Mechanisms of early improvement / resolution of type 2 diabetes after bariatric surgery

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Abstract

Bariatric surgery represents the main option for obtaining substantial and long-term weight loss in morbidly obese subjects. In addition, malabsorptive (biliopancreatic diversion, BPD) and restrictive (roux-en-Y gastric bypass, RYGB) surgery, originally devised to treat obesity, has also been shown to help diabetes. Indeed, type 2 diabetes is improved or even reversed soon after these operations and well before significant weight loss occurs.

Two hypotheses have been proposed to explain the early effects of bariatric surgery on diabetes—namely, the hindgut hypothesis and the foregut hypothesis. The former states that diabetes control results from the more rapid delivery of nutrients to the distal small intestine, thereby enhancing the release of hormones such as glucagon-like peptide-1 (GLP-1). The latter theory contends that exclusion of the proximal small intestine reduces or suppresses the secretion of anti-incretin hormones, leading to improvement of blood glucose control as a consequence.

In fact, increased GLP-1 plasma levels stimulate insulin secretion and suppress glucagon secretion, thereby improving glucose metabolism. Recent studies have shown that improved intestinal gluconeogenesis may also be involved in the amelioration of glucose homeostasis following RYGB.

Although no large trials have specifically addressed the effects of bariatric surgery on the remission or reversal of type 2 diabetes independent of weight loss and/or caloric restriction, there are sufficient data in the literature to support the idea that this type of surgery—specifically, RYGB and BPD—can lead to early improvement of glucose control independent of weight loss.

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1. Introduction

At present, bariatric surgery represents the main option for obtaining substantial and long-term weight loss in morbidly obese (BMI ≥ 40 kg/m²) or obese (BMI ≥ 35 kg/m²) individuals who also have other co-morbidities such as diabetes or arthritis [1].

Interestingly, although bariatric surgery was originally devised to treat obesity, it has also been found to help diabetes [2,3]. In fact, type 2 diabetes is seen to improve or even revert to normal soon after bariatric operations, and well before any significant weight loss has taken place. This observation prompted scientists to investigate the effects of bariatric surgery—now dubbed ‘metabolic surgery’—on diabetic patients with a BMI < 35 kg/m² [4–7].

Bariatric operations, which are effective for weight loss as well as diabetes reversal, alter the anatomical connections between the stomach and small intestine, thereby changing the normal pathway for food. This observation suggests that the intestine plays a part in the pathogenesis of type 2 diabetes.

The tight physiological relationship between the intestine and endocrine pancreas has been extensively reported in the literature. During ontogenesis, the septum transversum generates two pancreatic buds at the level of the junction between the foregut and midgut, involving dorsal and ventral endoderm, which then fuse to form the pancreas. The dorsal bud arises first and generates most of the pancreas. The ventral bud arises next to the bile duct, and makes up only part of the head and uncinate process of the pancreas [8]. The small intestine shares with the pancreas the same endodermal derivation and probably many endocrine functions as well.

The term ‘enteroinsular axis’ arises from the fact that the gastrointestinal tract plays a major role in controlling glucose metabolism [9–11]. Glucose ingestion stimulates insulin secretion 50% more than glucose infusion even in the presence of similar circulating levels of glucose [12].

The reason(s) for the diabetes improvement/reversibility—and, in particular, the greater insulin sensitivity—are currently unknown. However, it has been speculated that, in addition to altered incretin secretion, other, unknown factors regulating insulin sensitivity may be involved that are altered by the surgical treatment [13–15]. Clearly, identification of such mechanisms are of major importance, as that might lead to the development of effective new treatments for type 2 diabetes and, specifically, reversal of insulin resistance. Also, it is worth noting that the improvement in insulin sensitivity after bariatric surgery can be as much as 70% or more [13,16], a figure far above that achieved by the currently available therapies.

At present, it is not clear which aspect of the surgical procedure is responsible for the observed increase in insulin sensitivity. It has, however, been suggested that certain surgical procedures are more effective than others, as it appears that not all operations are equal. In a recent meta-analysis and review of the literature looking at all types of bariatric surgery together [17], resolution of the clinical manifestations of diabetes occurred in 78.1% of patients, while diabetes control improved in 86.6% of the cases. Indeed, biliopancreatic diversion (BPD), or the so-called ‘duodenal switch’, had the best results with 95.1% of diabetes resolution, followed by roux-en-Y gastric bypass (RYGB) with 80.3%, gastroplasty with 79.7% and laparoscopic adjustable gastric banding (LAGB) with 56.7%.

In the present review, the available data in the literature on the early effects of bariatric surgery on type 2 diabetes are reviewed in an effort to elucidate the mechanisms through which glucose disposal is improved or normalized independent of weight loss.

2. Effect of gastric banding on type 2 diabetes

Laparoscopic gastric banding (Fig. 1) appears to be effective in improving the metabolic syndrome and type 2 diabetes [18,19]. A recent randomized trial comparing LAGB-induced weight loss with conventional therapy for management of type 2 diabetes in obese participants showed better glycaemic control and diabetes remission rates with adjustable gastric banding. However, the data reported in this trial covered the later effects of LAGB at 2 years, when weight loss was at its maximum point.

In contrast, the efficacy of the operation for early improvement of type 2 diabetes has been found in few studies. In one involving 93 subjects, the first effects on glucose control appeared 6 months after LAGB, when the percentage of excess weight lost was about 29% [19]. However, a close correlation between weight loss and reduction of circulating levels of glucose was observed, suggesting that the mechanism of glucose metabolism improvement was essentially related to the weight loss.

3. Early effects of RYGB and BPD on type 2 diabetes

RYGB is a mostly restrictive operation that reduces gastric volume to about 30 ml, and excludes the duodenum and of a portion of the jejunum from food transit by creating a gastrojejunal anastomosis (Fig. 2). In contrast, BPD is mainly a malabsorptive procedure, leaving a gastric remnant of 300–400 ml
and bypassing a major portion of the small intestine—namely, the duodenum, the whole of the jejunum and the proximal ileum (Fig. 3). Thus, BPD is characterized by lipid malabsorption with frank steatorrhoea. The early effects of RYGB and BPD on type 2 diabetes are summarized in Table 1.

The literature includes data from diabetic patients with BMIs that are either > 35–40 kg/m² or < 35 kg/m² [7,13,16,20–30] and, with the exception of Smith et al. [23], who found a 42% diabetes remission, and Scopinaro et al. [28], who found a figure of 74%, all the other studies reported a 97–100% improvement/remission of diabetes within 1 month of the operation. It is worth noting that these effects of metabolic surgery were seen before any significant weight loss. Also, at least in those who underwent a malabsorptive procedure such as BPD, the patients were subject to no food energy restrictions, but were following a free, ad libitum diet.

4. Mechanisms of improvement/reversibility of diabetes

Two main hypotheses have been proposed to explain the early effects of metabolic surgery on diabetes: the hindgut hypothesis; and the foregut hypothesis. The former states that diabetes control results from the more rapid delivery of nutrients to the distal small intestine, thereby enhancing the release of hormones such as glucagon-like peptide-1 (GLP-1) [31], a physiological sign of improved glucose metabolism. On the other hand, the foregut hypothesis contends that the exclusion of the proximal small intestine reduces or suppresses the secretion of anti-incretin hormones [13–15], with a consequent improvement in blood glucose control. Indeed, increased GLP-1 plasma levels stimulate insulin secretion and suppress glucagon secretion, thereby improving glucose metabolism [32–34].

Recently, it was shown that gastric bypass can also bring about significant improvement in hepatic insulin sensitivity, most likely through reduced hepatic gluconeogenesis and without affecting peripheral insulin sensitivity [35]. Moreover, gastric bypass promotes intestinal gluconeogenesis and stimulates the hepatoporal glucose sensor via a GLUT2-dependent pathway, while the lack of gluconeogenic response is associated with absence
of the anti-diabetic effects following the operation. This finding suggests that, to some extent at least, intestinal gluconeogenesis is involved in the improvement of glucose homoeostasis after RYGB.

Interestingly, RYGB differs from BPD in terms of effects on insulin sensitivity and secretion. While BPD results in rapid improvement of insulin sensitivity, with a consequent reduction of insulin secretion [13,30], RYGB improves diabetes control through increased insulin secretion. Indeed, it has been repeatedly shown that RYGB stimulates gastric inhibitory peptide (GIP) and GLP-1 secretion, with stimulation of insulin secretion as a consequence. Thus, insulin oversecretion together with the quicker absorption of ingested glucose and other carbohydrates could explain the reported postabsorptive episodes of hypoglycaemia.

Also, sporadic cases of nesidioblastosis have been reported after RYGB for morbid obesity [36,37]. Nesidioblastosis refers to inappropriate insulin secretion resulting in recurrent severe hypoglycaemia, and is related to hypertrophy and hyperplasia of the islets of Langerhans. Patients who develop nesidioblastosis after RYGB often experience severe hypoglycaemia that, in a few instances, may require total pancreatectomy [37].

Table 1

<table>
<thead>
<tr>
<th>Authors</th>
<th>Source</th>
<th>Subjects (n)</th>
<th>BMI (kg/m²)</th>
<th>Diabetes /IGT</th>
<th>Time since operation</th>
<th>Diabetes improvement/ remission/ IGT reversal</th>
<th>Type of operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pories WJ et al.</td>
<td>Ann Surg 1987</td>
<td>141</td>
<td>40</td>
<td>88/53</td>
<td>10 days</td>
<td>100%</td>
<td>RYGB</td>
</tr>
<tr>
<td>Rubino F et al.</td>
<td>Ann Surg 2004</td>
<td>6</td>
<td>40</td>
<td>6</td>
<td>3 weeks</td>
<td>100%</td>
<td>RYGB</td>
</tr>
<tr>
<td>Cohen R et al.</td>
<td>Surg Obes Relat Dis 2006</td>
<td>37</td>
<td>&lt;35</td>
<td>37</td>
<td>6 months</td>
<td>97%</td>
<td>RYGB</td>
</tr>
<tr>
<td>Smith BR et al.</td>
<td>Am Surg 2008</td>
<td>59</td>
<td>40</td>
<td>59</td>
<td>1 month</td>
<td>42%</td>
<td>RYGB</td>
</tr>
<tr>
<td>Laferrère B et al.</td>
<td>Diabetes Care 2007</td>
<td>8</td>
<td>&gt;35</td>
<td>8</td>
<td>1 month</td>
<td>100%</td>
<td>RYGB</td>
</tr>
<tr>
<td>Laferrère B et al.</td>
<td>JCEM 2008</td>
<td>9</td>
<td>35</td>
<td>9</td>
<td>1 month</td>
<td>100%</td>
<td>RYGB</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>207</td>
<td>40</td>
<td>88/53</td>
<td></td>
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</tr>
</tbody>
</table>

5. Effects of energy restriction on diabetes

One of the most relevant challenges in the study of the pathophysiology of metabolic surgery and, in particular, its rapid effect on glucose disposal, is to differentiate the role of the operation per se from the effects of energy restriction. A number of studies have shown marked improvement of plasma glucose in type 2 diabetics that was disproportionate to the weight loss and after only short periods of energy restriction [38]. However, the factors responsible for the early benefits of energy restriction on glycaemia are still not clear, partly because of the difficulty in isolating the effects of energy restriction from those of weight loss when the first measurements are taken 7–10 days into the diet [38]. Nevertheless, one study demonstrated clear glycaemic benefits with energy restriction [39], including an associated improvement in insulin sensitivity, but failed to address the hepatic vs peripheral contributions or the determinants of basal glycaemia.

Similarly, it is difficult to isolate the effects of weight loss from those of energy restriction. Four days of dieting (reducing energy intake by around 1000 kcal/d) led to a large increase in insulin suppression of hepatic glucose output and, thus, increased hepatic insulin sensitivity [40], and continuation of the diet for
6. Conclusion

Although no large trials have specifically addressed the effects of bariatric or metabolic surgery on remission or reversal of type 2 diabetes, independent of weight loss and/or caloric restriction, there are sufficient data from the literature to suggest that this type of surgery—and, specifically, RYGB and BPD—can bring about early improvement of glucose control that is independent of weight loss. Although the specific mechanism of action underlying this early consequence of the RYGB and BPD procedures has yet to be elucidated, at present at least, it appears that the major players are probably incretins and, possibly, anti-incretins and intestinal gluconeogenesis.

Conflicts of interests

The authors have reported no conflict of interests.

References


