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Interleukin-6 and Human Immunodeficiency Virus Load, But Not Plasma Leptin Concentration, Predict Anorexia and Wasting in Adults with Pulmonary Tuberculosis in Malawi

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Background: Wasting is a prominent feature of tuberculosis and may be more severe among individuals with HIV coinfection. It is likely that several biological mechanisms, including the anorexia of infection, are contributing to wasting.

Objective: The purpose of this study was to determine whether leptin concentrations, in relation to the inflammatory cytokine response and level of HIV infection, are contributing to loss of appetite and wasting in adults with pulmonary tuberculosis and HIV infection.

Design: We characterized plasma leptin concentrations in relationship with self-reported loss of appetite, body mass index, fat mass (FM), IL-6, and HIV load in a cross-sectional study of 500 adults who presented with pulmonary tuberculosis in Zomba, Malawi.

Results: Plasma leptin concentrations, associated with FM, significantly decreased by increasing tertile of plasma HIV load ($P = 0.0001$). Leptin concentrations were inversely associated with plasma IL-6 concentrations after adjusting for sex, age, FM, and HIV load. Plasma leptin concentrations were associated with neither loss of appetite nor wasting. Inflammation, reflected by increased IL-6 concentrations, was associated with loss of appetite (odds ratio, 3.41; 95% confidence interval, 1.91–6.09), when adjusted for sex, age, FM, leptin concentrations, and HIV load. A high plasma HIV load was associated with severe wasting, defined as body mass index less than 16.0 kg/m$^2$ (odds ratio, 2.14; 95% confidence interval, 1.09–4.19) when adjusted for sex, age, IL-6, FM, and leptin concentrations.

Conclusion: This study suggests that the anorexia and wasting seem primarily determined by the level of inflammation and the level of HIV infection in patients with tuberculosis and HIV coinfection.

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Abbreviations: BIA, Bioelectrical impedance analysis; BMI, body mass index; CI, confidence interval; FM, fat mass; OR, odds ratio.

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UBERCULOSIS HAS REEMERGED with the AIDS pandemic to become the world’s leading cause of death from a single infectious agent, accounting for a quarter of the avoidable adult deaths in the developing world (1, 2). Wasting is a prominent feature of tuberculosis and is probably one of the determinants of disease severity and outcome. Coinfection with HIV and tuberculosis may worsen the wasting seen in tuberculosis or HIV infection alone (3). It is likely that several biological mechanisms, including the anorexia of infection, are contributing to wasting. Inflammatory cytokines are principal candidates as mediator of the metabolic changes resulting in tuberculosis-associated wasting. Inflammatory cytokines trigger the host’s acute phase response and possibly also the anorexia during infections (4). Several microbial products as well as leptin and cytokines reduce food intake after parental administration, suggesting a role of these substances in the anorexia of infection (4, 5).

The fat-derived hormone leptin is best known as a key mediator of energy metabolism (6). High leptin concentrations signal the presence of sufficient energy stores to the hypothalamus, which respond by reducing appetite and increasing energy expenditure. Leptin concentrations are proportional to fat mass (FM) and are reduced in starvation (7). In addition to playing a role in energy regulation, leptin also regulates endocrine and immune functions and belongs to the same class of cytokines as IL-6 (8). Animal studies have suggested that leptin mediates anorexia in chronic inflammatory states (9). On these bases, leptin may be involved in the cross-regulation between nutritional status and the immune response in tuberculosis.

Leptin concentrations may be low as a result of low body fat in tuberculosis or high as a result of the host inflammatory response. High leptin concentrations in tuberculosis patients could suppress appetite and food intake, which could be one of the contributing factors of weight loss and wasting. Low leptin concentrations may suppress immunity and worsen disease outcome. Two studies from Turkey suggested high leptin concentration in adults with tuberculosis (10, 11), whereas one study from Indonesia found low leptin concentrations in adults with tuberculosis (12).

The role of leptin and the inflammatory cytokine response in the anorexia and wasting of patients with tuberculosis and HIV infection have not been characterized. The purpose of this study was to characterize plasma leptin concentrations...
in HIV-infected and uninfected adults with pulmonary tuberculosis in relation to nutritional status, level of inflammation, and level of HIV infection. Moreover, we aimed to determine whether leptin concentrations, in relation to inflammation and level of HIV infection, are contributing to loss of appetite and wasting.

To address these objectives, we characterized plasma leptin concentrations in relationship with self-reported loss of appetite, body mass index (BMI), FM derived from bioelectrical impedance analysis (BIA), plasma IL-6, and plasma HIV load in a cross-sectional study of 500 adults who presented with pulmonary tuberculosis in Zomba, Malawi.

Subjects and Methods

The study population consisted of 500 adults who presented with new sputum-positive pulmonary tuberculosis in Zomba Central Hospital between July 1999 and September 2001. This cross-sectional sample was drawn from a micronutrient supplementation study. Subjects were offered HIV testing and screened for HIV antibodies after written informed consent. All subjects were given appropriate pre- and posttest HIV counseling. Subjects received standard short course chemotherapy for tuberculosis as per guidelines of the Malawi National Tuberculosis Program (13). Adults with a previous history of treated pulmonary tuberculosis were excluded. Three sputum samples from each subject were examined with Auramine-O dark fluorescent staining method. Sputum-positive pulmonary tuberculosis was considered proven when at least one of three sputum stains showed acid-fast bacilli. HIV infection was diagnosed on the basis of a positive rapid test (Determine 1/2 Rapid test; Abbott Laboratories, Johannesburg, South Africa) and confirmed by positive ELISA for HIV-1 antibodies (Wellozyme; Wellcome Diagnostics, Dartford, Kent, UK).

Body weight was determined to the nearest 0.1 kg using an adult balance (Seca 700 balance, Seca Corp., Hanover, MD), and standing height was determined to the nearest centimeter. Wasting was defined as BMI (weight/height$^2$) less than 18.5 kg/m$^2$ and severe wasting as BMI less than 16.0 kg/m$^2$, in accord with World Health Organization strata for BMI grading for severity of malnutrition (14).

Single-frequency BIA was performed at 50 kHz and 800 μA (RIL Systems, Inc., Detroit, MI) with standard tetrapolar lead placement. BIA measurements were performed in triplicate for each subject. The reproducibility of repeated BIA measurements was greater than 99%. To calculate FM and body cell mass, equations that were validated in a reference material 986C (National Institute of Standards and Technology, Gaithersburg, MD). Throughout all analyses, the plasma samples were run in a masked fashion. Due to the unavailability of some sample aliquots, plasma IL-6 and HIV load could not be measured in 1 and 16 samples, respectively.

Comparisons of categorical data were made using χ$^2$ tests. Comparisons between continuous variables were made using t tests. Appropriate variable transformations were made to reduce the skewness of the data, such as log$\_10$ transformation for leptin, IL-6, and HIV load. Univariate ANOVA was used to test for linear trends of plasma leptin concentrations across categories of plasma HIV load. Linear regression models were used to explore the relationships between plasma leptin concentrations and FM, IL-6, and HIV load. Univariate and multivariate logistic regression models were used to evaluate determinants of self-reported loss of appetite and associations with severe wasting.

A significance level of P < 0.05 was used in this study. Statistical analyses were conducted using software packages SAS 8.01 (SAS Institute, Cary, NC) and SPSS 9.0 (SPSS, Inc., Chicago, IL). The protocol was approved by the institutional review boards of the Johns Hopkins School of Medicine (Baltimore, MD) and the College of Medicine, University of Malawi (Blantyre, Malawi), with final approval by the Office for Protection from Research Risk of the National Institutes of Health (Bethesda, MD).

Results

The study population consisted of 370 HIV-positive and 130 HIV-negative adults with sputum-positive pulmonary tuberculosis. Of all participants, 69% (156 of 227) of men and 78% (214 of 273) of women were HIV positive. Table 1 shows characteristics of study participants by sex and HIV status, such as age, body composition, IL-6, HIV load, and plasma leptin concentrations.

When comparing men and women (data not shown), men were older and had lower FM ($P = 0.0001$), log$\_10$ leptin concentrations ($P = 0.0001$) and higher body cell mass ($P = 0.0001$).

<table>
<thead>
<tr>
<th>Characteristic$^a$</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV negative (n = 71)</td>
<td>HIV positive (n = 156)</td>
<td>P*</td>
</tr>
<tr>
<td>HIV negative (n = 59)</td>
<td>HIV positive (n = 214)</td>
<td>P*</td>
</tr>
<tr>
<td>Age (yr)</td>
<td>33.1 ± 11.6</td>
<td>36.0 ± 7.9</td>
</tr>
<tr>
<td>Loss of appetite (%) reported</td>
<td>22.5</td>
<td>39.7</td>
</tr>
<tr>
<td>Loss of weight (%) reported</td>
<td>74.6</td>
<td>81.4</td>
</tr>
<tr>
<td>BMI (kg/m$^2$)</td>
<td>18.7 ± 3.1</td>
<td>18.5 ± 2.6</td>
</tr>
<tr>
<td>Wasting, BMI &lt;18.5 (%)</td>
<td>54.9</td>
<td>54.5</td>
</tr>
<tr>
<td>Severe wasting, BMI &lt;16.0 (%)</td>
<td>14.7</td>
<td>12.7</td>
</tr>
<tr>
<td>Body cell mass (% of weight)</td>
<td>41.0 ± 5.8</td>
<td>39.4 ± 3.1</td>
</tr>
<tr>
<td>FM (% of weight)</td>
<td>7.2 ± 4.8</td>
<td>7.4 ± 5.2</td>
</tr>
<tr>
<td>Log$_10$ IL-6 (pg/ml)</td>
<td>1.28 ± 0.6</td>
<td>1.32 ± 0.5</td>
</tr>
<tr>
<td>Log$_10$ HIV load</td>
<td>5.32 ± 0.5</td>
<td>5.32 ± 0.5</td>
</tr>
<tr>
<td>Log$_10$ leptin (pg/ml)</td>
<td>2.45 ± 0.5</td>
<td>2.33 ± 0.6</td>
</tr>
<tr>
<td>Leptin, actual range (pg/ml)</td>
<td>13.25–3,678.2</td>
<td>2.20–9,240.6</td>
</tr>
</tbody>
</table>

$^a$ Mean ± SD for continuous variables.

$^b$ P values assessed by t tests for continuous variables, χ$^2$ tests for categorical data.

TABLE 1. Characteristics of adults with and without HIV infection presenting with pulmonary tuberculosis in Zomba, Malawi.
Factors associated with plasma leptin concentrations in adults with pulmonary tuberculosis

There was no difference in BMI or the proportion of individuals with wasting between men and women. There was no difference in mean log10 IL-6 concentrations between men and women and no difference in mean log10 HIV load between male and female HIV-positive adults.

Figure 1 shows plasma leptin concentrations with 95% confidence interval (CI) by sex and categories of plasma HIV load. This figure illustrates that plasma leptin concentrations were not different between HIV-negative subjects and HIV-positive subjects in the lowest tertile of HIV load. However, plasma leptin concentrations significantly decreased by increasing tertile of plasma HIV load.

The linear relationships between plasma leptin concentrations and FM, IL-6, and HIV load are shown in Table 2. To determine an independent association of FM, inflammation, and HIV infection with leptin concentrations, we examined the relationships in multivariate linear models that adjusted for sex, age, and all other variables in the model. In univariate linear regression analysis, FM (P = 0.0001) was positively correlated with log10 leptin concentrations, whereas log10 IL-6 (P = 0.0001) and log10 HIV load (P = 0.0001) were inversely correlated with log10 leptin concentrations. In multivariate linear regression that adjusted for sex, age, and all other variables in the model, log10 leptin concentrations remained independently associated with FM (P = 0.0001) and inversely with log10 IL-6 concentrations (P = 0.02). The adjusted regression coefficient J for a linear association with log10 leptin concentrations was 4.18 (95% CI, 3.57–4.80) for FM and −0.10 (95% CI, −0.18 to −0.01) for log10 IL-6 concentrations. The association between log10 HIV load and log10 leptin concentrations did not reach significance in multivariate analysis (P = 0.06).

Figure 2 shows that plasma leptin concentration increases proportionally with percentage of body fat. In univariate analysis, the fitted regression lines for men and women were log10 leptin = 1.86 + 0.07*FM and log10 leptin = 2.26 + 0.04*FM, respectively, with a difference in the slope of the regression lines between log10 plasma leptin and FM among men and women (P = 0.001).

Determinants of appetite and wasting

The relationships between self-reported loss of appetite and plasma leptin concentrations, IL-6, and HIV load are shown in Table 3. To determine which factors contribute to loss of appetite, we examined the relationships in multivariate logistic regression models that adjusted for sex, age, FM, and all other variables in the model. This table shows that plasma leptin concentrations were not associated with loss of appetite. In a univariate logistic regression analysis, log10 IL-6 (P = 0.0001) and log10 HIV load (P = 0.03) were associated with loss of appetite. In multivariate logistic regression analysis, only higher log10 IL-6 (P = 0.0001) remained associated with loss of appetite. The adjusted odds ratio (OR)

### TABLE 2. Factors associated with plasma leptin concentrations in adults with pulmonary tuberculosis

<table>
<thead>
<tr>
<th>Variable</th>
<th>Regression coefficient, β univariate</th>
<th>95% CI</th>
<th>P</th>
<th>Regression coefficient, β multivariate</th>
<th>95% CI</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>FM (% of weight)</td>
<td>5.00</td>
<td>4.57 to 5.43</td>
<td>0.0001</td>
<td>4.18</td>
<td>3.57 to 4.80</td>
<td>0.0001</td>
</tr>
<tr>
<td>Log10 IL-6 (pg/ml)</td>
<td>−0.34</td>
<td>−0.45 to −0.23</td>
<td>0.0001</td>
<td>−0.10</td>
<td>−0.18 to −0.01</td>
<td>0.02</td>
</tr>
<tr>
<td>Log10 HIV load</td>
<td>−0.28</td>
<td>−0.39 to 0.17</td>
<td>0.0001</td>
<td>−0.08</td>
<td>−0.17 to 0.01</td>
<td>0.06</td>
</tr>
</tbody>
</table>

* Univariate and multivariate linear regression; adjusted for sex, age, and all other variables in the model.
for an independent association of \( \log_{10} \) IL-6 with loss of appetite was 3.41 (95% CI, 1.91–6.09).

The relationships between severe wasting and plasma leptin concentrations, IL-6, and HIV load are shown in Table 4. To determine which factors contribute to severe wasting, we examined the relationships in multivariate logistic regression models with severe wasting, defined as BMI less than 16 kg/m², as the outcome variable. In univariate analyses, \( \log_{10} \) leptin (\( P = 0.0001 \)), \( \log_{10} \) IL-6 (\( P = 0.0001 \)), and \( \log_{10} \) HIV load (\( P = 0.0006 \)) were associated with severe wasting. In multivariate analysis that adjusted for sex, age, the interaction between leptin and FM, and all other variables in the model, only higher HIV load (\( P = 0.03 \)) remained associated with severe wasting. The adjusted OR for an independent association of \( \log_{10} \) HIV load with severe wasting was 2.14 (95% CI, 1.09–4.19).

**Discussion**

This study demonstrates that plasma leptin concentrations are associated with FM and the inflammatory cytokine (IL-6) response. Leptin reflected the percentage of FM and decreased with the increase of HIV load. Inflammation, characterized by IL-6 concentrations, was associated with loss of appetite, and level of HIV-replication, characterized by plasma HIV load, was associated with severe wasting. This study suggests that leptin does not seem to account for the anorexia and weight loss in tuberculosis. The anorexia and wasting in patients with tuberculosis and HIV coinfection seem primarily determined by the level of inflammation and the level of HIV infection.

The role of leptin in tuberculosis has been limited to adults without tuberculosis and HIV coinfection (10–12, 17). In 30 patients with tuberculosis in Turkey, higher leptin concentrations were described among those with active tuberculosis, compared with controls (10). Similar results were reported in another study from Turkey involving 25 patients with tuberculosis (11). However, these differences were significant only among women but not among men in the first study (10) and only among men but not among women in the second study (11) from Turkey.

One study from Indonesia found lower leptin concentrations in 60 HIV-negative patients with active tuberculosis, compared with 30 healthy controls (12). And in effect, leptin concentrations in the untreated tuberculosis patients from Indonesia were similarly low as those in our study. In the present study, plasma leptin concentrations were not different between HIV-negative subjects and HIV-positive subjects in the lowest tertile of HIV load. However, plasma leptin concentrations significantly decreased by increasing tertile of plasma HIV load. The lower leptin concentrations in tuberculosis patients with high plasma HIV load may simply be attributed to further deprived nutritional status because body fat is the most important determinant of plasma leptin concentrations. This is consistent with the observation that the nutritional status in patients with pulmonary tuberculosis in Malawi significantly decreases by increasing HIV load (18).

We demonstrated that leptin concentrations reflected the percentage of FM, but although leptin concentrations were higher among female than among male patients, the regres-

**TABLE 3.** Factors associated with self-reported loss of appetite in adults with pulmonary tuberculosis

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Univariate OR (95% CI)</th>
<th>( P )</th>
<th>Multivariate OR (95% CI)*</th>
<th>( P )</th>
</tr>
</thead>
<tbody>
<tr>
<td>( \log_{10} ) leptin (pg/ml)</td>
<td>0.82 (0.62–1.09)</td>
<td>0.17</td>
<td>1.06 (0.65–1.72)</td>
<td>0.81</td>
</tr>
<tr>
<td>( \log_{10} ) IL-6</td>
<td>2.60 (1.73–3.91)</td>
<td>0.0001</td>
<td>3.41 (1.91–6.09)</td>
<td>0.0001</td>
</tr>
<tr>
<td>( \log_{10} ) HIV load</td>
<td>1.52 (1.04–2.33)</td>
<td>0.03</td>
<td>1.38 (0.90–2.12)</td>
<td>0.14</td>
</tr>
</tbody>
</table>

* Univariate and multivariate logistic analysis; adjusted for sex, age, FM, and all other variables in the model.
Theories mechanisms can be drawn. First, HIV infection per se (through nonleptin- and non-IL-6-mediated mechanisms) results in wasting and loss of body fat. Furthermore, decreased leptin concentrations as a result of loss of body fat occur mainly with higher concentrations of HIV load (perhaps suggesting that these changes happen only with more severe or longer duration of HIV infection, which may be of relevance regarding the pathophysiology lipodystrophy syndrome in HIV-infected patients on HAART). Second, increased IL-6 concentrations (either directly or through other mechanisms of chronic inflammation) results in blunting of appetite, which aggravates weight loss, fat loss, and subsequently a decrease in leptin production.

A limitation of this study is that blood samples were not uniformly collected in a fasted state, which would have increased the confidence of our conclusions.

This study suggests that leptin does not play a role in the anorexia and wasting in tuberculosis but that it may play a role as a mediator between nutritional status and host defense, which could explain thin people’s susceptibility to tuberculosis or the link between malnutrition and disease outcome. In addition, IL-6 production was associated with loss of appetite. Current knowledge (4) on the different mechanisms involved in the anorexia of infection suggests some therapeutic options for treatment, including substances that antagonize cytokine action in combination with nutritional support.

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