>1.33 ± 0.08‡**</td>
<td>1.32 ± 0.08</td>
</tr>
</tbody>
</table>

*P < 0.05.
†P < 0.01 and ††P < 0.001 for type 2 diabetic patients before insulin therapy vs normal subjects.
§P < 0.05 and ‡‡P < 0.01 for type 2 diabetic patients before vs after 6 months of insulin therapy.
¶P < 0.05 and #P < 0.01 for type 2 diabetic patients 6 months vs 3.5 years of insulin therapy.
**P < 0.05 and ††P < 0.01 for type 2 diabetic patients before vs after 3.5 years of insulin therapy.
dose 10.7±0.9 versus 12.6±1.0 mL/dL per minute; \( P=0.10 \); type 2 diabetic patients versus normal subjects, respectively) but not significantly different from blood flow in the normal subjects (Figure 1). After 3.5 years of insulin treatment, blood flows during the low-dose (11.6±1.1 mL/dL per minute versus 9.2±0.8 mL/dL per minute, insulin-treated versus normal group) and high-dose (16.6±1.5 mL/dL per minute versus 12.6±1.0 mL/dL per minute, insulin-treated versus normal group) infusions of SNP were significantly higher in the patients with type 2 diabetes than in the normal subjects (\( P=0.05 \) for ANOVA).

To determine the possible causes of enhanced endothelial function during insulin therapy, simple correlation coefficients (Spearman) were calculated between changes in metabolic parameters and those of endothelium-dependent and endothelium-independent vasodilatation. At 6 months, the percent change in flow during infusion of the low dose of ACh was inversely correlated with the change in fasting plasma glucose (\( r=-0.83, P=0.0014 \); Figure 2) and the percent change in HbA1c (\( r=-0.69, P=0.02 \); Figure 2). In multiple linear regression analysis, these associations were independent of changes in weight and insulin concentration.

At 6 months, the percent change in flow during infusion of the high dose of ACh was inversely correlated with the change in the fasting plasma glucose concentration (\( r=-0.62, P=0.04 \)). At 3.5 years, the change in blood flow during infusion of the high dose of ACh and the percent change in flow during infusion of the high dose of SNP correlated positively with the change in the plasma fasting free insulin concentration (Figure 2). These associations were independent of changes in HbA1c.

**Discussion**

In the present study, we examined effects of long-term insulin glargine therapy on vascular function in patients previously treated with metformin monotherapy. Before insulin therapy, the type 2 diabetic patients had blunted vasodilatory responses to the endothelium-dependent vasodilator ACh. After 6 months of therapy, the vasodilatory responses to ACh and SNP had improved significantly and were similar in the type 2 diabetic patients and in the normal subjects. In the group studied twice without insulin treatment at 6-month intervals, vascular function remained unchanged. After 3.5 years of therapy, the vasodilatory responses to ACh and SNP continued to improve, and responses to SNP even exceeded those in the normal subjects. The improvements in vascular function were significantly correlated with decreases in glucose and increases in insulin concentrations.

The improvement in vascular function may not be specific to glargine, because we did not study a control group using NPH. We chose, however, to use combination therapy with bedtime insulin glargine and metformin as the insulin treatment regimen, because effects of glargine on vascular function have not previously been studied. Although use of glargine is associated with less nocturnal hypoglycemia13,14 and dinner-time hyperglycemia13 than NPH insulin in patients with type 2 diabetes, the ultimate usefulness of any drug used to treat type 2 diabetes is determined by its effects on cardiovascular disease. The present study is limited by the small group of patients studied; because of the 3.5 years’ duration of treatment, we were not able to include a time-control group beyond 6 months. The latter is because glycemirc control in patients with oral agents alone progressively tends to worsen, and patients often have to be transferred to insulin. Also, it was not possible to perform a randomized study because use of placebo insulin injections was not considered ethical. A positive control was not included; however, over the same time period that this study was performed, we performed endothelial function tests in 47 women losing moderate amounts of weight with or without orlistat.15 In this study, the improvement in vascular function was closely correlated with the magnitude of LDL-lowering.

Based on in vitro studies, insulin appears to have, at least acutely, beneficial effects on endothelial function. It increases NO production in cultured endothelial cells16 by increasing the expression and activity of endothelial nitric oxide synthase (eNOS).17,18 Activation of insulin receptor substrate-1
(IRS-1), phosphatidylinositol (PI)-3 kinase, and Akt appear necessary for this action of insulin, which results in phosphorylation of eNOS at a serine residue. The ability of insulin to induce vasodilatation increases slowly but steadily in vivo during several hours. This has been attributed to increased expression of the eNOS gene. It is presently unknown whether glargine regulates vascular function, although recent in vitro studies have independent vascular responses (Figure 2). There are no studies comparing the two insulins are needed to firmly establish this conclusion.

Multiple metabolic changes could have contributed to the observed enhancement in vascular responses to ACh and SNP. Insulin therapy is known to increase LDL size and lower free fatty acid concentrations, which were not measured in the present study but which could improve endothelial function. We did observe significant relationships between decreases in glucose and increases in serum free insulin concentrations and improvement in endothelium-dependent and endothelium-independent vascular responses (Figure 2). There are no studies in humans examining effects of chronic hyperglycemia, per se, on vascular function, although recent in vitro studies have to human skeletal muscle cells, or in the ability of the two insulins to stimulate glucose uptake or insulin signaling. Compared with our previous study in which we found 6 months of therapy with NPH insulin to increase endothelium-dependent and endothelium-independent vasodilatation, the present data are remarkably similar, although direct comparison of the two insulins are needed to firmly establish this conclusion.

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**TABLE 2. Forearm Blood Flow Responses to Intra-arterial SNP and ACh Infusions in the Normal Subjects at Baseline and in the Type 2 Diabetic Patients at 6 Months, and 3.5 Years**

<table>
<thead>
<tr>
<th></th>
<th>Saline</th>
<th>SNP 3</th>
<th>SNP 10</th>
<th>ACh 7.5</th>
<th>ACh 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controls at baseline (n=16)</td>
<td>2.0±0.2</td>
<td>9.2±0.8</td>
<td>12.6±1.0</td>
<td>9.8±1.1</td>
<td>12.0±1.1</td>
</tr>
<tr>
<td>Type 2 at baseline (n=11)</td>
<td>2.1±0.3</td>
<td>7.7±0.5</td>
<td>10.7±0.9</td>
<td>7.1±0.8</td>
<td>8.8±0.9</td>
</tr>
<tr>
<td>Type 2 at 6 months (n=11)</td>
<td>2.0±0.2</td>
<td>9.9±0.6</td>
<td>13.4±1.0</td>
<td>8.8±1.0</td>
<td>13.0±1.9</td>
</tr>
<tr>
<td>Type 2 at 3.5 years (n=11)</td>
<td>2.5±0.2</td>
<td>11.6±1.1</td>
<td>16.6±1.5</td>
<td>11.6±1.4</td>
<td>14.7±1.6</td>
</tr>
</tbody>
</table>

*P<0.05 for type 2 diabetic patients before insulin therapy vs normal subjects.
†P<0.05 and ‡P<0.01 for type 2 diabetic patients before vs after 6 months of insulin therapy.
§P<0.05 and ‖P<0.01 for type 2 diabetic patients before vs after 3.5 years of insulin therapy.
SNP 3 indicates sodium nitroprusside at a rate of 3 μg/min; SNP 10, sodium nitroprusside at a rate of 10 μg/min; ACh 7.5, acetylcholine at a rate of 7.5 μg/min; ACh 15, acetylcholine at a rate of 15 μg/min; controls, normal subjects; type 2, type 2 diabetic patients.
identified mechanisms underlying hyperglycemia-induced endothelial dysfunction. Hyperglycemia inhibits eNOS activity in cultured bovine aortic endothelial cells by activating the hexosamine pathway via mitochondrial overproduction of superoxide, which increases O-glycosylation of eNOS and thereby decreases its activity.29

We conclude that insulin glargine therapy induces a sustained improvement in glycemic control and markedly improves endothelium-dependent and endothelium-independent vasodilatation in forearm resistance vessels. The response to the endothelium-independent agent SNP became even super-normal, possibly as a consequence of hyperinsulinemia. The recent prospective data showing that the better the vasodilatory responses in the forearm in patients with essential hypertension3 and coronary artery disease,6 the less likely the coronary responses in the forearm in patients with essential hypertension3 and coronary artery disease,6 the less likely the

Acknowledgments

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References


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