Increased plasma levels of N-terminal brain natriuretic peptide (NT-proBNP) in type 2 diabetic patients with vascular complications

S Beer¹, S Golay², D Bardy³, F Feih³, RC Gaillard¹, C Bachmann³, B Waebër², J Ruiz¹

Summary

Aims: The plasma levels of either brain natriuretic peptide (BNP) or the N-terminal fragment of the prohormone (NT-proBNP) have recently gained extreme importance as markers of myocardial dysfunction. Patients with type 2 diabetes are at high risk of developing cardiovascular complications. This study was aimed to assess whether plasma NT-proBNP levels are at similar levels in type 2 diabetics with or without overt cardiovascular diseases.

Methods: We assayed plasma NT-proBNP in 54 type 2 diabetics, 27 of whom had no overt macro- and/or microvascular complications, while the remaining ones had either or both. The same assay was carried out in 38 healthy control subjects age and sex matched as a group with the diabetics.

Results: Plasma NT-proBNP was higher in diabetics (median 121 pg/ml, interquartile range 50-240 pg/ml) than in those without complications (37 pg/ml, 21-54 pg/ml, P < 0.01). Compared with the controls (55 pg/ml, 40-79 pg/ml), only diabetics with vascular complications had significantly increased plasma NT-proBNP levels (P < 0.001). In the diabetics, coronary heart disease and nephropathy (defined according to urinary excretion of albumin) were each independently associated with elevated values of plasma NT-proBNP.

Conclusions: In type 2 diabetes mellitus, patients with macro- and/or microvascular complications exhibit an elevation of plasma NT-proBNP levels compared to corresponding patients with no evidence of vascular disease. The excessive secretion of this peptide is independently associated with coronary artery disease and overt nephropathy. The measurement of circulating NT-proBNP concentration may therefore be useful to screen for the presence of macro- and/or microvascular disease.

Key-words: Diabetes mellitus, type 2 · Natriuretic peptide, brain · Myocardial diseases · Coronary disease · Diabetic nephropathy.

Mots-clés : Diabète de type 2 · Peptide natriurétique · Maladie coronarienne · Maladies cardiaques · Néphropathie diabétique · Complications vasculaires.

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**Introduction**

Brain natriuretic peptide (BNP) is a 32-amino-acid peptide first described in porcine brain [1], and later found to be synthetized also by cardiac myocytes [2]. In humans the left ventricle subjected to an increased wall tension is the main source of BNP. In the circulation, the peptide is present not only as BNP, but also as an inactive N-terminal pro-BNP (NT-proBNP) resulting from the cleavage of the precursor form of BNP (proBNP). The actions of BNP are similar to those of the atrial natriuretic peptide (ANP), which is produced primarily by atrial tissue, and include enhanced renal sodium and water excretion, vasorelaxation, and suppression of the activity of the renin-angiotensin-aldosterone system. Abnormally high plasma levels of BNP and/or NT-proBNP have been found in a number of pathological states, in particular in patients with cardiac failure or hypertrophy [2-5]. This led to consider the measurement of these peptides as a useful tool for the early detection of left-ventricular abnormalities.

Patients with type 2 diabetes represent a high risk population in terms of cardiovascular and renal complications [6-8]. Such patients show a disproportionate increase in left-ventricular dysfunction and left-ventricular hypertrophy [9]. Increased plasma BNP levels have been reported in certain patients with type 2 diabetes, in association with coronary heart disease [10], and BNP screening has been proposed for the easy identification of subclinical diabetic cardiomyopathy [9]. Other studies suggest that elevated plasma BNP level could also be a marker of incipient microvascular complications, including diabetic nephropathy [11] and retinopathy [12].

In a recent study, BNP levels were reported to be a reliable predictor of cardiac and all-cause mortality in diabetic patients [13]. Actually, elevated plasma levels of NT-proBNP have been reported in type 2 diabetics without overt cardiovascular disease compared with non-diabetic controls [14], but it is still unclear whether there exists a difference in terms of BNP secretion between type 2 diabetes with or without macro- and/or microvascular disease. The present study was carried out in a cohort of unselected patients with type 2 diabetes in an attempt to answer this specific question.

**Methods**

We recruited 54 consecutive patients with type 2 diabetes referred to our outpatient clinic. The diagnosis of type 2 diabetes was based on the 1998 WHO criteria [15]. Thirty-eight healthy subjects matched for gender and age served as controls. The latter had all a fasting glycaemia < 6.1 mmol/l, a body mass index (BMI) < 30 kg/m² and a blood pressure (BP) < 140/90 mmHg. They had no past history of heart, lung, kidney, endocrine or liver disease and were not taking any medication. The protocol was approved by the Ethics Committee at our institution, and carried out in accordance with the principles of the Declaration of Helsinki as revised in 2000. Informed consent was obtained in writing from all subjects.

Our diabetic patients were routinely screened for macro- and microangiopathy (history of claudication or stroke, examination of carotid and peripheral arteries, eye fundoscopy by an ophthalmologist). In presence of two or more risk factors on top of diabetes a myocardial radionuclide scintigraphy or a stress echocardiography was performed [16]. This was followed by a coronarography if required. Coronary heart disease was considered present if anyone of the following criteria was met: history of transmural myocardial infarction, history of coronary angioplasty, history of coronary bypass surgery, positive evidence for coronary artery disease on either an exercise tolerance test, a stress echocardiogram, a myocardial scintigraphy, or a coronary angiogram. Ultrasonographic examinations of carotid and peripheral arteries were obtained where appropriate. Diabetic nephropathy was defined as an albumin creatinine ratio > 2 mg/mmol in a morning urine spot [17,18].

**Assay of plasma NT-proBNP**

The blood sample used to measure plasma NT-proBNP was collected in a 2.7 ml EDTA-coated tube. After centrifugation, the plasma was stored at -20°C. NT-ProBNP was determined using an Elecsys proBNP sandwich immunoassay on an Elecsys 2010 analyzer (Roche, Rotkreuz, Switzerland). The interseries coefficient of variation was 3.6% (n = 16) at a level of 263 ng/l and 3.1% (n = 15) at a level of 5812 ng/l. The analytical range extends from 5 to 35000 ng/l. The intra-assay coefficient of variation was 2.9%.

**Statistical analysis**

Results are presented as means ± SD. Plasma levels of NT-proBNP, due to their skewed distribution, are also summarized as the median and interquartile range. Three groups of subjects (controls, diabetics without any vascular complication, and diabetics with either microvascular or macrovascular complications) were compared with simple parametric analysis of variance (carried out on log-transformed data in the case of plasma NT-proBNP). Where justified by very asymmetric distribution not amenable to logarithmic transform, a Kruskall-Wallis test was used instead. When the F (or chi-square) value was significant, pairwise comparisons were carried out with Dunn’s test (or its
nonparametric adaptation as described [19]). In diabetic patients, association of plasma NT-proBNP with putative predictors was examined with multiple regression. In this analysis, the values for NT-proBNP were log transformed, categorical independent variables were coded as dummies, and a backward elimination algorithm was used (F to enter 0.25, F to remove 0.10). The alpha level of all tests was set at 0.05. All computations were performed with the JMP software, version 3.2.2 (SAS Institute, Cary, NC).

Results

Characteristics of the study population

The baseline characteristics of the study subjects are summarized in Table I. Diabetic patients were divided into 2 subgroups according to the presence (n = 27) or the absence (n = 27) of micro- and/or macrovascular complications. Among the former patients, 9 exhibited microvascular complications and 5 macrovascular complications only, whereas 13 patients had both types of complications. The body mass index (BMI) as well as systolic and diastolic blood pressures were significantly higher in the 2 groups of diabetics than in controls. Mean plasma HDL-cholesterol levels were significantly lower and plasma triglyceride levels significantly higher in diabetics compared with controls. Significant differences in mean levels of HbA1c, fasting and postprandial plasma glucose, fasting plasma insulin, plasma creatinine, and urinary albumin/creatinine ratio were observed between the 2 groups of diabetics. An exercise tolerance test, a coronary angiogram, a stress echocardiogram and a myocardial radionuclide scintigraphy was performed in 6, 5, 24 and 11 patients, respectively. All patients who underwent the echocardiographical examination showed an ejection fraction above 50%.

Table II shows the various treatments received at the time of examination. Blockers of the renin-angiotensin system, β-blockers and antiplatelet agents were taken significantly more often in patients with than in those without vascular complications.

Plasma NT-proBNP levels in diabetic patients versus control subjects

Plasma levels of NT-proBNP are depicted in Figure 1. Analysis of variance on the raw data indicated a signifi-
cantly higher dispersion of data in diabetics with vascular complications, in comparison with the other two groups (P < 0.001, Levene’s test). Subsequent analyses were carried out on log-transformed data. Plasma pro-BNP was on the average higher in diabetics with (median 121 pg/ml, interquartile range 50-240 pg/ml, P < 0.01) than in those without vascular complications (median 37 pg/ml, interquartile range 21-54 pg/ml). Compared with the controls (median 55 pg/ml, interquartile range 40-70 pg/ml), only diabetics with vascular complications had significantly increased plasma NT-proBNP levels (P < 0.001). Expressed as means ± SD, the plasma NT-proBNP levels averaged 62 ± 34 pg/ml in controls, compared with 194 ± 230 and 46 ± 37 pg/ml in diabetic patients with and without complications, respectively.

Table II
Number of patients (%) on various therapies.

<table>
<thead>
<tr>
<th></th>
<th>Diabetics without vascular complications</th>
<th>Diabetics with vascular complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin</td>
<td>13 (48%)</td>
<td>19 (70%)</td>
</tr>
<tr>
<td>Oral antidiabetics</td>
<td>19 (70%)</td>
<td>15 (56%)</td>
</tr>
<tr>
<td>ACE-I or AT1-receptor blocker</td>
<td>14 (52%)</td>
<td>21 (78%)</td>
</tr>
<tr>
<td>b-blocker</td>
<td>0</td>
<td>12 (44%)</td>
</tr>
<tr>
<td>Diuretic</td>
<td>8 (30%)</td>
<td>13 (48%)</td>
</tr>
<tr>
<td>Calcium antagonist</td>
<td>7 (26%)</td>
<td>9 (33%)</td>
</tr>
<tr>
<td>Statin</td>
<td>10 (37%)</td>
<td>16 (59%)</td>
</tr>
<tr>
<td>Antiplatelet agents</td>
<td>9 (33%)</td>
<td>24 (89%)</td>
</tr>
</tbody>
</table>

ACE-I=Angiotensin converting enzyme inhibitor.
NS=not significant.

**Figure 1**
A) diabetics without vascular complications. B) diabetics with vascular complications. Small dots: individual values. Horizontal bars within rectangles: medians and interquartile range. Statistical analysis: parametric analysis of variance on log-transformed data. ** P < 0.01

Association of plasma NT-proBNP levels with specific vascular complications in diabetic patients

In diabetic patients, the presence of either nephropathy, retinopathy, or coronary artery disease, but not of peripheral arteriopathy or arterial hypertension was associated, on univariate tests, with significantly higher plasma levels of NT-proBNP (Table III). Only 4 patients had cerebrovascular disease, precluding any meaningful comparison concerning this specific complication. Because many patients presented with more than one of the conditions listed in Table III, a multivariable approach was applied next, showing that nephropathy and coronary heart disease were each independently associated with elevated values of plasma NT-proBNP (Table IV). Notably, all but one of the 19 patients with nephropathy were hypertensive, whereas 11 of the 35 diabetics without nephropathy were normotensive (P = 0.03, univariate chi-square test).

Discussion

The plasma levels of brain natriuretic peptides are now widely accepted as markers of myocardial dysfunction. In principle, either the active C-terminal (BNP), or the inactive N terminal moieties (NT-proBNP) of the 108 amino acids prohormone convey similar information regarding abnormalities of cardiac function [20]. When screening for abnormalities of cardiac function, the assay of NT-proBNP rather than BNP may be advantageous because a longer biologic half-life (70 minutes, versus 20 minutes for BNP) [21] makes the circulatory levels of this peptide somewhat less susceptible to short-term fluctuations, resulting in a better intraindividual reproducibility of the assay [22]. For this reason, we chose to assay the N-terminal peptide in the present study. In the control group of healthy subjects, we obtained a mean NT-proBNP level (± SD) of 62 ± 32 pg/ml, in reasonable agreement with the values reported by Hunt and associates in similar conditions (10.8 ± 6.8 pmol/l, equivalent to 92 ± 57 pg/ml) [23].

In spite of the high prevalence of myocardial dysfunction in diabetes, there is surprisingly little specific data concerning the plasma levels of brain natriuretic peptides...
NT-proBNP and diabetes

in this pathology. The available studies mostly sought to establish whether the presence of microvascular complications was a determinant of plasma BNP levels, and therefore enrolled patients with or without microalbuminuria or retinopathy, but without overt evidence of heart disease. Results were variable. In 100 subjects with type 2 diabetes who had normal blood pressure and cardiothoracic ratio, no history of coronary heart disease, and no ultrasound evidence of left ventricular hypertrophy, Isotani et al. found mostly normal plasma levels of BNP which did not differ between subjects with and without microangiopathy [24]. Asakawa and associates reported the same findings in another cohort of 100 type 2 diabetics without evidence of cardiac or macrovascular complications [10]. In contrast, data by Yano et al. collected in 42 type 2 diabetics with characteristics similar to those in the Isotani study indicate higher plasma BNP levels in presence than in absence of microalbuminuria (16.7 ± 2.4 vs 9.6 ± 1.3 pg/ml, mean ± SEM, P < 0.01) [11]. Finally, Siebenhofer et al. examined 71 type 1 diabetic patients who had normal echocardiography, no history of coronary artery disease and no end-stage renal disease. Median levels of plasma NT-proBNP were more than four-fold higher in subjects with micro-(187 pg/ml) or macroalbuminuria (193 pg/ml) than in normoalbuminuric subjects (43 pg/ml, P = 0.016 versus both other groups) [25]. Finally, plasma NT-proBNP were measured in 253 patients with type 2 diabetes without overt cardiovascular disease and compared with those determined in 230 matched controls [14]. The diabetic patients showed significantly higher NT-proBNP values than normal counterparts.

In contrast with these studies, no exclusion criteria were applied in the present work, so that patients with and without overt vascular disease were included. Consequently, the collected data are reasonably representative of what may be expected in daily practice, with the caveat that none of our patients had end-stage renal disease. In patients devoid of complications by contrast, both the dispersion and mean value of this marker were abnormally high (194 ± 230 pg/ml). Figure 1 shows the

<table>
<thead>
<tr>
<th>Vascular Complication</th>
<th>Absent</th>
<th>Present</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nephropathy</td>
<td>35</td>
<td>19</td>
<td>&lt; 0.0001</td>
</tr>
<tr>
<td>number of patients</td>
<td>38 (21-56)</td>
<td>136 (83-284)</td>
<td></td>
</tr>
<tr>
<td>plasma NT-proBNP</td>
<td>47 (23-82)</td>
<td>126 (77-262)</td>
<td>0.011</td>
</tr>
<tr>
<td>Retinopathy</td>
<td>41</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>number of patients</td>
<td>47 (23-82)</td>
<td>126 (77-262)</td>
<td></td>
</tr>
<tr>
<td>plasma NT-proBNP</td>
<td>147.5 (78-296)</td>
<td>0.0008</td>
<td></td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>42</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>number of patients</td>
<td>44.5 (22-91)</td>
<td>147.5 (78-296)</td>
<td></td>
</tr>
<tr>
<td>plasma NT-proBNP</td>
<td>102 (54-217)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peripheral arteriopathy</td>
<td>44</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>number of patients</td>
<td>47.5 (22-126)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>plasma NT-proBNP</td>
<td>102 (54-217)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treated arterial hypertension</td>
<td>42</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>number of patients</td>
<td>37.5 (23-54)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>plasma NT-proBNP</td>
<td>57 (28-174)</td>
<td>0.13</td>
<td></td>
</tr>
</tbody>
</table>

Table IV

Independent predictors of plasma NT-proBNP levels in diabetic patients. Stepwise multivariable regression of log-transformed plasma levels of NT-proBNP, using backward elimination. Variables initially included in model: age, sex, duration of diabetes, and presence of specific vascular complications (nephropathy, retinopathy, coronary heart disease, peripheral arteriopathy, and treated arterial hypertension, each included as a separate dummy variable). Ranges in parentheses are 95% confidence intervals.

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Predicted fold increase in plasma NT-proBNP</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nephropathy</td>
<td>1.70 (1.49-1.94)</td>
<td>&lt; 0.0001</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>1.54 (1.32-1.78)</td>
<td>0.006</td>
</tr>
</tbody>
</table>

Table III

Plasma levels of NT-proBNP (pg/ml) in diabetics with and without specific vascular complications.
individual values of plasma NT-proBNP in the control subjects and the 2 groups of diabetics. Further analyses showed that presence of coronary artery disease and nephropathy were two independent predictors of plasma NT-proBNP in the diabetic subjects (Table III). The first association is of course highly expected, as coronary heart disease is a major cause of myocardial dysfunction. The association of plasma NT-proBNP with nephropathy, defined according to urinary excretion of albumin, is consistent with the Isotani as well as the Siebenhofer studies mentioned above [24, 25] and could be due to a number of factors. It could reflect an altered clearance of the peptide by the diseased kidney. Although this possibility cannot be discounted on the basis of our data, it seems unlikely when considering studies in patients with terminal renal failure, in whom the plasma levels of BNP were essentially normal in absence of ultrasonographically detectable myocardial dysfunction [26]. A more plausible link between nephropathy and elevated NT-proBNP implies endothelial dysfunction, which is known to play a pivotal role in the pathogenesis of vascular disease in diabetics [27]. Microalbuminuria not only predicts the future progression of renal disease in patients with type 2 diabetes, but also represents a strong predictor of cardiovascular complications [28]. Notably, microalbuminuria is regarded nowadays as an indicator of endothelial dysfunction [29]. Finally, short term infusions of BNP have caused microalbuminuria in previously normoalbuminuric type 1 diabetics [30], raising the possibility that abnormally high plasma levels of BNP-secondary to cardiac dysfunction -could elicit or amplify a cardiac diagnostic feature of diabetic nephropathy.

Not surprisingly, the treatment was heavier in patients with than in those without vascular complications (Table II). Significant differences were observed with regard to the use of blockers of the renin-angiotensin system, b-blockers and antiplatelet agents. Whether such differences in drug regimen might influence BNP secretion has to be considered, but no clear answer can be given based on data presented herein.

The aim of the present study was not to investigate the relationship between plasma BNP levels and left ventricular mass or function. This explains why only a fraction of our patients underwent an echocardiogram or a myocardial scintigraphy. The primary aim was to assess whether the measurement of BNP might serve as an indicator of macro- and/or microvascular disease in patients with type 2 diabetes. Our findings show that this is indeed the case as increased NT-proBNP levels were independently associated with both overt coronary artery disease and diabetic nephropathy.

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