

MUFA-rich diet prevents central body fat distribution and decreases postprandial adiponectin expression induced by a carbohydrate-rich diet in insulin-resistant subjects.

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Short running title: MUFA-rich diet prevents central body fat

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**Objective** — Central obesity is associated with insulin resistance through factors that are not fully understood. We studied the effects of three different isocaloric diets on body fat distribution, insulin sensitivity and peripheral adiponectin gene expression.

**Research Design and Methods** — Eleven volunteers, offspring of obese type 2 diabetic patients with abdominal fat deposition were studied. These subjects were considered insulin resistant as indicated by their Matsuda Index  $< 4$  after OGTT and they maintained HBA1c  $< 6.5\%$  without therapeutic intervention. All subjects underwent three dietary periods of 28 days each in a crossover design: a) diet enriched in saturated fat (SAT), b) diet rich in monounsaturated fat (MUFA; Mediterranean diet) and c) diet rich in carbohydrates (CHO).

**Results** — Weight, body composition and resting energy expenditure remained unchanged during the three sequential dietary periods. Using dual-energy X-ray absorptiometry we observed that when patients were fed a CHO-enriched diet their fat mass was redistributed towards the abdominal depot while periphery fat accumulation decreased compared with isocaloric MUFA-rich and high SAT diets (ANOVA  $< 0.05$ , respectively). Changes in fat deposition were associated with decreased postprandial mRNA adiponectin levels in peripheral adipose tissue and lower insulin sensitivity indices (SI) from a frequently sampled insulin-assisted intravenous in patients fed a CHO-rich diet compared with a MUFA-rich diet (ANOVA  $< 0.05$ , respectively).

**Conclusions** — An isocaloric MUFA-rich diet prevents central fat redistribution and postprandial decrease in peripheral adiponectin gene expression and insulin resistance induced by a carbohydrate-rich diet in insulin-resistant subjects.

## INTRODUCTION

A positive energy balance leading to obesity is associated with insulin resistance and increased risk of Type 2 diabetes (T2D). According to our studies in rodents, adipose tissue expandability seems to be a key determinant linking obesity and its associated complications (1, 2). Expansion of the intraabdominal depot has been associated with increased insulin resistance, as well as increased prevalence of fatty liver and beta cell failure (3, 4).

The factors that regulate body fat distribution are not well understood. We hypothesise that the specific macronutrient composition of the diet may be an important environmental factor that controls nutrient partitioning to specific adipose tissue depots (5). It is now well established that adipose tissue is not simply an energy storage organ, but in fact the “largest” endocrine gland controlling energy homeostasis (6). It is conceivable that specific diet composition may directly influence the molecular events that govern gene expression in adipocytes (7), adipokines production, and adipocyte lipid and glucose metabolism (8).

Adiponectin adipocyte-secreted adipokine plays an important role in modulating insulin sensitivity and concentrations of circulating plasma glucose and non-sterified fatty acid (NEFA) (9, 10). A lower concentration of circulating plasma adiponectin seems to be a good predictor of reduced insulin sensitivity and increased risk of type 2 diabetes (11, 12). Plasma adiponectin concentration is negatively correlated with body fat percentage and preferential central fat distribution (13).

In humans, the optimal diet for individuals at risk of developing T2D is still controversial. It is unclear, for example, whether during weight-maintenance phases there is any metabolic advantage in administering diets preferentially enriched in monounsaturated fat or carbohydrates, a question that becomes particularly relevant when most overweight patients fail to maintain long-term weight loss.

The aim of this study was to compare the effects of three isocaloric diet models that differed in fatty acid and carbohydrate composition: a diet rich in saturated fat (SAT), one enriched in monounsaturated (MUFA; Mediterranean diet) fat and a carbohydrate-rich diet (CHO); on body fat composition and distribution, insulin sensitivity and adiponectin expression on peripheral adipose tissue.

## RESEARCH DESIGN AND METHODS

Fifty-nine potential subjects were recruited in 2003 and 2004 and invited to attend a screening session. The study protocol was reviewed and approved by the Ethics and Clinical Investigation Committee of the Reina Sofia University Hospital of Córdoba (Spain). Clinical inclusion criteria were: Subjects should have a history of fasting glycemia  $< 125$  mg/dL with glycosilated hemoglobin (HbA<sub>1c</sub>)  $< 6.5\%$  without any drug or previous insulin treatment. A body-mass index (BMI)  $> 25$  kg/m<sup>2</sup> and waist circumference  $\geq 102$  cm and  $\geq 88$  cm in men and women were required. Clinical exclusion criteria were: Microvascular or macrovascular complications; cigarette smoking and alcohol consumption; use of diuretics, steroids and  $\beta$ -blockers or use of medications that might affect glucose metabolism.

Finally, included in this study were eleven subjects with an insulin sensitivity index (ISi) of less than 4.0, which is regarded as insulin resistant (lower values indicates greater insulin resistance) (14). They were four males and seven females of  $62 \pm 9.4$  years of age, with a mean BMI of  $32.6 \pm 7.8$  and mean HbA<sub>1c</sub> of  $6.0 \pm 0.5\%$ . They presented fasting serum glucose levels of  $5.47 \pm 0.5$  mmol/L and 2 h after oral glucose load  $8.75 \pm 1.6$  mmol/L, and fasting serum insulin  $87.5 \pm 26.6$  pmol/L and 2 h after oral glucose load  $959 \pm 486$  pmol/L. The mean Matsuda index (ISi) was  $2.9 \pm 0.9$ . Experimental design and dietary methodology. In brief, each subject

completed a 3-day food-intake diary and energy expenditure was measured in the fasting state, by indirect calorimetry, to estimate normal energy intake. Patients were randomly divided into three groups (Williams Latin Square) and underwent three dietary periods of 28 days each: a low-fat high-carbohydrates diet (CHO) contained 65% as CHO and 20% FAT (6% SAT, 8% MUFA, 6% PUFA), a high-fat MUFA-rich diet (MUFA; Mediterranean diet) contained 47% carbohydrates and 38% fat (9% SAT, 23% MUFA, 75% of which was provided as extra virgin olive oil and 6% PUFA) and a diet rich in saturated fat (SAT) [47% CHO, 15% PROT and 38% FATS (23% SAT, 9% MUFA, 6% PUFA)]. Subjects were controlled in order to maintain their weight and usual exercise concentration during the study. Dietary adherence was determined by measuring the fatty acid content extracted from plasma phospholipids at the end of dietary period by means of gas chromatography using a Hewlett Packard 5890 (Avondale, PA, USA) (15).

Breakfast meals used for postprandial studies. Postprandial studies were conducted on the last day of each diet period. At 8 A.M. the subjects met in the laboratory after an overnight fast. The breakfast meals contained 443 Kcal and were consumed within 15 min. The CHO-rich breakfast comprised 200 mL skim milk, 70 g of bread, and 75 g marmalade; the MUFA-rich breakfast diet, 200 mL skim milk, 50 g bread and 27 g olive oil; the SAT-rich breakfast consisted of 200 mL whole milk, 50 g bread and 25 g butter. Venous blood samples were taken before the breakfast and afterwards, at the following points in time, -10', -5', 0', 15', 30', 60', 90', 120', 150', 180'.

Insulin sensitivity calculations. A frequently sampled intravenous-glucose-tolerance test was performed as previously described (16). Values for glucose and insulin were entered into the MINMOD MILLENIUM 2002 computer program® (Version 6.02, Richard N. Bergman) for determination of the acute

insulin response (AIR) and insulin sensitivity (SI).

Anthropometry and body composition. Stature was measured to 0.5 cm on a stadiometer and weight was measured to 0.1 kg on a balance scale. The waist circumference of each subject was measured at the umbilicus with a fiberglass tape measure to the nearest millimeter. Bioelectrical impedance was performed and body fat mass was determined by subtracting lean body mass (LBM) from body weight (17). For assessment of body fat distribution, all subjects underwent a Dual-energy X-ray absorptiometry whole-body scan (DEXA) in a Lunar DPX-IQ 240 densitometer at baseline and at the end of each dietary treatment. Analysis of the total and regional body composition was performed using Extended Research Mode with Lunar software (Lunar software version 1.3; Madison, WI, USA) to provide data on whole-body and regional data (limbs and trunk) (18). The trunk region or upper body fat includes the chest and abdomen, excluding the pelvis. The leg region includes the entire hip, thigh, and leg. The coefficient of variation for the DEXA is  $\leq 2\%$ .

Indirect calorimetry. The energy production (EP) and respiratory quotient (Rq) were measured by continuous indirect calorimetry using a computerized, flow-through canopy gas analyzer system (Deltatrac; Datex, Helsinki, Finland) (19).

Analytic procedures. Plasma glucose was measured by the glucose oxidase method. Plasma insulin concentrations were measured by microparticle enzyme immunoassay (MEIA; Abbott Diagnostics, Matsudo-shi, Japan; CV 2.5-6%). Serum human glucagon peptide was measured by competitive format by ELISA (Wako Chemicals, Osaka, Japan). The measurement of adiponectin protein used a human ELISA kit (Linco Research, St. Charles, MO; CV 4.3%). Serum leptin concentrations were measured by Human ELISA kit (Linco Research, St. Charles, MO; CV 4.8%). Resistin was measured by human ELISA Kit (Linco Research, St. Charles, MO; CV

3.2%). Serum fatty acids (FFA; nonesterified fatty acids [NEFAs]) concentrations were measured in triplicate in each sample using an enzymatic colorimetric assay (Roche Molecular Biochemical, Mannheim, Germany; CV 7.8%). Fasting blood samples were analyzed for cortisol, testosterone, estrone, 17-OH-progesterone, dehydroepiandrosterone (DHEA), DHEAs and androstenedione by specific RIAs (Diagnostic Systems Laboratories, Inc., Sinsheim, Germany). Peripheral adipose adiponectin quantification with RT-PCR. At 7:00 a.m. patients ingested a 443-calories breakfast in each dietary period and after 180' were obtained samples of peripheral fatty tissue (~300 mg) were obtained from the outer upper quadrant of the buttocks. Total RNA was isolated using Tri Reagent® (MRC, Cincinnati, USA), homogenized with Ultra-Turrax® T25 (Wolf laboratories, York, UK) and quantified by spectrophotometry (NanoDrop, Wilmington, USA). First-strand complementary DNA (cDNA) was generated from 1 µg RNA by means of a iScript™ cDNA synthesis kit (Bio-Rad Laboratories) and cDNA synthesis using a Mastercycler® gradient (Eppendorf, NY, USA). The cDNA obtained was used as a template in quantitative real-time PCR using QuantiTect™ SYBR Green PCR kit (QIAGEN, Hilden, Germany) and a LightCycler system (Roche Molecular Biochemicals, Mannheim, Germany). Primer and probes were designed with the aid of PRIMER EXPRESS software package version 1.0 (Applied Biosystems, CA, USA) from gene sequences obtained from GenBank (National Library of Medicine, Bethesda, MD; Internet: [www.ncbi.nih.gov/blast/](http://www.ncbi.nih.gov/blast/)). The forward primer used for adiponectin was: 5'GGAGATCCAGGTCTTATTGG3' and the reverse primer used was: 5'GTAAAGCGAATGGGCATGTT3'. The PCR product obtained was 194 bp and was analyzed by melting curves and in agarose gels electrophoresis. The signal for β-actin (GenBank-X00351) was used to normalize

against differences in RNA isolation and degradation, and the efficiencies of the reverse transcription and PCR reactions. Samples were run in duplicate, were quantitated by normalizing the adiponectin signal with the β-actin signal and are expressed in arbitrary units, with the values for adiponectin mRNA concentrations during saturated rich fat arbitrarily set at 1.00.

#### Statistical analysis

The data presented were all tested for normality of distribution. Data of mRNA adiponectin expression were log transformed in order to normalize the distribution. Changes in anthropometry, plasma lipids and lipoproteins, and glycemic variables were analyzed by means of a two-factor analysis of variance model with repeated measures. The postprandial (pp) excursion of plasma glucose, fatty acids, insulin and glucagon were analyzed by calculating the incremental area under the curve (AUC) for 180 min after the meal intake, with a formula based on the trapezoid rule with adjustment for baseline concentrations. Results are presented as the mean ± SEM, unless otherwise indicated.

## RESULTS

### Effects of macronutrient diet composition on energy balance.

As expected, the mean energy consumed remained unchanged throughout the three dietary phases (9565±769 kJ [SAT], 9586±743 kJ [MUFA], 9526±716 kJ [CHO]; ANOVA p=0.7). Resting energy expenditure (REE) at initial evaluation  $93.01 \pm 5.02 \text{ kJ} \cdot \text{kg}^{-1} \cdot \text{d}^{-1}$  was not changed during the three dietary periods (5.49±0.38 kJ/min, 5.23±0.36 kJ/min, 5.02±0.37 kJ/min; ANOVA p=0.3). Fasting fat oxidation rate was increased during high-SAT and MUFA-rich diets compared with the high-CHO diet (1.60±0.11 kJ/min; 1.82±0.11 kJ/min; 1.38±0.13 kJ/min; ANOVA P < 0.05). Carbohydrate and protein oxidation rates were unchanged

( $2.45 \pm 0.18$  kJ/min;  $1.88 \pm 0.13$  kJ/min;  $1.98 \pm 0.13$  kJ/min and  $1.44 \pm 0.09$  kJ/min;  $1.53 \pm 0.12$  kJ/min;  $1.66 \pm 0.11$  kJ/min; Anova  $p=0.5$  and  $p=0.07$ , respectively). The efficacy of the dietary treatment was confirmed as the proportions of palmitic, stearic and total saturated fatty acids were increased after consuming SAT-rich diets (ANOVA  $p < 0.01$ ,  $p < 0.05$  and  $p < 0.01$ , respectively), the proportions of oleic (18:1, n-9) and total MUFA fatty acids were higher after eating MUFA-rich diets (ANOVA,  $p < 0.01$ ,  $p < 0.05$ , respectively) and total polyunsaturated (PUFA) fatty acids were unchanged.

Diet-specific effects on adipose depot fat deposition.

The mean BMI ( $32.5 \pm 2.4$  Kg/m<sup>2</sup>) and mean waist circumference at baseline ( $109.5 \pm 5$  cm) were not modified during the study (Table 1). Body composition remained unchanged as indicated by stable total body fat and lean body mass. We observed increased accumulation of fat deposited in the trunk depot when experimental subjects were fed the carbohydrate enriched diet. This was associated with a decrease in the amount of fat mass deposited in the leg when they were fed the CHO-rich diet compared with MUFA and SAT rich diets ( $16459 \pm 1653$  g,  $14842 \pm 1437$  g,  $14313 \pm 1362$  g and  $7358 \pm 1253$  g,  $8036 \pm 1398$  g,  $8517 \pm 1588$  g; respectively, ANOVA  $p < 0.05$ ). This resulted in an increase in the abdominal fat: leg fat ratio after CHO-rich diet compared with MUFA and SAT rich diets ( $2.50 \pm 0.2$ ,  $2.1 \pm 0.2$  and  $1.9 \pm 0.3$ ; respectively, ANOVA  $p < 0.05$ ).

Diet-specific effects on carbohydrate and lipid metabolism.

Fasting glucose concentrations decreased during MUFA-rich and CHO-rich diets compared with the SAT-rich period (ANOVA,  $p < 0.05$ ) (Table 2). Insulin sensitivity assessed as  $S_I$  index was improved by the MUFA enriched diet

compared with the SAT-rich and CHO-rich diets ( $3.9 \pm 0.6$ ,  $3.3 \pm 0.5$  and  $3.5 \pm 0.4 \times 10^{-4}$  min<sup>-1</sup>/ (μU/mL), respectively; ANOVA  $p < 0.05$ ). Insulin secretion assessed as AIR fell during the SAT-rich diet as compared with the MUFA-rich and CHO-rich diets ( $264.7 \pm 82.7$ ,  $335.6 \pm 85$  and  $347.4 \pm 75.5$ , respectively; ANOVA  $p < 0.05$ ). The postprandial integrated AUCs for glucose and insulin concentrations were higher in response to the standard CHO-rich breakfast than to standard high-MUFA and high-SAT breakfasts (ANOVA,  $p < 0.05$ , and  $p < 0.01$ , respectively). Fasting fatty acid concentrations remained constant throughout the three dietary periods, but postprandial excursions of NEFA were lower after the CHO-rich breakfast than after the high-MUFA and SAT-rich breakfasts (ANOVA,  $p < 0.05$ ). The AST/ALT ratio was unchanged after high SAT, high MUFA and CHO rich diets ( $1.01 \pm 0.05$ ,  $1.14 \pm 0.07$ ,  $1.04 \pm 0.05$ , respectively; ANOVA  $p=0.13$ ).

Diet-specific effects on plasma hormone and adipokines concentrations. Fasting and postprandial serum adiponectin concentrations remained unchanged during the three dietary phases (Table 2). The fasting serum leptin concentration was lower after the MUFA-rich dietary period than following the SAT-rich and CHO-rich diets ( $23.7 \pm 7.4$ ,  $31.6 \pm 9.4$ ,  $32.1 \pm 10.3$ , respectively; ANOVA  $p < 0.05$ ). Postprandial leptin concentrations fell in response to the three breakfasts, and finally were similar after the three diets. Fasting serum resistin concentrations after the three dietary periods and in responses to the three breakfasts remained unchanged. Since changes in steroid metabolism might have been responsible for the observed changes in adipose tissue distribution, we also examined the effects of these diets on fasting serum concentrations of cortisol, androstenedione, testosterone, 17-OH-progesterone, estrone, DHEA and DHEAs. None of these hormones changed in response to the macronutrient composition

of the diet. Finally, we looked at whether postprandial adiponectin mRNA expression in peripheral adipose tissue (gluteus) of insulin resistant subjects was affected by the macronutrient composition of the three breakfast models (Figure 1). The mRNA abundance of adiponectin was lower after a CHO-rich breakfast than after MUFA-rich and SAT-rich breakfasts (ANOVA  $p < 0.05$ ). The expression of the reference gene  $\beta$ -actin was not modified during the three dietary periods.

## DISCUSSION

This controlled, randomized cross-over trial investigated the effects of ad libitum consumption of a high-CHO diet vs a high-MUFA diet on body fat distribution, postprandial adiponectin gene expression on peripheral adipose tissue and insulin sensitivity in normoglycemic insulin-resistant first-degree relatives of type 2 diabetic patients.

In our opinion the most interesting finding of our research is the demonstration that specific macronutrient composition affects the topography of fat distribution. After a low-fat CHO-enriched diet our patients presented a preferential redistribution of their body fat from peripheral adipose tissue in the leg to central body depots in the trunk compared to when an isocaloric high-MUFA diet was fed. The consumption of CHO-rich diets has been associated with weight loss that could partially explain some of its metabolic effects (20). On the other hand, it has also been shown that low-CHO diets may have beneficial effects by reducing body weight and improving insulin resistance in type 2 diabetic patients (21). There is evidence that type 2 diabetic patients on weight-maintenance with a very low-fat CHO-enriched diet tend to have a disproportionate loss of lower-body to upper body fat as compared with patients fed a diet high in monounsaturated fats (22). However, using hypocaloric diets leading to weight loss has not revealed preferential regional specific fat mass loss, either with high-fat or

very low-fat diets (23). Our study was designed to specifically address the effects of three diets with different macronutrient composition but with similar caloric intake. As expected, at least in the short run, the macronutrient compositions of isocaloric diets did not have significant effects on body weight.

Since different diet composition may have heterogeneous effects on glucose, fatty acids, hormones and adipokines concentrations, we investigated the effect on these parameters. In compar with high fat diets, CHO-rich diets displayed, during the postprandial phase, higher glucose and insulin concentrations and lower fatty acid and glucagon levels. However, in the fasting state after a period of CHO-rich diet, glucagon concentration rose while fatty acids concentrations remained similar compared to high-fat diets. In the fasting state, adipose tissue is the most important contributor to the plasma NEFA (~80%) concentrations, and it is well known that subcutaneous adipocytes have high lipolytic activity (24, 25). We hypothesised that a glucagon-mediated lipolytic effect on peripheral adipose tissue may occur in the fasting state when patients are fed a CHO-rich diet, relocating fatty acids from peripheral to central body fat depots (26, 27). Alternatively, it is possible that hepatic lipogenesis may have contributed to the postprandial increase in plasma concentrations of glucose and insulin observed in individuals fed CHO-rich diets that may stimulate de novo lipogenesis (28, 29).

Several mechanisms may have been implicated in the changes in insulin sensitivity observed during these nutritional manipulations. These include nutritionally-induced differences in hormone secretion, as well as differences in glucose- and lipid-buffering capacity (18, 30, 31). Regional differences in patterns of adipokines production and/or fatty acids handling may also influence the relative effects on adipose tissue deposition and insulin sensitivity. Interestingly, our results show that fasting

plasma leptin concentrations fell during MUFA-rich periods. Plasma leptin is an important signal for regulation energy stores regulation and has been associated with improved insulin action (32, 33), and its concentrations seems to be increased by high-carbohydrate diets (34). However, this finding should be interpreted with caution since elevated leptin concentrations in the context of obesity are generally viewed as evidence for leptin resistance and insulin resistance (35).

Our study has also documented differential postprandial regulation of adiponectin gene expression on peripheral adipose tissue in response to differences in the macronutrient composition of diets. After a CHO-rich breakfast lower adiponectin mRNA expression levels were detected than when MUFA-rich and SAT-rich diets were ingested. However, fasting and postprandial adiponectin plasma concentrations did not differ significantly among the three diets. It can be speculated that in spite of similar levels of adiponectin in plasma, the paracrine effects of adiponectin may facilitate depot-specific effects that promote adipocyte differentiation and peripheral lipid accumulation (10). In fact, direct adiponectin action on adipose tissue expandability seems to be an important factor for the differences on insulin sensitivity in responses to the macronutrient composition of diets, in the context of energy balance.

In obese patients, adiponectin mRNA in peripheral adipose tissue can acutely respond to the short-term energy restriction associated with increased insulin sensitivity (36). In animals, dietary factors, such as fish oil and linoleic acid have been associated with higher plasma concentrations and gene expression of adiponectin, which is consistent with these fatty acids exerting a protective effect on the development of diabetes (8, 37). Similarly, adiponectin has been suggested as a potent insulin enhancer linking adipose tissue and whole-body glucose metabolism (38). Furthermore,

plasma adiponectin concentrations progressively decrease with age in plasma in a rhesus monkey model of progressive development of type 2 diabetes (12). Moreover, insulin resistance in lipotrophic mice was completely reversed by the combination of physiological doses of adiponectin and leptin, but only partially by either adiponectin or leptin alone (39).

In conclusion, our results indicate that the macronutrient composition of diets may influence the body fat distribution and carbohydrate metabolism without affecting total body weight. After a low-fat carbohydrate-rich diet, insulin-resistant patients presented a redistribution of their body fat from peripheral adipose tissue to central body depots. Conversely, a MUFA-rich diet improved insulin sensitivity, and this was associated with increased postprandial adiponectin mRNA gene expression.

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TABLE 1. Composition and body fat distribution after three dietary interventions in insulin-resistant subjects.

	Baseline	High-SAT	High-MUFA	High-CHO	p
EE, (kJ/min)	5,36±0,40	5,49±3,90	5,23±0,37	5,02±0,36	0,30
Antropometry					
Weight, kg	84.4±5.7	83.2±5.7	83.6±5.8	81.8±6.03	0.3
Total body fat, kg	36.8±4.1	35.0±4.0	35.6±4.0	34.9±4.3	0.1
Lean body mass, kg	47.5±2.5	48.1±2.5	48.9±2.6	46.8±2.1	0.2
Waist to hip ratio	0.99±0.01	0.99±0.01	0.98±0.01	0.98±0.01	0.9
DEXA analysis					
Total body trunk, g	-	37101±2026	38154±1911	39134±2104	0.3
Fatty body trunk, g	-	14313±1362	14842±1437	16459±1653	<0.05
Total body limb, g	-	36420±3886	36239±3862	32887±3825	0.7
• Fat in arm, g	-	7097±1528	7652±1339	7225±1830	0.4
• Fat in leg, g	-	8517±1588	8036±1398	7358±1253	<0.05
Fat trunk:fat leg ratio	-	1.9±0.3	2.1±0.2	2.50±0.2	<0.05

Data are Mean ± SE. P value is analysis of variance for repeated variables. Energy expenditure (EE). Saturated fat (SAT), monounsaturated fat (MUFA) and carbohydrates rich (CHO) diets. DEXA is dual energy x-ray absorptiometry.

TABLE 2. Hormonal, adipokines and metabolic parameters after the three dietary periods in insulin-resistant subjects.

	High-SAT	High-MUFA	High-CHO	p
Glucose, mmol/L				
Fasting	5.5±0.2	5.0±0.1	5.0±0.1	< 0.05
AUC, mmol · 180 min/L	5.8±1.2	7.8±1.3	11.9±2.7	< 0.05
Insulin, pmol/L				
Fasting	64.1±9.6	60.7±12.4	75.2±12.3	0.3
AUC, pmol · 180 min/L	142.4±28.9	113.8±29.6	259.3±74.2	< 0.05
SI [ $\times 10^{-4}$ min <sup>-1</sup> / ( $\mu$ U/mL)]	3.3±0.5	3.9±0.6	3.5±0.4	< 0.05
AIR ( $\mu$ U/mL)	264.7±82.7	335.6±85	347.4±75.5	< 0.05
Glucagon, $\mu$ g /L				
Fasting	322±75	436±110	495±102	< 0.05
AUC, ng · 180 min/mL	125±162	466±210	-55±67	0.07
Adiponectin, mg/L				
Fasting	8.6±1.7	9.4±1.5	12±1.7	p=0.08
Postprandial (180')	11.1±2.3	11.2±1.9	10.7±2.4	p=0.8
Resistin, $\mu$ g /L				
Fasting	10.3±1.1	10.5±1.3	11.5±1.8	p=0.8
Postprandial (180')	10.3±1.0	10.4±1.2	10.4±0.9	p=0.8
Leptin, $\mu$ g /L				
Fasting	31.6±9.4	23.7±7.4	32.1±10.3	P<0.05
Postprandial (180')	20.3±4.4	21.1±7.0	24.7±7.4	P=0.4

Data are means  $\pm$  SEM. P value is analysis of variance for repeated variables. Saturated fat-rich (SAT), monounsaturated fat-rich (MUFA) and high-carbohydrates (CHO) diets. NEFA is nonesterified fatty acids.

Figure 1

Panel A, shows diet-specific postprandial responses to glucose and non-ester fatty acid (NEFA) levels. Mean ( $\pm$ SE) postprandial responses of glucose and NEFA to the three isocaloric (443 Kcal) standard breakfasts: a breakfast rich in carbohydrates ( $\blacksquare$  – CHO), a Mediterranean breakfast enriched with virgin olive oil ( $\blacktriangledown$  – MUFA) and a standard breakfast high in saturated fat ( $\bullet$  – SAT). Repeated measures ANOVA and Tukey’s tests were used. Panel B, shows postprandial adiponectin gene expression in peripheral adipose tissue after 180 min after each isocaloric breakfast. Values represent the mean  $\pm$  S.E. with the values for adiponectin mRNA concentrations in SAT-rich diet arbitrarily set at 1. After log transformation, the data were normalized and ANOVA for repeated measures was used for overall comparison. A 5%  $\alpha$  risk concentrations was required for statistical significance ( $p < 0.05$ ).

