Improvement of Nonalcoholic Fatty Liver Disease With Carnitine-Orotate Complex in Type 2 Diabetes (CORONA): A Randomized Controlled Trial

Diabetes Care 2015;38:1245–1252 | DOI: 10.2337/dc14-2852

OBJECTIVE
We aimed to evaluate the effects of carnitine-orotate complex in patients with nonalcoholic fatty liver disease (NAFLD) and diabetes.

RESEARCH DESIGN AND METHODS
Eight hospitals in Korea participated in this randomized, controlled, double-blind trial of patients with diabetes and NAFLD. Seventy-eight patients were randomly assigned in a 1:1 ratio to receive carnitine-orotate complex (824 mg, three times daily) or matching placebo. The primary study outcome was decline in alanine aminotransferase (ALT) to the normal range. Secondary study outcomes were change in ALT, radiological hepatic steatosis, parameters for anthropometry, liver function, lipid profiles, and glycemic control. Hepatic steatosis was assessed using Hounsfield units on noncontrast computed tomography (CT) imaging with hepatic attenuation.

RESULTS
After 12 weeks of treatment, compared with placebo group, carnitine-orotate complex–treated participants had a significantly higher rate of normalization of serum ALT level (17.9% vs. 89.7%, P < 0.001). On hepatic CT analysis, participants treated with carnitine-orotate complex showed an increased liver attenuation index (0.74 ± 8.05 vs. 6.21 ± 8.96, P < 0.008). A significant decrease in HbA1c was observed in the carnitine-orotate complex group (−0.33 ± 0.82% [−3.6 ± 9.0 mmol/mol], P = 0.007), but no significant change was seen in the placebo group.

CONCLUSIONS
Treatment with carnitine-orotate complex improves serum ALT and may improve hepatic steatosis as assessed by CT in patients with diabetes and NAFLD. Further studies using more advanced magnetic resonance imaging and liver histology as an end point are needed to assess its efficacy in NAFLD.

Ectopic fat accumulation in a visceral organ is associated with insulin resistance (1). As an example of such ectopic fat accumulation, nonalcoholic fatty liver disease (NAFLD) is now recognized as the hepatic component of metabolic syndrome and is even reportedly associated with insulin resistance independent of obesity and other metabolic components. Therefore, NAFLD can be a major determinant of insulin resistance in type 2 diabetes (2–4). In fact, NAFLD is now recognized as the hepatic component of metabolic syndrome and is even reportedly associated with insulin resistance independent of obesity and other metabolic components. Therefore, NAFLD can be a major determinant of insulin resistance in type 2 diabetes (2–4).
The primary study outcome was a decline in the alanine aminotransferase (ALT) to the normal range (30 IU/L in men or <19 IU/L in women) at week 12 in subjects who entered the study with ALT 50–250 IU/L. The secondary study outcomes were change in ALT, radiological hepatic steatosis, other parameters for anthropometry, liver function, lipid profiles, and glycemic control from baseline. Hepatic steatosis was assessed using Hounsfield units (HU) on noncontrast computed tomography (CT) imaging with hepatic attenuation. The study was approved by the independent institutional review boards of each hospital before patient enrollment. Written informed consent was obtained from each participant. The trial was performed in accordance with the Declaration of Helsinki and Good Clinical Practice Guidelines.

Subjects
Individuals aged 20–70 years with known diabetes who met all of the following inclusion criteria were eligible to participate in the study: 1) a previous diagnosis of type 2 diabetes at least 3 months before screening, 2) glycated hemoglobin (HbA1c) greater than 6.4% (46 mmol/mol) or fasting plasma glucose 130–300 mg/dl (inclusive) at screening, and 3) ALT 50–250 IU/L at screening. We excluded subjects with alcohol intake >30 g/day in men or >20 g/day in women, those with positive serologic markers for hepatitis A, B, or C virus at screening, those with known history or clinical evidence of liver cirrhosis (serum total bilirubin ≥1.8 mg/dL, albumin <3.5 g/dL, international normalized ratio ≥1.3, or platelet count <150,000/mm³), and those with other liver disease such as acute hepatitis or drug-induced hepatitis (19). We also excluded subjects taking thiazolidinediones for treatment of diabetes, those who received an antiobesity drug within 1 month before screening, those with a history of malignancy, those with a history of severe heart disease (angioplasty, stent placement, bypass surgery, myocardial infarction, unstable angina pectoris, congestive heart failure, or ventricular arrhythmia within 6 months before screening), and women who were pregnant or lactating.

Individuals who met inclusion and exclusion criteria (n = 88) underwent hepatic CT at each study site. Subjects without fatty liver on hepatic CT (n = 10) were then excluded. Of 123 patients who were screened, 78 were eligible for the study. Among the 88 patients who underwent hepatic CT before randomization, contrast-enhanced CT was performed in 6 (CT protocol deviation). All 6 of these patients with protocol deviation showed fatty liver on the contrast CT image, did not undergo follow-up CT, and were excluded from the hepatic CT attenuation analysis (Supplementary Fig. 1).

Randomization
Investigators enrolled patients, and eligible participants were randomly assigned in a 1:1 ratio to receive the carnitine-orotate complex capsule or matching placebo. The randomization sequence was produced by an independent clinical research organization (Medical Excellence, Seoul, Korea) and was computer-generated and stratified by sites with block sizes of four. Allocation concealment was implemented by use of sequentially numbered, opaque, and sealed envelopes. All patients and investigators were masked to the treatment assignment. The matching placebo capsule was identical in appearance, taste, and smell to the carnitine-orotate complex capsule.

Procedure
After baseline vital signs and anthropometric measurements were collected, participants were randomly assigned to treatment groups and instructed to take the first dose of the study drug at the study site. Randomization was performed within 28 days after the blood sample was collected at the screening visit. Throughout the 12-week treatment period, all trial medications were provided by Celltrion Pharm. Patients were instructed to take the medication as two capsules orally, three times daily after a meal. In the treatment group, a daily dose of carnitine-orotate complex totaled 2,472 mg. Participating patients were instructed to maintain their usual diet and exercise patterns throughout the study period. Participating investigators were instructed to maintain the patient’s usual medication regimen, including antidiabetic, antihypertensive, antiplatelet, and lipid-lowering drugs without changes during the 12-week treatment period. The concurrently used medications were reviewed at every visit.

At screening, participants were surveyed for demographic information,
medical histories, and information on alcohol consumption. Vital sign and anthropometric measurements, except for height, were collected at the screening, on day 1 of treatment (baseline), and at weeks 6 and 12. Height was measured only at screening. Blood samples for hematologic and biochemical assays were obtained from the antecubital vein after an overnight fast (≥12 h) at screening and at weeks 6 and 12. Blood chemistry testing included liver function tests, lipid profile, and glycemic parameters. Serological testing for hepatitis A, B and C was performed at the screening. Changes in insulin resistance were assessed with the HOMA of insulin resistance (HOMA-IR): HOMA-IR = fasting insulin (µIU/mL) × fasting plasma glucose (mmol/L)/22.5. β-Cell insulin secretion was assessed with the HOMA of β-cell function (HOMA-B).

Safety variables were adverse events and abnormal findings related to physical examination, vital signs, and laboratory testing. Treatment-emergency adverse events were analyzed from the time the patient was first given the study drug to 28 days after the end of treatment. All clinical and safety laboratory samples were analyzed by a central laboratory (Neodin Medical Institute, Seoul, Korea; Clinical Laboratory Improvement Amendments certified) using standard validated methods. Plasma ALT was measured by the enzymatic method using a commercial kit (Sekisui Medical, Tokyo, Japan) on a Hitachi 7180 biochemical analyzer (Hitachi Ltd., Tokyo, Japan). Measurement of HbA1c was performed using high-performance liquid chromatography with a Tosoh HLC-723 G8 automatic analyzer (Tosoh Corp., Tokyo, Japan).

CT Imaging
Noncontrast CT scans of the liver were performed before randomization at 120 kVp, 50–75 mAs, and 5-mm slice thickness. Liver CT examinations for follow-up were performed at the end of the study visit (week 12) in the same way. Contiguous transverse images were obtained from the dome of the diaphragm to the bottom of the liver during a single breath hold. All scans were performed in each hospital, and five different multidetector CT scanners were used, including a 16-detector LightSpeed Ultra 16 (GE Healthcare Milwaukee, WI) (n = 12), a 16-detector Somatom Sensation 16 (Siemens Healthcare, Forchheim, Germany) (n = 20), a 64-detector LightSpeed VCT (GE Healthcare) (n = 18), a 64-detector Brilliance 64 (Philips Healthcare, Best, the Netherlands) (n = 12), and a 128-detector Somatom Definition AS+ (Siemens Healthcare) (n = 16).

Images were reviewed on a picture archiving and communication system (Centricity 1.0; Integrated Imaging Solutions, GE Medical Systems, Mt. Prospect, IL) monitor by one abdominal radiologist blinded to patient data and randomization status. When interpreting follow-up CT images, the radiologist was also blinded to initial CT image results. Hepatic steatosis was assessed using HU on CT with hepatic attenuation. For each case, the hepatic attenuation was measured by means of 12 circular regions of interest (ROIs) on three transverse sections at different hepatic levels containing the confluence of the right hepatic vein, the umbilical portion of left portal vein, and the posterior branch of the right portal vein. At each representative level, the liver was divided into four sectors (right posterior, right anterior, left medial, and left lateral). One ROI was randomly drawn inside each sector, avoiding the large vessels and any focal lesions. Mean splenic attenuation was also calculated by three random area ROI values of attenuation measurement on three transverse sections at different splenic levels. The size of each ROI was defined as 1.0–1.1 cm² (20). With splenic attenuation acting as a control or reference value, the liver attenuation index (LAI), defined as the difference between mean hepatic attenuation and mean splenic attenuation, was used as an indicator of the degree of hepatic steatosis. Fatty liver disease was defined as a LAI below 5 HU on the unenhanced hepatic CT image at screening (21) and as an LAI below −18.5 HU on the contrast-enhanced CT image (22). LAI in all subjects who underwent contrast-enhanced CT (n = 6) was evaluated between 80 and 120 s after injection of a contrast bolus.

Statistical Analyses
Except for hepatic fat content analysis, all randomly assigned patients (intention to treat) were included in the analysis of results (Supplementary Fig. 1). The independent t test and paired t test were used for analyzing normally distributed continuous variables. The Wilcoxon rank sum test, Wilcoxon signed rank test, and Kruskal-Wallis test were used for analyzing nonnormally distributed continuous variables. Differences in baseline characteristics between carnitine-orotate complex and placebo groups were analyzed using the independent t test or the Wilcoxon rank sum test. Intrasubject differences in variables between baseline and week 12 were analyzed using the paired t test or the Wilcoxon signed rank test with last observation carried forward imputation. The Wilcoxon rank sum test or the independent t test was used for comparing the changes in all baseline variables between treatment groups except ALT, aspartate aminotransferase (AST), and BMI. Because the baseline BMI, AST, and ALT levels were higher in the carnitine-orotate complex group, ANCOVA with baseline values as covariates was used for analyzing the changes in these variables between treatment groups. Simple correlation analysis was performed between the change in ALT levels and the change in the LAI. When subjects who underwent follow-up CT scan were classified into tertiles by LAI changes from baseline at 12 weeks, the Kruskal-Wallis test was used to compare the changes in variables between tertile groups. Statistical data analysis was performed using SAS 9.3.1 software (SAS Institute, Inc., Cary, NC). All the reported P values are two-tailed, and statistical significance was set at P < 0.005.

The sample size was calculated assuming that the proportion of patients with a decline in ALT to the normal range at week 12 would be 65% in the treatment group and 30% in the placebo group. A sample size of 64 patients would provide statistical power of 82%, with two-sided α level of 0.05. A final sample size of 78 was selected assuming 20% lost to follow-up.

RESULTS
The participants were obese, with a mean BMI of 27.4 kg/m² and waist circumference of 93.7 cm. Participants were a mean age of 51 years, and 69% were men. Baseline clinical characteristics of the two randomized treatment groups were similar, except for the BMI, AST, and ALT levels, which were higher in the carnitine-orotate complex group than in the placebo group (Table 1). In particular,
Effect of Carnitine-Orotate Complex on NAFLD in men or placebo group (only 17.9% showed normalization in the normalization of serum ALT levels (carnitine-orotate complex showed normalization). Randomized treatment groups at baseline. No differences were seen in mean liver attenuation level, LAI, glycemic level, or adverse event (rib fracture) was reported by one patient in the placebo group (Supplementary Table 1).

### Table 1—Baseline characteristics of participants

<table>
<thead>
<tr>
<th></th>
<th>Carnitine complex (n = 39)</th>
<th>Placebo (n = 39)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>50.6 ± 9.3</td>
<td>52 ± 9.4</td>
<td>0.522*</td>
</tr>
<tr>
<td>Male</td>
<td>25 (64.1)</td>
<td>29 (74.4)</td>
<td>0.326†</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>76.3 ± 11.5</td>
<td>74.8 ± 12.0</td>
<td>0.567*</td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
<td>28.2 ± 2.6</td>
<td>26.7 ± 3.7</td>
<td>0.007†</td>
</tr>
<tr>
<td>Waist circumference (cm)</td>
<td>93.6 ± 6.5</td>
<td>93.8 ± 9.0</td>
<td>0.641*</td>
</tr>
<tr>
<td>Fasting glucose (mg/dL)</td>
<td>143.6 ± 32.2</td>
<td>153.4 ± 64.4</td>
<td>0.317†</td>
</tr>
<tr>
<td>HbA1c (%)</td>
<td>7.64 ± 0.94</td>
<td>7.64 ± 0.95</td>
<td>0.988‡</td>
</tr>
<tr>
<td>HbA1c (mmol/mol)</td>
<td>60.0 ± 10.3</td>
<td>60.0 ± 10.4</td>
<td>0.988‡</td>
</tr>
<tr>
<td>HOMA-IR</td>
<td>5.69 ± 4.41</td>
<td>6.29 ± 6.69</td>
<td>0.320†</td>
</tr>
<tr>
<td>HOMA-B</td>
<td>80.7 ± 63.1</td>
<td>86.0 ± 104.3</td>
<td>0.579‡</td>
</tr>
<tr>
<td>AST (IU/L)</td>
<td>61.8 ± 25.5</td>
<td>51.7 ± 22.1</td>
<td>0.034‡</td>
</tr>
<tr>
<td>ALT (IU/L)</td>
<td>94.9 ± 36.4</td>
<td>79.2 ± 27.2</td>
<td>0.008‡</td>
</tr>
<tr>
<td>ALP (IU/L)</td>
<td>151.8 ± 103.2</td>
<td>169.6 ± 122.7</td>
<td>0.441†</td>
</tr>
<tr>
<td>γ-GT (IU/L)</td>
<td>94.6 ± 78.2</td>
<td>73.5 ± 51.3</td>
<td>0.242‡</td>
</tr>
<tr>
<td>Systolic BP (mmHg)</td>
<td>129.6 ± 13.5</td>
<td>126.1 ± 12.1</td>
<td>0.226*</td>
</tr>
<tr>
<td>Triglyceride (mg/dL)</td>
<td>227.6 ± 273.9</td>
<td>188.1 ± 164.3</td>
<td>0.310‡</td>
</tr>
<tr>
<td>HDL-cholesterol (mg/dL)</td>
<td>44.3 ± 7.1</td>
<td>44.1 ± 7.9</td>
<td>0.893*</td>
</tr>
<tr>
<td>LDL-cholesterol (mg/dL)</td>
<td>97.8 ± 36.9</td>
<td>96.4 ± 28.0</td>
<td>0.844*</td>
</tr>
<tr>
<td>CT attenuation (HU)</td>
<td>n = 36</td>
<td>n = 36</td>
<td></td>
</tr>
<tr>
<td>Whole liver</td>
<td>39.6 ± 10.8</td>
<td>42.8 ± 9.3</td>
<td>0.213‡</td>
</tr>
<tr>
<td>Spleen</td>
<td>50.7 ± 3.4</td>
<td>51.9 ± 4.3</td>
<td>0.225‡</td>
</tr>
<tr>
<td>Whole liver-spleen (LAI)</td>
<td>−11.1 ± 10.3</td>
<td>−8.8 ± 9.3</td>
<td>0.308‡</td>
</tr>
</tbody>
</table>

Concomitant medication

- Metformin: 34 (87.2%); 32 (82.1%); 0.530†
- Sulfonylurea: 15 (38.5%); 23 (59.0%); 0.070†
- DPP-4 inhibitor: 18 (46.2%); 14 (35.9%); 0.357†
- Statin: 26 (66.7%); 23 (59.0%); 0.482‡
- Antplatelet: 14 (35.9%); 23 (59.0%); 0.041‡
- ACE inhibitor/AT-1 antagonist: 15 (38.5%); 14 (35.9%); 0.815‡

Data are mean ± SD or n (%). ALP, alkaline phosphatase; AT-1, angiotensin II type 1 receptor; BP, blood pressure; DPP-4, dipeptidyl peptidase 4; γ-GT, γ-glutamyl-transpeptidase.*By independent t test. †By Pearson χ² test. ‡By Wilcoxon rank sum test.

Compliance and Adverse Events

At the study end point, drug compliance (defined as taking more than 70% of the given trial medicine) was 89.5% in the carnitine-orotate complex group and 86.5% in the placebo group (P = 0.736, not significant). During 12 weeks of treatment, 17 adverse events were reported by 13 patients (33.3%) in the carnitine-orotate complex group, and 21 adverse events were reported by 20 patients (51.3%) in the placebo group (P = 0.109, not significant). One serious adverse event (rib fracture) was reported by one patient in the placebo group.

**CONCLUSIONS**

In this CORONA trial, carnitine-orotate complex significantly improved hepatic steatosis in patients with diabetes and NAFLD. Carnitine-orotate complex also improved the HbA1c level in relation to improvement of hepatic steatosis.

In our study, no weight change occurred in the carnitine-orotate complex group during the 12-week treatment period. Despite no changes in weight or usual medications, serum ALT levels normalized in 89.7% of the participants treated with carnitine-orotate complex. Furthermore, hepatic CT analysis showed reduction in hepatic fat content in participants treated with carnitine-orotate complex. Carnitine acts as a carrier for fatty acids across the mitochondrial membrane for subsequent β-oxidation, which is essential for the body to convert fat into energy (18). Reduced oxidation of fatty acids in hepatocytes increases the amount of hepatic free fatty acids, causing increased triglyceride accumulation within the cytoplasm of hepatocytes.
Meanwhile, accumulating evidence suggests that hepatic mitochondrial dysfunction is crucial to the pathogenesis of NAFLD (23–26), and excessive reactive oxygen species production is considered one of the possible mechanisms of the mitochondrial dysfunction found in NAFLD patients and animal models (10,27). During NAFLD, fatty acid oxidation increases in mitochondria as a metabolic adaptation to fat accumulation, but this adaptation secondarily induces oxidative stress resulting in mitochondrial dysfunction (26,27). Carnitine has shown antioxidant activity protecting hepatocytes or hepatocyte cell lines against intracellular oxidative stress in several studies (13–15). These roles of carnitine in oxidation of mitochondrial free fatty acids and reducing oxidative stress in hepatocytes might explain the improvement of hepatic steatosis and liver function in our participants treated with carnitine-orotate complex.

In addition to improvement of hepatic steatosis, improved glycemic control was also shown in our participants treated with carnitine-orotate complex. Besides its role in hepatocytes, the beneficial effect of carnitine supplementation on glucose tolerance and insulin sensitivity has been reported in several human studies and different animal models (18). It is well known that carnitine enhances mitochondrial oxidation of long-chain fatty acids. Accumulation of long-chain fatty acids and other fatty acid metabolites impair insulin signaling and contribute to the development of Mitochondria are the primary sites for fatty acid oxidation, and hepatocytes are rich in mitochondria, which occupy 18% of the entire liver cell volume (10). Meanwhile, accumulating evidence 18% of the entire liver cell volume (10). Therefore, the role of mitochondria in the pathogenesis of NAFLD is crucial.
insulin resistance in skeletal muscle and heart (18). Some studies reported that subjects with diabetes have reduced plasma free carnitine concentrations compared with healthy subjects, indicating an association between impaired carnitine status and glucose intolerance (18,28,29). All participants in our study had diabetes and experienced significant decreases in HbA1c after 12 weeks of carnitine-orotate complex treatment compared with no significant change in the placebo group. Evidence suggests that oxidative stress damages mitochondrial DNA, resulting in mitochondrial respiratory dysfunction, which aggravates the insulin signaling pathway (30–32). A recent clinical study showed that treatment with carnitine-orotate complex (Godel, Celltron Pharm) reduced systemic oxidative stress and increased mitochondrial DNA copy number in patients with impaired glucose metabolism (33). Several other mechanisms of action of carnitine on glucose tolerance have also been documented (18).

Although the serum ALT value is used as a surrogate marker of liver injury, ALT values do not correlate well with the severity of NAFLD because the entire histologic spectrum of NAFLD can be seen in individuals with normal ALT values (34). Instead of comparing ALT activity itself with severity of NAFLD, we focused on changes in ALT level and hepatic fat content on CT. In our study, subjects with NAFLD were identified by elevated ALT, and the reduction in the ALT level correlated well with the increments in the LAI. This result suggests that improvement of ALT activity represents improvement of hepatic steatosis in a concentration-dependent manner in individuals with fatty liver identified by presence of elevated ALT.

When subjects were classified into tertiles by LAI changes from baseline at 12 weeks, participants in the highest tertile of LAI changes showed significant decreases in fasting glucose, HbA1c, and HOMA-IR from baseline. These results indicate that improvement of hepatic steatosis is associated with improvement of glycemic control in relation to insulin resistance. Hepatic steatosis is well known to be closely associated with insulin resistance, which plays an integral role in the pathogenesis of type 2 diabetes (2,3,35). Despite this close association of hepatic steatosis with insulin resistance, a causal relationship between NAFLD and glucose metabolism has not been clearly established. Only a few studies evaluating NAFLD as a risk factor for the development of diabetes have been reported (4,5,7). In the context of a suspected causal relationship, the results obtained at week 6 appear to provide further information. Reductions in the HbA1c level and hepatic fat content were both seen in patients with diabetes and NAFLD after 12 weeks of treatment with carnitine-orotate complex. At week 6, however, there was no significant change in glycemic control despite a significant reduction in ALT levels from baseline in the carnitine-orotate complex group (Supplementary Table 2). Taken together with the above results, this study demonstrates that an improvement of hepatic steatosis might have an effect on the improvement of glycemic control in relation to insulin resistance. Also, our results would support a previous finding that the presence of NAFLD can aggravate insulin resistance independent of other metabolic components (3).

The trial medication, the carnitine-orotate complex capsule, consists of various components besides carnitine. Although the effect of carnitine on NAFLD or glucose metabolism has been documented in several human and animal studies (11–16,18), those of other components have not been revealed. These other components might have an effect on NAFLD or glucose metabolism. Indeed, orotate, the other main component of the trial medication, has been reported to have a favorable effect on energy metabolism by promoting fatty acid oxidation in the heart (36).

Limitations
Despite the reduction in HbA1c, there was no change in markers related to insulin sensitivity after treatment. The short trial duration of 12 weeks, small sample size, and the use of low-dose carnitine (carnitine-orotate, 900 mg/day) may limit conclusions about metabolic efficacy. Indeed, several clinical trials with longer treatment duration, a larger sample size, and the use of higher dose carnitine (2–4 g/day) have shown the benefits of carnitine treatment on metabolic morbidity improving anthropometric parameters, lipid profiles, and insulin resistance.

Table 3—Changes from baseline in metabolic parameters according to tertile by LAI changes from baseline at 12 weeks

<table>
<thead>
<tr>
<th>LAI change tertile</th>
<th>0 or &lt;0 (H U) (n = 22)</th>
<th>0–8 (H U) (n = 22)</th>
<th>&gt;8 (H U) (n = 24)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AST (U/L)</td>
<td>2.0 ± 20.7</td>
<td>0.685</td>
<td>−15.6 ± 34.6</td>
</tr>
<tr>
<td>ALT (U/L)</td>
<td>−15.1 ± 38.1</td>
<td>0.068</td>
<td>−40.2 ± 53.2</td>
</tr>
<tr>
<td>Fasting glucose (mg/dL)</td>
<td>−15.9 ± 69.7</td>
<td>0.974</td>
<td>0.3 ± 37.5</td>
</tr>
<tr>
<td>HbA1c (%)</td>
<td>−0.09 ± 0.92</td>
<td>0.676</td>
<td>−0.19 ± 1.05</td>
</tr>
<tr>
<td>HbA1c (mmol/mol)</td>
<td>−1.1 ± 10.1</td>
<td>0.697</td>
<td>−2.1 ± 11.5</td>
</tr>
<tr>
<td>HOMA-IR</td>
<td>−1.82 ± 6.12</td>
<td>0.486</td>
<td>−1.27 ± 4.79</td>
</tr>
<tr>
<td>HOMA-B</td>
<td>−17.03 ± 91.6</td>
<td>0.987</td>
<td>−12.89 ± 66.28</td>
</tr>
<tr>
<td>Triglyceride (mg/dL)</td>
<td>19.2 ± 112.6</td>
<td>0.661</td>
<td>−11.8 ± 92.7</td>
</tr>
<tr>
<td>LDL-cholesterol (mg/dL)</td>
<td>−1.3 ± 15.6</td>
<td>0.733</td>
<td>−1.5 ± 15.7</td>
</tr>
<tr>
<td>HDL-cholesterol (mg/dL)</td>
<td>−0.14 ± 4.87</td>
<td>0.68</td>
<td>2.09 ± 6.38</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>0.47 ± 1.97</td>
<td>0.386</td>
<td>−0.22 ± 1.38</td>
</tr>
</tbody>
</table>

Data are mean ± SD, except as indicated. *By Wilcoxon signed rank test. †P for between LAI change tertiles by the Kruskal-Wallis test.
resistance (18). There was no liver biopsy, and subjects with simple steatosis cannot be differentiated from those with nonalcoholic steatohepatitis (NASH). Thus, we do not have an idea whether patients who were included in the trial were candidates for treatment, because NAFLD without NASH is not an indication for treatment. Also, we could not evaluate whether there was improvement in inflammatory changes after treatment.

The use of CT to diagnose fatty liver was also another limitation. CT is reasonably accurate but cannot identify mild fatty infiltration of the liver below the threshold of 30% (37) and might have resulted in the exclusion of subjects with NAFLD. Magnetic resonance (MR)–based assessment is better than CT in quantifying liver fat content, and based on the results from recent clinical trials, MR-based imaging was even better than histology in assessing quantitative changes in liver fat (37–40). In our further study, we plan to use advanced MR imaging and liver histology as an end point to assess the effects of carnitine-orotate complex in patients with NASH.

Summary

Participants treated with carnitine-orotate complex showed biochemical and radiological improvement in NAFLD as well as improved glycemic control. An improvement of ALT activity correlated well with the improvement of hepatic steatosis in a concentration-dependent manner in individuals with fatty liver. Improvement of ALT activity preceded the improvement of glycemic control, suggesting that improvement of hepatic steatosis may have an effect on the improvement of glycemic control.

The results obtained from the CORONA trial suggest that treatment with carnitine-orotate complex improves hepatic steatosis in patients with diabetes and NAFLD and has a beneficial effect on glucose metabolism, particularly in relation to improvement of hepatic steatosis.

Acknowledgments. The authors thank Dae Won Jeon (Hanyang University, Seoul, Korea), who provided many helpful suggestions.

Funding. This study was funded by Celltrion Pharm (Seoul, Korea). The sponsor (Celltrion Pharm) and all authors agreed on the study design, protocol, and statistical plan. The sponsor was responsible for trial management but had no role in data collection, data analysis, data interpretation, or writing of the report. The data management team of an independent clinical research organization (Novelis Excellence, Seoul, Korea), blinded to the patients’ study drug assignment, was responsible for database management and all statistical analyses.

Duality of Interest. Y.C.J. is a full-time employee of Celltrion Pharm for Clinical Research. M.-K.L. has received research grants from Celltrion Pharm. No other potential conflicts of interest relevant to this article were reported.

Author Contributions. J.C.B., W.Y.L., K.H.Y., J.Y.P., H.S.S., K.A.H., K.W.L., and J.T.W. acquired the data and contributed to the execution of the trial. J.C.B., W.Y.L., H.S.S., K.W.L., and W.J.L. participated in the analysis and interpretation of data. J.C.B. drafted the report, which was critically revised for important intellectual contents by W.Y.L. and M.-K.L. W.Y.L., K.H.Y., J.Y.P., H.S.S., K.A.H., K.W.L., J.T.W., Y.C.J., and M.-K.L. contributed to the study design. W.Y.L. and Y.Y.C. provided technical support for the study. All authors contributed to the development and revision of the report and approved the final report for submission. M.-K.L. is the guarantor of this work and, as such, had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Prior Presentation. Parts of this study were presented in abstract form at the 50th European Association for the Study of Diabetes Annual Meeting, Vienna, Austria, 15–19 September 2014.

References

1. Lim S. Ectopic fat assessment focusing on cardiometabolic and renal risk. Endocrinol Metab (Seoul) 2014;29:1–4
26. Bechrée K, Igoudjil A, Pessayre D, Fromenty B. Mitochondrial dysfunction in NASH: causes,
consequences and possible means to prevent it.

Mitochondrion 2006;6:1–28


35. Kahn SE. The relative contributions of insulin resistance and beta-cell dysfunction to the pathophysiology of Type 2 diabetes. Diabetologia 2003;46:3–19


