The importance of hypertriglyceridemia as a cardiovascular disease risk factor continues to be a controversial topic, and patients with obesity frequently exhibit hypertriglyceridemia. In the Framingham Heart Study, the incidence of coronary heart disease was significantly greater with than without insulin resistance at either the lowest plasma high-density lipoprotein cholesterol values or the highest triglyceride values. The mechanism of hypertriglyceridemia in the setting of obesity has been linked to insulin resistance, wherein an increased flux of adipose tissue–derived free fatty acids (FFAs) gives rise to increased rates of hepatic triglyceride synthesis and secretion of very-low-density lipoprotein (VLDL) triglycerides (Figure). A recent report has also related increased FFA flux to the secretion of apolipoprotein CIII (apoCIII)-containing VLDL. Moreover, there is additional evidence that the hyperinsulinemia that ensues in the setting of insulin resistance is associated with increases in intrahepatic gene expression of genes of triglyceride biosynthesis, eg, sterol regulatory element-binding protein-1C. In the presence of increased intrahepatic triglycerides, nonalcoholic fatty liver disease or hypertriglyceridemia often occur, yet not all patients with obesity are insulin resistant.

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In the study by Taskinen et al published in the current issue of *Arteriosclerosis, Thrombosis and Vascular Biology,* both overproduction of large VLDL (VLDL1) and reduced VLDL1 fractional catabolic rate (FCR) were found to be associated with hypertriglyceridemia in obese subjects. A sophisticated multicompartmental model was used to simultaneously determine the kinetics of apoB and triglycerides in VLDL after a bolus injection of [(2)H(3)]leucine and [(2)H(5)]glycerol. Although the sample size was small, there were associations between large VLDL1 secretion and the amount of subcutaneous adipose tissue (measured by magnetic resonance imaging) + intrahepatic fat, and between VLDL1 FCR and plasma levels of apoCIII.

The finding that <20% of the hypertriglyceridemia in these obese men was associated with increases in VLDL1 secretion but almost 50% related to impaired FCR is somewhat consistent with the literature. However, VLDL triglyceride overproduction is more emphasized as the pathophysiology of hypertriglyceridemia than defects in VLDL FCR. The association of plasma levels of apoCIII with reductions in VLDL1 FCR was of particular interest, noting the well-appreciated inhibitory effect of apoCIII on lipoprotein lipase (LPL). ApoCIII is a 79-amino-acid glycoprotein synthesized by the liver and intestines that is mostly associated with triglyceride-rich lipoproteins (VLDL and chylomicrons) and high-density lipoprotein, with rapid exchange of the apoprotein between these lipoprotein classes during lipolysis. Increased hepatic production of VLDL apoCIII is characteristic of subjects with higher body weights and insulin resistance and is strongly related to the plasma concentration and level of production of VLDL triglycerides. Because insulin is known to inhibit apoCIII gene transcription, overproduction of apoCIII may be a further manifestation of hepatic insulin resistance. Moreover, recent evidence indicates that once glucose intolerance develops, activation of apoCIII gene transcription by hyperglycemia could lead to worsening hypertriglyceridemia. Not to be dismissed is the role of insulin in increasing apoB degradation in the liver. Once insulin resistance occurs, this is another mechanism that could relate to the overproduction and secretion of VLDL in patients with obesity.

The fact that the inverse relationship between VLDL1 FCR and apoCIII appeared to extend across the entire cohort suggests that a continuous relationship exists between apoCIII production and plasma triglycerides. However, not stated was whether or not levels of apoCIII also related to VLDL1 production or hepatic fat. There was, however, no evidence of any apoCIII variants in the study participants that have recently been linked to fatty liver. Although it is presumed that the effect on clearance of VLDL1, in the obese hypertriglyceridemic group was an inhibitory effect on LPL, only LPL mass was quantified. Because most of the LPL in plasma is inactive mass and there is no predictability of postheparin LPL activity by LPL activity in preheparin plasma, additional studies are needed to discern whether or not the presumed inhibitory effect of apoCIII on LPL as a contributor to the hypertriglyceridemia can be distinguished from simply a defect in FCR related to VLDL pool size.

The debate continues as to the relative importance of increases in intraabdominal or visceral fat versus subcutaneous fat in hepatic FFA delivery. Although in this study the subcutaneous adipose tissue depot appeared to relate to VLDL1 secretion rate more than visceral adipose tissue, increases in lipolysis and fatty acid flux from the visceral depot seems more etiologic in explaining fatty liver and hypertriglyceridemia. Despite the direct link between the visceral depot and the liver, intraabdominal adipose tissue...
quantitatively remains a relatively minor contributor. In a
study in obese men, splanchnic FFA levels ranged from
10% to almost 50%, with an increasing contribution as
visceral adipose tissue volume increased. When obese
subjects with nonalcoholic fatty liver disease were
compared with those with normal levels of intrahepatic fat,
the increased VLDL triglyceride secretion was primarily
due to fatty acid sources other than the systemic circulation,
 ie, from visceral or intrahepatic sites.

Both obese groups appeared to be hyperinsulinemic, al-
though the sample size limited the distinction between
the nonobese fasting insulin of 5.7±0.8 mU/L in the nonobese
normotriglyceridemic group from 10.0±1.9 mU/L in the
obese normotriglyceridemic group. The fasting insulin of
12.9±1.7 mU/L in the hypertriglyceridemic obese group
was clearly not different from that in the obese normotrige-
ryidemic group, as was the homeostasis model assessment
of insulin resistance. Thus, these crude assessments of insulin
sensitivity do not appear to be related to the mechanism of the
hypertriglyceridemia. Despite the sample size and lack of
robust tests of insulin action, some attempt to relate VLDL
kinetics to fasting insulin and homeostasis model assessment
of insulin resistance may have helped clarify whether a
gradient or threshold relationship existed. Moreover, a eugly-
cemic clamp with stepwise increments in the insulin infusion
rate assessing both the effects of insulin on antilipolysis and
FFA flux, in addition to hepatic and peripheral insulin
resistance in glucose metabolism, would be informative.

Overall, Taskinen et al§ appropriately stress a simplistic
approach to identifying patients at high cardiometabolic risk
by measuring waist circumference and fasting triglycerides,
revisiting the hypertriglyceridemic waist, a concept devel-
oped by the Despres group more than a decade ago. Defined
as a waist circumference of ≥90 cm and a triglyceride level of
≥2.0 mmol/L in men and a waist circumference of ≥85
cm and a triglyceride level of ≥1.5 mmol/L in women, this
easily quantified metric has been used to identify patients
with added metabolic disturbances related to insulin resist-
ance and higher risk for coronary heart disease. Finally,
apoCIII remains a fascinating lipoprotein constituent that

Figure. Insulin resistance is associated with an expanded adipose tissue mass. In this setting, many of the metabolic effects of insulin
are reduced, including increases in basal lipolysis and less suppression of lipolysis by feeding and insulin. In addition, there is a reduc-
tion in the intrahepatic effects of insulin action that relate to apolipoprotein metabolism. Under physiological conditions, insulin sup-
presses apolipoprotein C-III (apo C-III) gene transcription and increases apolipoprotein B-100 (apo B-100) degradation, whereas in
insulin-resistant states, both effects of insulin are reduced. However, the ability of insulin to increase sterol regulatory element-binding
protein-1c gene transcription is preserved. Thus, with increased free fatty acid (FFA) flux and esterification to triglycerides (TG) and
increased lipogenesis, hepatic steatosis frequently occurs. Moreover, in the presence of more TG, the increased availability of apo C-III
and apo B-100 enhances the synthesis and secretion of very-low-density lipoprotein (VLDL). In addition, in the circulation the inhibitory
effect of VLDL apo C-III on lipoprotein lipase (LPL) reduces the fractional catabolic rate of VLDL and contributes to the burden of the
hypertriglyceridemia.
demands further characterization and epidemiology before its measurement is ready for prime time.

Acknowledgments

The author thanks Dr Hong Wang for her assistance with the figure.

Disclosures

None.

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Key Words: insulin resistance • lipids • lipoproteins • metabolism • obesity
The Complex Metabolic Mechanisms Relating Obesity to Hypertriglyceridemia

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Arterioscler Thromb Vasc Biol. 2011;31:1946-1948
doi: 10.1161/ATVBAHA.111.233049
Arteriosclerosis, Thrombosis, and Vascular Biology is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 1079-5642. Online ISSN: 1524-4636

The online version of this article, along with updated information and services, is located on the World Wide Web at:
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