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Research Article

Glutamic Acid Decarboxylase Autoantibodies Role in Reclassifying Diabetes of Adulthood in Basrah

Abstract

Aim: To determine the prevalence and phenotypic characteristics of diabetes subtypes based on glutamic acid decarboxylase autoantibodies (GADA) status in those newly presented diabetic to the Al-Faiha Specialized Diabetes, Endocrine and Metabolism Center (FDEMC) in Basrah, Southern Iraq.

Methods : The study design is cross-sectional and includes adult diabetic patients if they are free of insulin treatment for at least 6 months from diagnosis and to be 30 years of age and over from the period of January 2013 to March 2013.

Results: Of our diabetics with age 30 years and more, 26.4% were GADA-positive. The only significantly higher variables seen more among GADA-positive diabetes groups were normal weight and current insulin uses. GADA-positivity was not associated with gender, age, BMI, family history, smoking, hypertension, duration of diabetes, or specific HbA1c in the current study.

Conclusion: A quarter of adults diabetic in Basrah were GADA positive. GADA positivity means more likely to be normal weight diabetics and currently on insulin use.

Introduction

Glutamic acid decarboxylase autoantibodies (GADA), also called 65kDa antibodies, is the most frequent form of autoantibodies in type 1 diabetic children and also occurs in some patients who initially present with adult-onset non-insulin requiring diabetes, also called latent adult-onset autoimmune diabetes (LADA) [1]. GADA is no longer only used in theory but are beginning to be used in clinical practice to reclassify type 2 diabetes mellitus [2].

LADA was introduced in 1994 to separate a GADA positive subgroup of adult patients initially diagnosed with type 2 diabetes [3]. Using this definition with the add-on criteria of no exogenous insulin during the first 6–12 months, the prevalence of LADA among unselected “type 2 diabetic patients” is variable, ranging between 25% in subjects less than 35 years and between 4 and 13% in subjects older than 35 years at diagnosis in diabetics of European origin [4].

On follow up researches, a progressive defect in insulin secretion was observed in 50–60% of LADA patients within 6–10 years [5], which led the World Health Organization (WHO) to include those patients in a category called a slowly progressing form of type 1 diabetes in the classification of diabetes [6].

LADA is clearly different from type 2 diabetes, in that LADA is associated with histocompatibility (HLA) genes, diabetes-associated autoantibodies, less insulin secretion, no need for insulin therapy initially after diagnosis, and less prevalence of metabolic syndrome [7]. And it's may be considered as a slowly progressive form of autoimmune β -cell destruction, given that people with LADA have evidence of islet autoimmunity, namely circulating islet antibodies and type 1 diabetes susceptibility HLA class II alleles DQ2 and/or DQ8 [8]. A majority of adults with diabetes in the United Kingdom

Prospective Diabetes Study (UKPDS), who had detectable GADA, required insulin treatment within 6 years of diagnosis [5].

A suggestion for diagnostic criteria for LADA as the age of 30 years or more at clinical presentation and not requiring insulin for > 6 months post-diagnosis might help with the definition of this disease [9], which represent a variable proportion (2–22%) [10]. In a large cohort of white European diabetics (n =3, 672) aged 25 –65 years in the UKPDS, the prevalence of LADA was 10% [5].

GADA persist in LADA for several years after diagnosis, which is in contrary to what observed in classical Type 1 diabetic patients [11]. LADA patients have a similar risk of complications and death to patients with clinically diagnosed type 2 diabetes without GADA, except for a lower prevalence and incidence of nephropathy [12]. There are suggestions that LADA phenotype is different from that of patients with GADA negative type 2 diabetes [13], with some features (including younger age, relative leanness and greater glycemia) that could influence the development of complications, at least theoretically. At diagnosis, patients with adult-onset autoimmune diabetes are usually non – insulin requiring and clinically indistinguishable from patients with type 2 diabetes though they tend to be younger and leaner. Only with screening for autoantibodies, especially GADA, can they be identified with certainty [7].

In the age limit, the Immunology of Diabetes Society had suggested an age limit of ≥ 30 to define LADA [14]. However, this is not always universal, as islet antibody-positive and slowly progressive diabetes has also been described in patients less than 30 years of age [15].

The aim of this study was to determine the prevalence and phenotypic characteristics of diabetes subtypes based on GADA

status in those newly presented diabetic (regardless the duration of diabetes) to the Al-Faiha Specialized Diabetes, Endocrine and Metabolism Center (FDEMC) in Basrah, Southern Iraq.

Subjects, Materials and Methods

Setting

FDEMC is a tertiary referring center in Basrah Southern Iraq. The ethics committee in the Basrah College of Medicine approved the study.

Design

The study design is cross-sectional and includes adult diabetic patients if they are free of insulin treatment for at least 6 month from diagnosis and to be 30 years of age and over for the period of January 2013 to March 2013. Diabetes was designated according to standard criteria, and LADA was defined as patients aged at time of diagnosis 30 years or more with GADA-positive who did not require insulin treatment for at least 6 months after diagnosis [16]. Participants were classified according to the following definitions: type 1 diabetes, insulin-dependent <6 months from diagnosis; LADA, GADA-positive, age \geq 30 years and insulin-independent \geq 6 months from diagnosis; type 2 diabetes, GADA-negative and insulin-independent \geq 6 months from diagnosis.

Exclusion criteria: Patients with incomplete data, current pregnancy, renal disease with a raised creatinine level.

All patients were given informed consent form. Data were collected on clinical characteristics (age, gender, symptoms, family history of diabetes, anthropometric features: height, weight, BMI, biological parameters like glycosylated hemoglobin (HbA1c), immunological markers (GADA).

Variables

Current smoking was defined as smoking all or part of a cigarette within the 30 days preceding the enrollment.

Family history of diabetes was defined as having diabetes in any of the following family members: parents, grandparents (either paternal or maternal), and siblings.

Height and weight were measured without shoes and heavy clothes. BMI was calculated as weight in kilograms divided by the square of height in meters.

Hypertension was defined as systolic blood pressure 140 mmHg or more and or diastolic blood pressure 90 mmHg or more on two occasions in seated patients for at least 5 minutes or history of hypertension and currently on drugs.

Biochemical tests

Blood (10mL) was collected for determination of biochemical parameters. HbA1c was determined by high-pressure liquid chromatography (HPLC) using D-10 Hemoglobin Testing System from Bio-Rad Laboratories, Inc., Hercules, CA 94547.

Antibody Measurement

Estimation of GADA. GADA were determined by GAD kit

(Diametra, Italy). The kit was used for an in vitro qualitative ELISA test for detection of circulating autoantibodies against GAD antigens. (Sensitivity: 92,3%; Specificity: 98,6%). The intra-assay variability is \leq 7.6%, and inter-assay variability is \leq 8.2%. The upper normal limit for anti-GAD is 4 unit/ml. Subjects were considered positive for GADA if the value was 5 U/ml or higher.

Statistical Analysis

For continuous variables, the comparisons between GADA group and others were based on the t test as univariate analysis. Similarly, for categorical variables, the χ^2 test was used. Data were considered significant at $P < 0.05$. Statistical analysis was performed using SPSS-15 statistical software.

Results

Total enrolled patients were 760 (Table 1). They were divided into two groups (GADA- positive diabetes and GADA- negative). GADA-positive diabetes constituted 26.4% of this cohort (57.2% men). Mean age of GADA- positive diabetes group was 40.8 ± 8.1 years, which was not statistically different from that GADA-negative. The mean BMI was 27.1 ± 24.8 kg/m² with no significant difference from GADA-negative. Of those GADA-positive diabetes, 53.3% was having normal weight vs. 32.3% GADA-negative ($P < 0.0001$). Family history was positive in 59.7% and current cigarette smoking was seen in 18.9% of GADA-positive patients, respectively, but none of these statistically different from GADA-negative. About 13.4% of GADA-positive were hypertensive, which is again not statistically different from those GADA-negative.

There was no difference between two groups in the duration of diabetes or onset of starting insulin, but 78.6% of GADA-positive were currently on insulin ($P < 0.0001$). Again, presenting HbA1c not different between the two groups.

GADA-positive diabetes, according to age group is present in (Table 2). About 45.7% of the patients were in the age group 30-39 year. No significant difference in GADA positivity in all age groups (P value=0. 595).

Discussion

Of our diabetics with age 30 years and more, 26.4% were GADA-positive. The only significantly higher variables seen more among GADA-positive diabetes groups were normal weight and current insulin users in this study. GADA-positivity was not associated with gender, age, BMI, family history, smoking, hypertension, duration of diabetes, or specific HbA1c in the current study.

The family history among patients with LADA are conflicting among studies. Some people suggest that LADA patients are unlikely to have a family history of type 2 diabetes [17], while Carlsson et al indicate presence of family history as an important risk factor for the development of LADA [18].

The studies on LADA in the Middle East were scanty. We come across one study from Iran, where, among 500 patients with type 2 diabetes GADA positivity was reported in 14.2%. GADA positivity was more associated with 50-59 Years, but not associated with hypertension, family history of diabetes, and cigarette smoking [19].

Table 1: Comparative analysis between GADA-positive diabetes and GADA-negative groups.

		GADA positive diabetes	GADA negative diabetes	P value
Number (%)		201(26.4)	559(73.6)	
Gender (%)	Men	115 (57.2)	294 (52.6)	0.260
	Women	86(42.8)	265(47.4)	
Age at recruitment years (mean±SD)		40.8±8.1	41.3±9.1	0.502
BMI (kg/m ²)- (mean±SD)		27.1±24.8	27.5±5.4	0.703
Overweight (%)		57(28.9%)	203(36.6%)	<0.0001
Obese (%)		35(17.8%)	173(31.2%)	
Normal weight (%)		105(53.3%)	179(32.3%)	
Family history (%)		120(59.7)	393(70.3)	0.006
Current cigarette smoking (%)		38(18.9)	119(21.3)	0.474
Hypertension (%)		27(13.4)	123(22.0)	0.009
Duration of diabetes years (mean±SD)		6.7±4.5	6.2±5.3	0.231
Onset of starting insulin years (mean±SD)		4.0±3.8	4.0±4.4	0.957
Current insulin use (%)		158(78.6)	337 (60.3)	<0.0001
HbA1c at recruitment % (mean±SD)		11.4±2.5	11.1±2.6	0.497

Table 2: Age ranges between GADA-positive diabetes and GADA-negative groups.

Age range	GADA-positive diabetes (%)	GADA-negative diabetes (%)	Total (%)	P value
30-39	84(41.8)	263(47.0)	347 (45.7)	0.595
40-49	84(41.8)	202 (36.1)	286(37.6)	
50-59	19 (9.5)	57 (9.5)	76(10.0)	
60-69	6 (3.0)	20(3.6)	26(3.4)	
≥70	8(4.0)	17(3.0)	25(3.3)	
Total	201	559	760	

While in Saudi Arabia, of patients with type 2 DM, 8/99 patients were GADA positive [20]. Furthermore, in a small cohort from Turkey GADA-positive cases were seen in 31% among 54 initially diagnosed type 2 diabetic patients [21].

Different data reported from Africa, where the prevalence range 14% in Nigeria to 13.5% in Ghana to 7.3% in Tanzania [22-24].

Furthermore, in Asia, GADA were detected in 16.1% of Chinese type 2 diabetic patients [25]. And the prevalence of GADA-positive diabetes cohort from three largest hospitals in Sri Lanka was 5.4% (n = 54; 95% CI 4.0 – 6.8). The prevalence of GADA positivity was much higher among those who were young and had a lower BMI compared with those who were older and more obese [26]. GADA positivity among men and women was 7.4% and 4.0%, respectively (p = 0.028). Compared with those that tested negative for GADA, GADA-positive participants had been diagnosed at a younger age, were leaner, had a lower frequency of hypertension, presented.

European data are exemplified in LADA in South Wales study, where the predictors of associations with increasing levels of GADA: younger age at presentation, increasing IA-2 concentration, decreasing C-peptide concentration, presence of other autoimmune disorders, lower BMI and increasing HbA1c [27]. Factors not statistically significant included: symptom at presentation, family

history of diabetes and family history of other autoimmune disorders. Multivariate analysis revealed that, out of the above, higher GADA levels were associated with higher IA-2, higher HbA1c, younger age and lower BMI. Ethnic background was not included in the analysis as 98.4% of the sample population were Caucasian [27].

Conclusion

A quarter of adults diabetic in Iraq are GADA positive. GADA positivity means more likely to be normal weight diabetics and currently on insulin use.

Acknowledgment

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Duality of interest

The authors declare that there is no duality of interest associated with this manuscript.

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