

# C-Reactive Protein and Glycemic Control in Adults With Diabetes

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**OBJECTIVE**—Recent evidence suggests that poor glycemic control is significantly associated with the development of macrovascular complications of diabetes. Studies have indicated that C-reactive protein (CRP) is an important risk factor for cardiovascular disease. The purpose of this study was to determine the relation between CRP and HbA<sub>1c</sub> in a large national sample of individuals with diabetes.

**RESEARCH DESIGN AND METHODS**—A nationally representative sample of noninstitutionalized U.S. adults aged 17 years and over with nongestational diabetes was derived from the National Health and Nutrition Examination Survey III (1988–1994) ( $n = 1,018$ ). Respondents with diabetes were stratified by HbA<sub>1c</sub> level. The main outcome measure was elevated ( $>0.30$  mg/dl) CRP.

**RESULTS**—In unadjusted analyses, respondents with diabetes who had elevated HbA<sub>1c</sub> levels ( $\geq 9.0\%$ ) had a significantly higher percent of elevated CRP than people with low ( $<7\%$ ) HbA<sub>1c</sub> levels ( $P < 0.001$ ). In adjusted regression analysis, after controlling for age, race, sex, smoking, length of time with diabetes, insulin, and BMI, HbA<sub>1c</sub> was significantly associated with an increased likelihood of elevated CRP for HbA<sub>1c</sub>  $>9.0\%$  (OR 2.15, 95% CI 1.07–4.32) and for HbA<sub>1c</sub>  $>11.0\%$  (4.40, 1.87–10.38). Higher HbA<sub>1c</sub> also predicted elevated CRP in the regression model when HbA<sub>1c</sub> was analyzed as a continuous variable (1.20, 1.07–1.34).

**CONCLUSIONS**—In this study, the likelihood of elevated CRP concentrations increased with increasing HbA<sub>1c</sub> levels. These findings suggest an association between glycemic control and systemic inflammation in people with established diabetes.

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C-reactive protein (CRP), a marker of systemic inflammation, is emerging as an independent risk factor for cardiovascular disease (1–3). High CRP levels have been linked to an increased risk of thrombotic events including myocardial infarction (3–5). Elevated CRP levels have also been linked to an increased risk of later development of diabetes (6,7). Furthermore, CRP levels are higher in people with diabetes compared with those without diabetes (8–10). Less

is known about whether CRP in people with diabetes is related to level of glycemic control. Wu et al. (11) found that CRP is associated with HbA<sub>1c</sub> levels; however, people with diabetes were excluded from the study. HbA<sub>1c</sub> was 5.4% in people with low CRP and 5.5% in people with medium or high CRP ( $P < 0.05$ ). Another study found an association between CRP and uncontrolled diabetes in 62 patients, but the study was limited by small a sample size (12).

To provide further insight into the role of inflammation in the development of cardiovascular disease in people with diabetes, we sought to elucidate the link between level of glycemic control and inflammation using a representative national sample. The purpose of the study was to investigate the relation between CRP and HbA<sub>1c</sub> in adults with diabetes.

## RESEARCH DESIGN AND METHODS

A sample of respondents  $\geq 17$  years of age was derived from the National Health and Nutrition Examination Survey III (NHANES III), 1988–1994, a cross-sectional study of a nationally representative sample of noninstitutionalized U.S. residents. Respondents with diabetes were identified using the question, “Has your doctor ever told you that you have diabetes?” Respondents who answered positively to either of two questions regarding having diabetes “confined only to pregnancy” were excluded. Respondents with diabetes were not identified using laboratory data because blood was drawn on only one occasion and because people with diabetes may not have had elevated serum glucose at the time the blood was drawn. The respondents that had a usable sample of serum for analysis for CRP form the basis of this report.

People who had used anti-inflammatory drugs or cholesterol-lowering drugs within the previous 30 days were excluded from the analysis, due to the possible effects the drugs might have on CRP levels (13,14). The use of anti-inflammatory drugs was measured by questions regarding the use of prescription medications along with specific questions about the nonprescription use of aspirin and ibuprofen. Prescribed and over-the-counter nonsteroidal anti-inflammatory drugs (NSAIDs) and corticosteroids were classed as anti-inflammatory medications. The use of cholesterol-lowering drugs was measured by a specific question regarding whether any medication was used for the treatment of elevated cholesterol.

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**Abbreviations:** CRP, C-reactive protein; NHANES III, National Health and Nutrition Examination Survey III; NSAID, nonsteroidal anti-inflammatory drug.

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

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### Dependent variable: C-reactive protein

CRP was measured between 1988 and 1994 on an ongoing basis as part of the NHANES III physical and laboratory examination. Standard phlebotomy techniques were used to obtain specimens. Serum specimens were frozen to  $-20^{\circ}\text{C}$  until analyzed for CRP (Behring Nephelometer Analyzer System; Behring Diagnostics, Somerville, NJ). The lower limit of detection was truncated at 0.30 mg/dl due to the limits of the diagnostic technique used. The value of 0.21 mg/dl was assigned to participants with CRP concentrations below the detection limit of 0.3. This lower limit of detection limited statistical analysis of CRP to elevated or nonelevated, because CRP was noncontinuous across the full range. Further details about the specific methods for laboratory procedures in the NHANES III are available elsewhere (15).

CRP level was evaluated as a dichotomous variable (elevated or not elevated). An elevated level of CRP was defined prospectively, using a cutoff ( $>0.30$  mg/dl) based on previous studies of cardiovascular disease and NHANES III data (11,16).

### Independent variable: HbA<sub>1c</sub>

HbA<sub>1c</sub> was measured in the NHANES III study by the Diabetes Diagnostic Laboratory at the University of Missouri using the Diamat Analyzer System (Bio-Rad Laboratories, Hercules, CA) (17). This ion-exchange high-performance liquid chromatography system measures HbA<sub>1c</sub> and has demonstrated excellent, long-term precision (interassay correlation value 2.0). It was standardized to the reference method that was used for the Diabetes Control and Complications Trial. Further information regarding the specific methods used is available elsewhere (15).

### Control variables

Demographic indicators (age, race, and sex) were included as control variables and categorized as in similar epidemiological studies, because CRP levels are known to vary according to these factors (17). In an effort to determine the independent relation between HbA<sub>1c</sub> level and CRP, additional variables were included that have been shown to influence the level of CRP, including smoking and BMI (8,9,18). Smoking was coded three ways: current smoker, ex-smoker, and never

smoker. BMI was calculated using the weight (in kilograms) divided by height (in meters squared) found in the examination file of the NHANES III and dichotomized at above or below 27 according to risk guidelines of the American Diabetes Association (19). Length of time with diabetes was included as a control variable to account for the greater likelihood of cardiovascular disease (and hence greater likelihood of elevated CRP) with a longer duration of diabetes. Fasting insulin levels were available on participants with diabetes and were included in the regression models as a possible confounding variable. Insulin was measured as a continuous variable in micromoles per milliliter.

### Statistical analysis

All analyses were performed using SUDAAN to account for the complex sampling design of the NHANES III. Respondents were stratified into levels of glycemic control according to level of HbA<sub>1c</sub> in 2% increments (HbA<sub>1c</sub>  $<7.0$ , 7.0–8.9, 9.0–10.9, and  $>11.0\%$ ). We first performed descriptive statistics to compare the demographic characteristics of the HbA<sub>1c</sub> groups using  $\chi^2$  and *t* tests. We then compared the percent of respondents with elevated CRP for each 2% increment of HbA<sub>1c</sub> using  $\chi^2$ .

Next, an adjusted model was constructed using elevated CRP as the response and HbA<sub>1c</sub> (continuous) as the predictor, controlling for the following variables: age, race, sex, smoking, length of time with diabetes, and BMI. Standardized  $\beta$ , *P* values, odds ratios, and 95% CIs were obtained from the logistic regression output. Statistical significance was defined as  $P \leq 0.05$ .

**RESULTS**— A total of 1,614 adults answered yes to the question regarding diabetes in the NHANES III database. After excluding 152 for gestational diabetes and 444 who were taking excluded drugs, 1,018 adults with nongestational diabetes had CRP levels available and were included in this analysis. The demographic and general health characteristics of the participants are described overall and according to level of HbA<sub>1c</sub> in Table 1. Mean percent elevated CRP values also are shown for each HbA<sub>1c</sub> group.

The percent of participants with elevated CRP was compared at different levels of HbA<sub>1c</sub>. For each level of HbA<sub>1c</sub>, the percent of elevated CRP was as follows:

$<7$ , 48.9%; 7–8.9, 45.4%; 9–10.9, 60.7%; and  $\geq 11$ , 70.6%. Overall, 51.5% of participants had elevated CRP. In unadjusted analyses, increasing HbA<sub>1c</sub> was significantly associated with a higher percent of patients with elevated CRP levels ( $P < 0.05$ ).

Results of adjusted logistic regression analyses using HbA<sub>1c</sub> as the predictor variable are shown in Table 2. After controlling for demographic variables, smoking, BMI, fasting insulin level, and length of time with diabetes, HbA<sub>1c</sub>  $>9\%$  and  $>11\%$  remained a significant predictor of elevation of CRP (Table 2). We also evaluated HbA<sub>1c</sub> in the same model using it as a continuous variable. Again we found that HbA<sub>1c</sub> was a significant predictor of elevated CRP (1.20 OR, 95% CI 1.07–1.34), which means that for every 1.0% increase in HbA<sub>1c</sub> there was a 20% increase in the likelihood of having an elevated CRP.

**CONCLUSIONS**— The present study demonstrated that a higher HbA<sub>1c</sub> is significantly associated with a greater likelihood of higher CRP among adults with diabetes. The relation was significant in unadjusted comparisons of the percent of people with elevated CRP according to HbA<sub>1c</sub> level and in logistic regression models to predict elevation of CRP after controlling for age, race, sex, smoking, BMI, insulin level, and length of time with diabetes.

Inflammatory markers such as CRP have been related to the development of insulin resistance and type 2 diabetes (6,7,11,20–22). Previous research has also established that CRP levels are higher in people with diabetes (8) and associated with HbA<sub>1c</sub> in people without diabetes (11). The results of the current study go a step further with the finding that among people with established diabetes, at successively higher levels of HbA<sub>1c</sub> the percent of people with CRP  $>0.30$  mg/dl is significantly higher. The main implication of these findings is that inflammation may not only be implicated in the development of diabetes, but also in ongoing levels of hyperglycemia once diabetes is established.

Due to the cross-sectional design of the study, we cannot infer from these results a cause and effect relation, i.e., whether poor glycemic control leads to inflammation or whether inflammation leads to higher glucose levels (or whether

Table 1—Demographic characteristics of adults with diabetes by HbA<sub>1c</sub> (N = 1,018)

	HbA <sub>1c</sub> level					P*
	Total	<7%	7–8.9%	9–10.9%	≥11.0%	
Age (years)						0.27
17–35	4.7	4.2	2.3	9.1	7.5	
36–50	21.1	20.2	15.7	26.6	35.3	
51–65	34.2	33.1	36.5	33.5	33.3	
66+	40.0	42.5	45.5	30.8	23.9	
Sex						0.30
Male	47.3	46.3	52.8	38.4	51.3	
Female	52.7	53.7	47.2	61.6	48.7	
Race						<0.01
White	74.4	74.1	79.6	70.5	64.6	
Black	14.8	15.1	10.4	16.3	26.6	
Mexican American	5.8	4.7	6.8	6.6	8.2	
Other	5.0	6.1	3.2	6.6	0.6	
Smoking						0.38
Nonsmoker	38.8	44.6	34.1	33.3	36.1	
Ex-smoker	41.0	37.1	46.6	42.8	37.3	
Smoker	20.2	18.3	19.3	23.9	26.6	
BMI (kg/m <sup>2</sup> )						0.41
≥27	61.5	66.0	56.9	57.5	62.1	
<27	38.5	34.0	43.1	42.5	37.9	
Elevated CRP (mg/dl)						0.03
≥0.30	51.5	48.9	45.4	60.7	70.6	
<0.30	48.5	51.1	54.7	39.3	29.4	
Diabetes duration (years)						0.30
<5	44.2	45.3	43.1	42.7	46.1	
5–10	20.2	14.7	27.5	20.2	23.3	
>10	35.6	40.0	29.4	37.1	30.6	
Fasting insulin (μmol/ml)	12.3	11.3	25.4	35.6	38.8	<0.01†

\*Data are % unless otherwise indicated.  $\chi^2$  analysis comparing HbA<sub>1c</sub> groups; †ANOVA test used to test differences between groups.

a third factor influences both). Prospective studies are needed to evaluate that question. However, either direction of causality would have important implications. If poor glycemic control leads to inflammation, then better glycemic control should lower inflammation and therefore lower the risk of cardiovascular complications. If inflammation leads to poor glycemic control, then treatment of inflammation with NSAIDs or hydroxymethylglutaryl-CoA reductase inhibitors may help improve glycemic control. In light of recent findings of an association among inflammatory proteins, endothelial dysfunction, and insulin resistance (23–25), the results of the current study provide additional support for a relation between glycemic control and systemic inflammation in people with established diabetes.

Recent research evidence supports a link between hyperglycemia and inflammation. CRP is known to be higher in

people with impaired glucose tolerance and frank diabetes (8,11). Furthermore, increased CRP has been found to be a risk factor for later development of diabetes (6,20,21). Festa et al. (22) found links between CRP and insulin resistance. Other studies have related hyperglycemia to inflammation by demonstrating simultaneous inflammation, endothelial dysfunction, and insulin resistance at the physiologic level (23,24). One of the several mechanisms proposed is oxidative stress on the endothelium, which promotes inflammation and is enhanced by hyperglycemia (26–28). Such evidence is consistent with the findings in the current study, which further documents the association between hyperglycemia and inflammation in adults with diabetes.

Limitations of this study include the fact that much of the data were by self-report, including the diagnosis of diabetes, use of anti-inflammatory medications, and smoking status. However, self-report

questions have shown good agreement with other measures in previous studies and have proved useful (29,30). Furthermore, the CRP measure used is a different and older technique than the highly sensitive CRP assay developed more recently (2,5). However, the method used was also used and validated in the Diabetes Control and Complications Trial (16). In addition, the current study focused on elevated levels rather than the lower levels detectable by newer methods.

A further limitation of this study is that we were unable to control for the use of thiazolidinedione drugs that can affect CRP (31). However, such medications were not in common use at the time of the survey and were not included in the questions in the NHANES III about medication use.

The current study demonstrates that higher HbA<sub>1c</sub> is significantly associated with elevation of CRP. These results imply a significant relation between inflamma-

Table 2—Adjusted regression model to predict elevation of CRP (&gt;0.30 mg/dl)

Factor	Odds ratio	95% CI	$\beta$	SE $\beta$	P
HbA <sub>1c</sub> (%)					
<7	1.00	1.00–1.00	0.00	0.00	
7–8.9	1.26	0.79–2.00	0.23	0.23	0.32
9–10.9	2.15	1.07–4.32	0.77	0.35	0.03
≥11	4.40	1.87–10.38	1.48	0.43	
Age (years)					
17–35	0.37	0.12–1.19	−0.98	0.58	0.09
36–50	0.64	0.32–1.30	−0.44	0.35	0.21
51–65	0.97	0.60–1.57	−0.03	0.24	0.90
66+	1.00	1.00–1.00	0.00	0.00	
BMI (kg/m <sup>2</sup> )					
≥27	2.17	1.40–3.36	0.22	3.56	
<27	1.00	1.00–1.00	0.00	0.00	
Sex					
Male	1.00	1.00–1.00	0.00	0.00	
Female	2.04	1.25–3.34	0.71	0.24	0.01
Smoking					
Nonsmoker	1.00	1.00–1.00	0.00	0.00	
Ex-smoker	0.98	0.55–1.74	−0.02	0.29	0.94
Smoker	1.29	0.66–2.56	0.26	0.34	0.45
Race					
Non-Hispanic white	1.00	1.00–1.00	0.00	0.00	
Non-Hispanic black	1.43	0.90–2.28	0.36	0.23	0.12
Mexican American	1.20	0.74–1.95	0.19	0.24	0.44
Other	1.78	0.60–5.26	0.58	0.54	0.29
Diabetes duration (years)					
≤5	1.00	1.00–1.00	0.00	0.00	
6–10	0.58	0.34–1.00	−0.54	0.27	0.05
>10	0.71	0.40–1.24	−0.35	0.28	0.22
Insulin	1.01	1.00–1.02	0.01	0.01	0.25

tion and glyceemic control in people with established diabetes. Prospective studies should be conducted to determine the direction of this association; such research would have important implications for the treatment of adults with diabetes.

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