

# HDL Cholesterol Subfractions and Risk of Developing Type 2 Diabetes Among Pima Indians

ANNE FAGOT-CAMPAGNA, MD  
WILLIAM C. KNOWLER, MD  
K.M. VENKAT NARAYAN, MD

ROBERT L. HANSON, MD  
JINAN SAADDINE, MD  
BARBARA V. HOWARD, PHD

**OBJECTIVE** — To examine the relationships between HDL cholesterol subfractions and the incidence of type 2 diabetes and to evaluate potential sex differences in these relationships.

**RESEARCH DESIGN AND METHODS** — Proportional hazards analyses were performed to examine the relationships between HDL subfractions and the development of type 2 diabetes in Pima Indian women and men. Results were controlled for age, BMI, systolic blood pressure, and 2-h glucose.

**RESULTS** — Some 54 of 123 women and 25 of 50 men developed type 2 diabetes during a mean follow-up of 10 (2–19) years. For women, in separate models, high levels of total HDL, HDL<sub>2a</sub>, and HDL<sub>3</sub> were negatively associated with incidence of type 2 diabetes; results were unchanged in models further controlled for fasting insulin level or alcohol consumption. For men, the results were inconsistent and associated with wide confidence intervals; high total HDL and HDL<sub>3</sub> were positively associated with incidence of type 2 diabetes in models further controlled for fasting insulin level, but the risk estimates were attenuated in models further controlled for alcohol consumption.

**CONCLUSIONS** — High levels of total HDL, HDL<sub>2a</sub>, and HDL<sub>3</sub> were potential protective factors against type 2 diabetes in women after accounting for alcohol consumption and insulin resistance. High levels of total HDL and HDL<sub>3</sub> were predictive of type 2 diabetes in men; the relationship in men appeared to be due to an association with alcohol consumption. The sex differences in the effects of HDL cholesterol may be related to the effects of sex hormones or lipoproteins.

*Diabetes Care* 22:271–274, 1999

Two recent epidemiological studies from different populations (Norwegians and Pima Indians) reported that a high level of HDL cholesterol was a potential protective factor against type 2 diabetes among women, but not among men. These associations persisted in models controlled for age, BMI, blood pressure,

glucose, alcohol consumption, physical activity (1), and insulin resistance (2). HDL cholesterol may thus play a direct role in the incidence of type 2 diabetes. However, a residual confounding effect (e.g., by alcohol consumption, physical activity, insulin resistance, abdominal obesity, or sex hormones) may be partially responsible for

the relationship between HDL cholesterol and type 2 diabetes in women, and the sex difference may be explained by the different sex hormone effects on HDL metabolism. HDL is a heterogeneous group of particles that can be subdivided based on density into larger and more buoyant HDL<sub>2b</sub> and HDL<sub>2a</sub> and smaller, denser HDL<sub>3</sub>. Physical activity (3) and alcohol consumption (4) increase both subfractions, but physical activity predominantly affects HDL<sub>2</sub>, whereas alcohol consumption predominantly affects HDL<sub>3</sub>. Obesity (5) and insulin resistance (6) are associated with low total HDL and HDL<sub>2</sub> and a higher proportion of HDL<sub>3</sub>. Exogenous estrogen increases predominantly HDL<sub>2</sub> (7), whereas testosterone may decrease HDL<sub>2</sub> (8). We report here on the relationship between HDL subfractions (HDL<sub>2b</sub>, HDL<sub>2a</sub>, and HDL<sub>3</sub>) measured in nondiabetic Pima Indians and the subsequent risk of developing type 2 diabetes.

**RESEARCH DESIGN AND METHODS** — Since 1965, the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) has conducted a longitudinal study of type 2 diabetes in the Gila River Indian Community in central Arizona (9). At each participant's biennial examination, blood pressure, height, and weight were measured, and BMI was calculated as weight (in kilograms) divided by the square of height (in meters). Self-reported levels of alcohol consumption were defined as nondrinking, moderate drinking (less than three drinks daily), or heavy drinking (three or more drinks a day, including occasional heavy drinking). A 75-g oral glucose tolerance test was administered after an overnight fast. Type 2 diabetes was diagnosed if the 2-h plasma glucose concentration was  $\geq 11.1$  mmol/l (200 mg/dl) (10) or if a glucose concentration  $\geq 11.1$  mmol/l was found in the course of routine medical care (11). Plasma insulin concentrations were determined by the Herbert modification of the radioimmunoassay of Berson and Yalow (12). From 1979 to 1982, plasma lipoproteins were measured at fasting for 1,625 participants

From the Division of Diabetes Translation (A.F.-C., K.M.V.N., J.S.), National Center for Chronic Disease Prevention and Health Promotion, Centers for Diseases Control and Prevention, Atlanta, Georgia; the National Institute of Diabetes and Digestive and Kidney Diseases (W.C.K., R.L.H.), National Institutes of Health, Phoenix, Arizona; and the Medlantic Research Institute (B.V.H.), Washington, DC.

Address correspondence to Dr. Anne Fagot-Campagna, Division of Diabetes Translation, National Center for Chronic Diseases Prevention and Health Promotion, CDC, 4770 Buford Hwy, NE (MS-K68), Atlanta, GA 30341-3724. E-mail: adf8@cdc.gov.

Received for publication 8 September 1998 and accepted in revised form 26 October 1998.

**Abbreviations:** HRR, hazards rate ratio; NIDDK, National Institute of Diabetes and Digestive and Kidney Diseases.

A table elsewhere in this issue shows conventional and Système International (SI) units and conversion factors for many substances.

Table 1—Characteristics of participants at baseline

	Women	Men
<i>n</i>	123	50
Age (years)	41 ± 14	42 ± 11
BMI (kg/m <sup>2</sup> )	32 ± 7	32 ± 7
Systolic blood pressure (mmHg)	117 ± 16	131 ± 21
2-h glucose (mmol/l)	7.1 ± 1.9	6.6 ± 2.0
Fasting insulin (pmol/l)	160 (75–336)	169 (60–360)
Triglycerides (mmol/l)	1.23 (0.70–2.17)	1.49 (0.82–2.61)
Total cholesterol (mmol/l)	4.51 ± 0.85	4.79 ± 0.74
Total HDL (mmol/l)	1.17 (0.83–1.59)	1.14 (0.89–1.62)
HDL <sub>2b</sub> (mmol/l)	0.15 (0.06–0.37)	0.11 (0.05–0.31)
HDL <sub>2a</sub> (mmol/l)	0.25 (0.15–0.44)	0.20 (0.10–0.39)
HDL <sub>3</sub> (mmol/l)	0.74 ± 0.15	0.81 ± 0.14
Alcohol consumption		
None	69 (82)	33 (16)
Moderate	26 (31)	48 (23)
Heavy	5 (6)	19 (9)

Data are means ± SD, geometric means (10th–90th percentiles), or % (*n*).

aged ≥15 years. HDL subfractions were measured for the 512 of these participants who had sufficient sera available, of whom 173 (50 men and 123 women) did not have diabetes at baseline and had at least one follow-up examination. Venous blood samples were collected in EDTA after an overnight fast. Plasma was separated after centrifugation at ~700g for 15 min at 10°C. A sample was removed for measurement of total cholesterol and triglyceride. Lipoproteins were isolated by using ultracentrifugation procedures previously described (13). Recovery of cholesterol in the lipoprotein fractions isolated by ultracentrifugation averaged 94%. Triglycerides and cholesterol in plasma and isolated lipoproteins were quantified by using an autoanalyzer II (Technicon Instruments, Tarrytown, New York) with the cholesterol extraction method of Rush et al. (14) and the triglyceride enzymatic method of Bucolo and David (15). These assays were standardized with control plasma calibration pools supplied by the Centers for Disease Control and Prevention (CDC) (Atlanta, GA), so that the assays were comparable to those of the Lipid Research Clinics. HDL<sub>2b</sub>, HDL<sub>2a</sub>, and HDL<sub>3</sub>, the first one being the largest and most buoyant, were isolated from HDL by ultracentrifugation (16). Recovery of total HDL cholesterol in the HDL subfractions isolated by ultracentrifugation averaged 102%. The coefficient of variation for the measurement of control pools was 2.8% for HDL cholesterol. The study was approved by the institutional

review board of the NIDDK and by the Gila River Indian Community.

Data were separately analyzed for men and women. Logarithms of total HDL, HDL<sub>2a</sub>, and HDL<sub>2b</sub>, cholesterol, triglyceride, and fasting insulin were used to normalize the respective distributions. Alcohol consumption was included in the analyses as two dichotomous indicator variables, moderate drinking (yes or no) and heavy drinking (yes or no), which were included together in the models.

The 50 men and 123 women who were selected for these analyses because they had HDL subfraction measurements (and sera available) were compared with the 215 men and 399 women who were included in the previously published analysis (2), for whom no HDL subfraction measurement was made. Men and women with HDL subfraction measurements were older ( $P < 0.0001$ ) than men and women with no measurement, and men with measurements had higher age-adjusted fasting insulin ( $P = 0.03$ ) and glucose levels ( $P = 0.02$ ) than men with no measurement. No difference in total cholesterol, total HDL cholesterol, or triglyceride levels was observed between the two groups of men or women.

The relationship between each baseline lipid measurement and incidence of type 2 diabetes was assessed by Cox's proportional hazards regression analysis (17) in separate models. The hazard rate ratio of developing type 2 diabetes was calculated by comparing the 90th with the 10th percentile of

each continuous variable. Interaction terms among predictor variables, evaluated by the likelihood ratio test (18), were not significant. The validity of the proportionality assumption for fixed covariates was determined as suggested by Kalbfleisch and Prentice (19). Proportional hazards models were stratified by 2-h glucose quartiles at baseline because 2-h plasma glucose violated the proportionality assumption.

**RESULTS** — The characteristics of the 123 women and 50 men at baseline are described in Table 1. During a mean of 10 (range 2–19) years of follow-up, 54 (44%) women and 25 (50%) men developed type 2 diabetes. For women, age (hazards rate ratio [HRR] = 3.3, 95% CI [1.4–7.8]) was a risk factor, as well as 2-h glucose (HRR = 3.6 [1.6–8.0]), systolic blood pressure (HRR = 2.0 [1.0–4.1]), and fasting insulin (HRR = 4.0 [2.1–7.6]), in separate models controlled for age. For men, BMI (HRR = 6.7 [2.3–20]), 2-h glucose (HRR = 5.0 [1.5–17]), and heavy drinking (HRR = 4.7 [1.4–16]) were significant risk factors for type 2 diabetes in separate models controlled for age.

Table 2 presents HRRs and 95% CIs for total HDL and subfractions as risk factors for type 2 diabetes by sex. For women, high levels of total HDL, HDL<sub>2a</sub>, and HDL<sub>3</sub> were protective factors against type 2 diabetes in separate models controlled for age, BMI, systolic blood pressure, and 2-h glucose; however, the effect of HDL<sub>2b</sub> was not statistically significant. Further controlling for fasting insulin, alcohol consumption, or total triglyceride level did not modify these results. Excluding women who were pregnant ( $n = 2$ ) or taking oral contraceptives ( $n = 4$ ) or antihypertensive treatment ( $n = 9$ ) also did not modify these results (data not shown).

For men, the relationships between total HDL and subfractions and the incidence of type 2 diabetes was inconsistent and associated with wide confidence intervals. A high level of total HDL cholesterol was positively associated with an increased incidence of type 2 diabetes in a model controlled for age, BMI, systolic blood pressure, and 2-h glucose, but the relationship was only statistically significant when fasting insulin was added to the model. A high level of HDL<sub>3</sub> was a risk factor for diabetes for men in a model controlled for age, BMI, systolic blood pressure, and 2-h glucose. This risk was enhanced when further controlled for fasting insulin, but was not

Table 2—HRRs and 95% CI for HDL cholesterol subfractions and incidence of type 2 diabetes

Separate models controlled for	Age	Age, BMI, sBP, and 2-h glucose	Age, BMI, sBP, 2-h glucose and fasting insulin*	Age, BMI, sBP, 2-h glucose and alcohol consumption†
Women				
HDL	0.31 (0.15–0.62)	0.29 (0.13–0.63)	0.32 (0.14–0.73)	0.28 (0.13–0.63)
HDL <sub>2b</sub>	0.51 (0.23–1.1)	0.48 (0.20–1.2)	0.56 (0.22–1.4)	0.49 (0.20–1.2)
HDL <sub>2a</sub>	0.32 (0.16–0.63)	0.29 (0.14–0.59)	0.37 (0.18–0.78)	0.30 (0.15–0.60)
HDL <sub>3</sub>	0.38 (0.21–0.72)	0.48 (0.25–0.90)	0.46 (0.23–0.92)	0.43 (0.22–0.85)
Men				
HDL	1.1 (0.45–2.6)	3.1 (0.91–11)	6.4 (1.3–31)	1.5 (0.35–6.9)
HDL <sub>2b</sub>	0.63 (0.23–1.7)	1.2 (0.25–6.2)	1.4 (0.26–7.7)	0.16 (0.01–1.4)
HDL <sub>2a</sub>	1.1 (0.43–3.1)	2.6 (0.64–10)	4.1 (0.84–20)	1.0 (0.21–4.9)
HDL <sub>3</sub>	1.6 (0.64–3.8)	3.8 (1.2–13)	12 (1.8–83)	2.9 (0.69–12)

Data are HRR (95% CI) and are taken from 123 women (54 diabetic patients) and 50 men (25 diabetic patients). Values were obtained from a comparison of the 90th with the 10th percentile using the proportional hazards model. Because of missing values for fasting insulin or alcohol consumption, numbers were \*120 women (51 diabetic patients) and 47 men (23 diabetic patients) and †118 women (52 diabetic patients) and 48 men (23 diabetic patients). sBP, systolic blood pressure.

significant in a model controlled for alcohol consumption. HDL<sub>2a</sub> and HDL<sub>2b</sub> had no significant effect on the incidence of type 2 diabetes for men.

**CONCLUSIONS** — In an earlier report (2), we showed that a high level of HDL cholesterol was a potential protective factor for type 2 diabetes among Pima Indian women but not among men, and similar findings were later described in a Norwegian population (1). In a smaller subgroup of the Pima population, we have now found that high levels of total HDL, HDL<sub>2a</sub>, and HDL<sub>3</sub> were strong potential protectors against type 2 diabetes in women, while high levels of total HDL and HDL<sub>3</sub> were potential risk factors for type 2 diabetes in men in models controlled for age, BMI, systolic blood pressure, 2-h glucose, and fasting insulin. In models that further controlled for alcohol consumption, high levels of total HDL and HDL<sub>3</sub> were less strongly and not significantly predictive of type 2 diabetes in men.

For women, high levels of HDL<sub>2a</sub> and HDL<sub>3</sub>, but not HDL<sub>2b</sub> (which is the largest, most buoyant, and most cardioprotective subfraction) were potential protectors against type 2 diabetes. However, the subfraction HDL<sub>2b</sub> corresponds to a very small proportion of HDL among Pima Indians, and HDL<sub>2a</sub> (which is larger and less dense than HDL<sub>3</sub>) had a slightly stronger protective effect in women than did HDL<sub>3</sub>. Adjustment for alcohol consumption, which predominantly increases HDL<sub>3</sub> (4), did not affect the relationships between HDL<sub>2a</sub> and HDL<sub>3</sub> and type 2 diabetes in women. Abdominal obesity (5) and insulin resis-

tance (6) are associated with a decreased concentration of HDL<sub>2</sub> and a higher proportion of HDL<sub>3</sub>. However, we controlled for BMI, which has a predictive value for type 2 diabetes similar to that of waist circumference among Pima Indians (20), and for fasting insulin, which is a good estimate of insulin resistance among nondiabetic individuals (21), and HDL<sub>2a</sub> and HDL<sub>3</sub> were still strong protectors against type 2 diabetes. Data on physical activity, which increases all subfractions, but predominantly HDL<sub>2</sub> (3), were not available for the present analysis. However, the range of physical activity is low among Pima Indian women and is lower than that among men (22). Therefore, physical activity is not likely to be responsible for the relationships with type 2 diabetes found for women.

Other factors not measured in the present study that could be involved in the relationships between HDL subfractions and incidence of type 2 diabetes include dietary and genetic factors and sex hormones. First, sex hormones are more related to HDL<sub>2</sub> than to HDL<sub>3</sub> (7,8), and high HDL<sub>2a</sub> had a slightly stronger protective effect on type 2 diabetes than HDL<sub>3</sub> did in women. Furthermore, we observed sex differences for the relationships between total HDL (2) and HDL subfractions and incidence of type 2 diabetes; high levels of total HDL and its subfractions were generally protective in women, while they were associated with a high incidence of type 2 diabetes in men. The present finding of an association of high total HDL levels with increased risk for type 2 diabetes in men is at odds with a previous analysis involving a larger group of men (2). Although the

subgroup of women did not differ substantially from its original population except for age, the subgroup of men also had higher glucose and insulin levels, and this may partially explain the discrepancies between the present and previous results (2) among men. Furthermore, controlling for alcohol consumption, which predominantly increases HDL<sub>3</sub> (4) and was a risk factor for type 2 diabetes in men in the present analysis, diminished the relationship between total HDL and HDL<sub>3</sub> and type 2 diabetes in men. Moderate to heavy drinking has been reported as a risk factor for type 2 diabetes in men (23) and not in women (23,24) in other populations. The present study suggests that heavy or binge drinking may be a risk factor for diabetes among Pima Indian men. This study also suggests that, if high HDL and HDL<sub>3</sub> levels predicted diabetes in men, this was due to a confounding effect of heavy or binge drinking. However, the analysis of the relationship between HDL subfractions and type 2 diabetes in men was limited by the small number of cases among men. The parameter estimates were unstable and the confidence intervals were wide among men, but not among women, and the present study was therefore inconclusive in men. Finally, it is also possible that high HDL<sub>2a</sub> and HDL<sub>3</sub> levels directly influence the risk of developing diabetes, which could be mediated by decreasing insulin resistance or affecting insulin secretion.

We suggest that both high levels of HDL<sub>2a</sub> and HDL<sub>3</sub> are potential protectors against type 2 diabetes in women. The sex difference in the relationship between HDL cholesterol and type 2 diabetes (2) suggests

that sex hormone activity, which may modify both HDL<sub>2</sub> and HDL<sub>3</sub>, may be involved in the mechanism. The role of HDL cholesterol subfractions and sex hormone activity on the incidence of type 2 diabetes should be further studied and may explain part of the attenuated sex differences in cardiovascular diseases between diabetic and nondiabetic individuals (25).

**Acknowledgments** — The authors would like to thank the members of the Gila River Indian Community who participated in the study and the staff of the Diabetes and Arthritis and Epidemiology Section, NIDDK, for their assistance.

**References**

1. Njölstad I, Arnesen E, Lund-Larsen PG: Sex differences in risk factors for clinical diabetes mellitus in a general population: a 12-year follow-up of the Finnmark study. *Am J Epidemiol* 47:49–58, 1998
2. Fagot-Campagna A, Narayan KMV, Hanson RL, Imperatore G, Howard BV, Nelson RG, Pettitt DJ, Knowler WC: Plasma lipoproteins and incidence of non-insulin-dependent diabetes mellitus in Pima Indians: protective effect of HDL cholesterol in women. *Atherosclerosis* 128:113–119, 1997
3. Goldberg L, Elliot DL: The use of exercise to improve lipid and lipoprotein levels. In *Exercise for Prevention and Treatment of Illness* Goldberg L, Elliot DL, Eds. Philadelphia, PA, Davis FA. Company, 1994, p.189–210
4. Srivastava LM, Vasisht S, Agarwal DP, Goedde HW: Invited review: Relation between alcohol intake, lipoproteins and coronary heart disease: the interest continues. *Alcohol Alcohol* 9:11–24, 1994
5. Laakso M, Pyörälä K: Adverse effects of obesity on lipid and lipoprotein levels in insulin-dependent and non-insulin-dependent diabetes. *Metabolism* 39:117–122, 1990
6. Tilly-Kiesi M, Knudsen P, Groop L, Taskinen MR: Hyperinsulinemia and insulin resistance are associated with multiple abnormalities of lipoprotein subclasses in glucose-tolerant relatives of NIDDM patients. *J Lipid Res* 37:1569–1578, 1996
7. Sacks FM, Walsh W: Sex hormones and lipoprotein metabolism. *Curr Opin Lipidol* 5:236–240, 1994
8. Asscheman H, Gooren LJJ, Megens JAJ, Kloosterboer HJ, Eikelboom F: Serum testosterone level is the major determinant of the male-female differences in serum levels of high-density lipoprotein (HDL) cholesterol and HDL<sub>2</sub> cholesterol. *Metabolism* 43:935–939, 1994
9. Bennett PH, Burch TA, Miller M: Diabetes mellitus in American (Pima) Indians. *Lancet* ii:125–128, 1971
10. World Health Organization: *Diabetes Mellitus: Report of a WHO Study Group* Geneva, World Health Org., 1985, p. 1–113 (Tech. Rep. Ser., no. 727)
11. Knowler WC, Bennett PH, Hamman RF, Miller M: Diabetes incidence and prevalence in Pima Indians: a 19-fold greater incidence than in Rochester, Minnesota. *Am J Epidemiol* 108:497–505, 1978
12. Herbert VJ, Gottlieb CW, Bleicher SJ: Coated charcoal immunoassay of insulin. *J Clin Endocrinol Metab* 5:1375–1384, 1995
13. Howard BV, Davis MP, Pettitt DJ, Knowler WC, Bennett PH: Plasma and lipoprotein cholesterol and triglyceride concentrations in the Pima Indians: distributions differing from those of Caucasians. *Circulation* 68:714–724, 1983
14. Rush RL, Leon L, Turrell J: Automated simultaneous cholesterol and triglyceride determination on the Auto analyzer instrument. In *Advances in Automated Analyses* Miami, FL, Thurman, 1970, p. 503
15. Bucolo G, David H: Quantitative determination of serum triglycerides by the use of enzymes. *Clin Chem* 19:476–482, 1973
16. Anderson DW, Nichols AV, Pan SS, Lindgren FT: High density lipoprotein distribution: resolution and determination of three major components in a normal population sample. *Atherosclerosis* 29:161–167, 1978
17. Cox DR: Regression models and life tables. *J R Stat Soc [B]* 34:187–220, 1972
18. Breslow NE, Day NE: Unconditional logistic regression for large strata. In *Statistical Methods in Cancer Research. Vol I: The Analysis of Case-Control Studies* (IARC publication no. 32). Lyon, France, International Agency for Research on Cancer, 1980, p. 191–259
19. Kalbfleisch JD, Prentice RL: Likelihood construction and further results on the proportional hazards model. In *Statistical Analysis of Failure Time Data* New York, John Wiley, 1980:119–142
20. Warne DK, Charles MA, Hanson RL, Jacobsson LTH, McCance DR, Knowler WC, Pettitt DJ: Comparison of body size measurements as predictors of NIDDM in Pima Indians. *Diabetes Care* 18:435–439, 1995
21. Laakso M: How good is insulin level for insulin resistance? *Am J Epidemiol* 137:959–965, 1993
22. Kriska AM, LaPorte RE, Pettitt DJ, Charles MA, Nelson RG, Kuller LH, Bennett PH, Knowler WC: The association of physical activity with obesity, fat distribution and glucose intolerance in Pima Indians. *Diabetologia* 36:863–869, 1993
23. Holbrook TL, Barrett-Connor E, Wingard DL: A prospective population-based study of alcohol use and non-insulin-dependent diabetes mellitus. *Am J Epidemiol* 132:902–909, 1990
24. Stampfer MJ, Colditz GA, Willett WA, Manson JE, Arky RA, Hennekens CH, Speizer FE: A prospective study of moderate alcohol drinking and risk of diabetes in women. *Am J Epidemiol* 128:549–558, 1988
25. Barrett-Connor EL, Cohn BA, Wingard DL, Edelstein SL: Why is diabetes mellitus a stronger risk factor for fatal ischemic heart disease in women than in men? The Rancho Bernardo Study. *JAMA* 265:627–631, 1991

Downloaded from http://diabetesjournals.org/care/article-pdf/22/2/271/448817/10333944.pdf by guest on 19 April 2025