

## Improvement of Glucose Homeostasis in Response to Short-Term Aerobic Training in Middle-Aged Men with Abdominal Obesity

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### Abstract

**Objective:** Overweight and obesity is associated with insulin resistance and is the most important risk factor of type 2 diabetes (T2DM). In present study, we assessed glycemic profile and insulin resistance response to a short term aerobic training in middle-aged men with abdominal obesity.

**Materials and Methods:** The subjects included 28 abdominally obese (waist circumference  $\geq 102$ cm) middle-aged men ( $39 \pm 5$  year) that were divided into exercise ( $n=14$ ) or control ( $n=14$ ) groups by randomly. Exercise subject were completed a short-term aerobic training at 55-70 % of maximal heart rate (6 weeks, 3 times / weekly) and control subjects remained no training. Pre-training and post-training of anthropometrical markers, fasting glucose, hemoglobin (HbA1C), insulin and insulin resistance were measured of 2 groups and compared by independent – paired t test (SPSS, Version 22.0).

**Results:** Aerobic exercise resulted in a significant decrease in glucose level ( $114 \pm 13$  versus  $101 \pm 11$  mg/dL,  $P: 0.009$ ) and HbA1C ( $6.14 \pm 1.11$  versus  $4.91 \pm 1.23$ ,  $P: 0.021$ ) in exercise group. But no significant changes were observed in insulin ( $8.31 \pm 4.12$  versus  $8.29 \pm 3.21$ ,  $P: 0.119$ ) and insulin resistance ( $2.34 \pm 0.51$  versus  $2.07 \pm 0.59$ ,  $P: 0.073$ ) in exercise groups.

**Conclusion:** Based on our finding, aerobic training independent of insulin function is associated with improved glucose in middle-aged obese men and this improvement can be attributed to other changes caused by exercise that requires further study in this area.


**Keywords:** Aerobic exercise, Obesity, Glucose, Insulin function

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## Introduction

In addition to psychological and social problems, obesity, especially abdominal obesity, has been associated with the prevalence of chronic diseases like cardiovascular diseases, diabetes, respiratory and liver diseases, and cancers (1). Although the molecular mechanisms underlying the relationship between obesity and its associated diseases have not been entirely grasped, it is inferred from scientific sources and research findings that increased adipose tissue mass, which is a hallmark of obesity, plays a significant role in metabolic disorders. In addition to genetics and inactivity, obesity is also one of the most important environmental factors that cause insulin resistance syndrome. In this regard, it can be mentioned that insulin level is balanced and insulin resistance is reduced following weight loss or reduction of body fat levels (2).

Insulin resistance is defined as an inadequate response of tissues such as liver, adipose tissue and skeletal muscle, as insulin-sensitive tissues to systemic insulin (3). Furthermore, the decrease in the number of insulin-receptor proteins in the presence of obesity in insulin-sensitive tissues provides the basis for increased insulin resistance (4). In addition, the activation of inflammatory pathways in immune cells by the greater influence of inflammatory cytokines and fatty acids or lipotoxins has led to the disruption of insulin-signaling pathways, which in turn result in increased insulin resistance, especially in healthy or obese-induced disease populations (5). Researchers have also suggested inflammatory processes as a mediator between obesity and insulin resistance (6). In contrast, increased adipose tissue leads to morphological and physiological changes including sequestration or secretion of macrophages and release of several pro-inflammatory cytokines. Moreover, some of these changes directly or indirectly affect insulin resistance and sensitivity by regulating

insulin symptoms and molecules involved in lipid and glucose metabolism (7).

In addition to obesity, an inactive lifestyle is associated with a high risk of increased insulin resistance and cardiovascular diseases. Moreover, hyperglycemia or high blood glucose is the major consequence of insulin resistance (8). Therefore, providing short- or long-term exercise training to improve insulin resistance and inflammatory profile, especially in healthy or diseased obese individuals has always been the focus of health science researchers. However, the findings are often contradictory in this regard depending on the type of activity in terms of duration, frequency, and intensity of the training program, the measurement tool, and the studied population. For example, some studies have reported a decrease in insulin resistance and blood glucose following aerobic exercises (9). Moreover, there was significant increase in insulin sensitivity and improvement in blood glucose in the absence of inflammatory profile change after 6 months of moderate-intensity physical activity (10). Other studies have also suggested that a significant reduction in body weight is required for improved insulin resistance (11). In contrast, in a relatively recent study, 8 months of aerobic exercise did not alter insulin resistance but improved blood glucose in obese adolescents (12). Despite the above-mentioned evidence, it is also questionable whether improving blood glucose or glycosylated hemoglobin (HbA1C) in response to external interventions such as exercise programs is directly dependent on insulin changes or insulin resistance or whether exercise training in the absence of their changes can also affect blood glucose or HbA1C. Therefore, our study aimed determining the effect of 6 weeks of aerobic training on fasting glucose, insulin, and insulin resistance in a group of inactive males with abdominal obesity.

## Materials and Methods

Twenty eight sedentary middle-aged (35–45 years) obese men with abdominal obesity (Table 1) participated in this experimental study and were randomly divided into exercise (aerobic training/6 weeks, n=14) and control (no-training, n=14). The experimental protocol and potential risks were explained to participants verbally and informed consent was obtained. Ethics approval was given by Ethics Committee of Islamic Azad University, Saveh Branch, Iran .

The participants who had weight stable ( $\pm 1$ kg) for 3 months before study and engaged in exercise less than once per week were included in the study. Athletes, smokers, and individuals with alcohol consumption, persons with a known diagnosis of diabetes, absence of restraining orthopedic/ neuromuscular diseases, asthma, arthritis, cancer, hypertension, heart attack, bronchitis or chronic cough and other chronic diseases were excluded. Exclusion criteria were also included medications that alter lipid and carbohydrate metabolism and inability to exercise. In this study, although the aim was to assess the impact of aerobic training in the absence of calorie restriction on dependent variables, but individuals were asked to use the food recall questionnaire 3 days before blood sampling. Each individual's records the type of food consumed 3 days before the first

blood sample (pre-training) and repeats the same diet program 3 days before the second blood sample (post-training).

## Anthropometry

Height and Body weight were measured to the nearest 0.1 cm and the nearest 0.1 kg, respectively when subjects were in a fasting state. Obesity measured by body mass index ( $\text{Kg}/\text{m}^2$ ). Body fat percentage and visceral fat was determined using body composition monitor (OMRON, Finland). Hip and abdominal circumferences were measured in the most condensed part using a non-elastic cloth meter after normal expiration. Bout measurements were made every 1 minute and average of two measurements used for analysis. Baseline variables for anthropometric and clinical marker are reported in Table 1.

## Training protocol

Aerobic training lasted 6-weeks (3 sessions/ weekly). Each session was supervised by an exercise physiologist. In each exercise session, they performed warm-up for 5-10 min, followed by a 15 – 30 min running, at a intensity of 55-70% of HRmax followed by a 5-10 min cooling-down (Table 2). The principle of overload in the training protocol was designed based on increasing the volume and intensity of training in 2 weeks. After 2 weeks of training, 5 minutes was added to the

**Table 1. The baseline Clinical and anthropometrical characteristics of the subjects**

Variables	Exercise group	Control group	P
Age (year)	40.7 ( $\pm 4.51$ )	41.2 ( $\pm 3.83$ )	0.681
Height (cm)	174 ( $\pm 5.11$ )	175 ( $\pm 4.23$ )	0.552
Weight (kg)	101.5 ( $\pm 10.14$ )	102.5 ( $\pm 9.28$ )	0.361
Abdominal circumference (cm)	111 ( $\pm 5.24$ )	113 ( $\pm 3.97$ )	0.492
Body mass index ( $\text{kg}/\text{m}^2$ )	33.50 ( $\pm 3.44$ )	33.49 ( $\pm 2.35$ )	0.411
Body fat (%)	34.03 ( $\pm 4.10$ )	34.11 ( $\pm 3.21$ )	0.544
Visceral fat	13.6 ( $\pm 0.91$ )	13.8 ( $\pm 0.74$ )	0.285
Glucose (mg/dL)	114 ( $\pm 13$ )	116 ( $\pm 11$ )	0.726
Insulin ( $\mu\text{IU}/\text{ml}$ )	8.31 ( $\pm 4.12$ )	9.01 ( $\pm 2.21$ )	0.323
Insulin resistance (HOMA-IR)	2.34 ( $\pm 0.51$ )	2.58 ( $\pm 0.72$ )	0.542
HbA1C (%)	6.14 ( $\pm 1.11$ )	6.21 ( $\pm 1.06$ )	0.721

Data represented by independent sample T-test.

**Table 2. Distribution of exercise intensity during exercise intervention**

Weeks	Exercise intensity (%HRmax)	Time of running
1 -2	%55 $\leq$ intensity $\leq$ %60	3 $\times$ 5 minute
3 - 4	%60 $\leq$ intensity $\leq$ %65	2 $\times$ 10 minute
5 - 6	%65 $\leq$ intensity $\leq$ %70	2 $\times$ 15 minute

running time and 5% to exercise intensity (HRmax). In each session, main exercise was running at mentioned intensity. In addition, exercise intensity was controlled using the Polar heart rate tester (H10: USA). Control subjects were instructed to maintain their habitual activities. The subjects were instructed to maintain usual diet throughout of the study.

### Laboratory assays

A venous blood sample was drawn from the cubital vein of all the subjects after a 10-12 h overnight fast (pre-training). All participants were asked to avoid doing any heavy physical activity for 48 h before sampling. After the last exercise session, participants rested for 48 h, then fasting blood samples were taken same to pretest (post-training). Serums were immediately separated and stored at  $-76^{\circ}$  until the assays were performed. Glucose was assessed by oxidase method (Pars Azmoon kit-Tehran). Insulin was determined by ELISA method (Demeditec, made Germany) and intra- assay and inter-assay coefficient of the method were 2.6% and 2.88 respectively. NycoCard kit used to determine HbA1C by Boronate affinity assay made in England. Insulin resistance index (HOMA-IR) index was calculated by the formula:

$$\text{HOMA1-IR} = \frac{\text{fasting plasma insulin } (\mu\text{U}/ \text{ml}) \times \text{fasting plasma glucose (mmol/L)}}{22.5 (13)}.$$

### Data analysis

Statistical analyses were performed through statistical software package (SPSS, Version 22.0, SPSS Inc, IL, USA). The Kolmogorov-Smirnov was applied to assess the variables with normal distribution. Independent student t test was used for comparison of variables between groups at baseline. To determine the impact of exercise training on variables, the delta between pre and post values of each variable were compared by independent t test between groups. Paired T-test used to assess the intra-group changes of variables in each group. A criterion alpha of  $P \leq 0.05$  was used for statistical comparisons.

### Ethical considerations

This study was approved by Research Department of Azad University of Saveh Branch, Saveh, Iran. (Project Code: 1181287110600).

### Results

Baseline variables for anthropometric and clinical marker are reported in Table 1. No significant differences were observed in anthropometrical indexes between groups at baseline ( $P > 0.05$ ). In addition, no differences were observed between groups for glucose ( $P: 0.726$ ), insulin ( $P: 0.323$ ), insulin resistance ( $P: 0.542$ ) and HbA1C ( $P: 0.721$ ) at baseline (Table 1).

To determine the change of each variables, first the delta of each variable (pre to post difference) in each group was assessed, then delta of each variable were compared by independent T-test between groups. Findings from independent T-test showed significant difference in delta for glucose ( $P: 0.014$ ) and HbA1C ( $P: 0.019$ ) between groups. Actually, findings from intra-group changes indicates that aerobic training resulted a significant decrease in glucose when compared with pre-test in exercise group ( $P: 0.009$ ), but this variable remained no change in control subjects ( $P: 0.236$ ). In addition, aerobic training resulted a significant decrease in HbA1C when compared with baseline levels in exercise group ( $P: 0.021$ ) but this variable remained no change in control subjects ( $P: 0.413$ ) (Table 3).

In contrast, delta comparison of other variables showed no significant differences between groups with regard to serum insulin ( $P: 0.411$ ) and insulin resistance ( $P: 0.263$ ). Actually, intra-group changes showed no significant differences between pre and post-training of insulin ( $P: 0.119$ ) and insulin resistance ( $P: 0.073$ ) in exercise group (Table 4). There were also no differences in these variables in the control group.

**Table 3. Anthropometrical indexes before and after intervention of 2 groups**

Variables		Baseline	After	P	Change	P
<b>Weight</b>	Exercise group	101.5 ( $\pm$ 10.14)	97.21 (6.28)	0.001	4.29	0.021
	Control group	102.5 ( $\pm$ 9.28)	102.3 ( $\pm$ 6.58)	0.231	0.2	
<b>AC</b>	Exercise group	111 ( $\pm$ 5.24)	106 (5.14)	0.001	5	0.014
	Control group	113 ( $\pm$ 3.97)	113 ( $\pm$ 4.13)	0.411	0	
<b>BMI</b>	Exercise group	33.50 ( $\pm$ 3.44)	32.08 (3.28)	0.011	1.42	0.033
	Control group	33.49 ( $\pm$ 2.35)	33.43 ( $\pm$ 2.88)	0.213	0.03	
<b>Body fat</b>	Exercise group	34.03 ( $\pm$ 4.10)	31.06 (2.28)	0.07	2.97	0.028
	Control group	34.11 ( $\pm$ 3.21)	34.28 ( $\pm$ 2.41)	0.423	- 0.17	
<b>Visceral fat</b>	Exercise group	13.6 ( $\pm$ 0.91)	11.08 (1.24)	0.001	2.52	0.009
	Control group	13.8 ( $\pm$ 0.74)	13.6 ( $\pm$ 0.79)	0.234	0.2	

AC, abdominal circumference; BMI: body mass index. Data represented by paired sample T-test.

**Table 4. Pre and post-training of diabetes markers of 2 groups**

Variables		Baseline	After	P	Change	P
<b>Glucose</b>	Exercise group	114 ( $\pm$ 13)	101 ( $\pm$ 11)	0.009	3	0.014
	Control group	116 ( $\pm$ 11)	118 ( $\pm$ 13)	0.236	- 2	
<b>Insulin</b>	Exercise group	8.31 ( $\pm$ 4.12)	8.29 ( $\pm$ 3.21)	0.119	0.02	0.411
	Control group	9.01 ( $\pm$ 2.21)	9.11 ( $\pm$ 2.29)	0.411	- 0.10	
<b>Insulin resistance</b>	Exercise group	2.34 ( $\pm$ 0.51)	2.07 ( $\pm$ 0.59)	0.073	0.27	0.236
	Control group	2.58 ( $\pm$ 0.72)	2.65 ( $\pm$ 0.68)	0.279	- 0.07	
<b>HbA1C</b>	Exercise group	6.14 ( $\pm$ 1.11)	4.91 ( $\pm$ 1.23)	0.021	1.23	0.019
	Control group	6.21 ( $\pm$ 1.06)	6.29 ( $\pm$ 0.93)	0.413	- 0.08	

Data represented by paired sample T-test

## Discussion

In the present study, despite a significant decrease in fasting glucose but insulin levels and insulin resistance did not change in response to six weeks of aerobic training. In addition, decreased HbA1C in response to aerobic training is also one of the main findings of the present study. In this regard, Balducci et al (2010) noted that 12 months of aerobic training (2 sessions/weekly) leads to a significant reduction in HbA1C and insulin resistance (14). Some recent studies have repeatedly proposed the hypothesis that glucose and insulin have pro-inflammatory and anti-inflammatory properties, respectively (15). Studies addressing adults have revealed that insulin resistance is an independent predictor of coronary heart disease, hypertension, cancer, heart attack and T2D. Moreover, the increased insulin function and insulin sensitivity are important protective factors against all of the mentioned clinical diseases (16).

It is well-acknowledged that dietary-induced obesity and its complications such as metabolic syndrome are one of the most central health problems in the world nowadays. The impairment of glucose

tolerance and the prevalence of T2D, especially in obese individuals increase with age (17). In this respect, more than 45% of older people meet the criteria for T2D. Multiple risk factors for T2D such as increased adipose tissue, decreased exercise, and inactivity that are associated with increased insulin resistance or beta-cell dysfunction are manifested with increasing age (18). The development of T2D, especially in obese individuals is associated with the inability of beta-cells to compensate for insulin resistance (19). Impairment of insulin secretion has also been observed in healthy older adults (20). In response to obesity, especially visceral obesity, insulin sensitivity decreases and is closely linked to dyslipidemia and systemic hypertension. The mentioned features are associated with the phenomenon of metabolic syndrome and all of the mentioned features are associated with increased cardiovascular risk factors (21). To put in a nut shell, the overall consequence of these metabolic disorders is elevated blood glucose or hyperglycemia and related diseases in obese individuals.

Although obesity increases the risk of insulin resistance, T2D and other cardiovascular abnormalities (22), it has been revealed that

physical fitness level, as compared with body weight is a more accurate predictor of mortality from cardiovascular diseases (21). It has been hypothesized that increased cardiovascular fitness leads to increased insulin function and decreased body fat tissue concurrently (23); however, some studies have reported that increased cardiovascular fitness, independent of changes in body composition and body weight changes insulin function or insulin sensitivity (24). In this regard, some studies have introduced VO<sub>2</sub>max as a predictor of insulin concentration (25). As some studies have indicated that cardiovascular fitness affects insulin function far above fat percentage levels, widespread efforts have been made to perform regular exercise trainings to improve insulin function in individuals susceptible to insulin resistance syndrome or T2D (26). Evidence suggests that exercise may delay or prevent the development of T2D in susceptible individuals (27). In addition, it has been suggested that the metabolic benefits of exercise are short-lived (28).

However, researchers have also mentioned that aerobic exercise with different time durations is associated with a significant improve in insulin sensitivity in obese or T2D (29). Exercise training has been shown to increase insulin sensitivity in insulin-resistant obese individuals or those with a family history of T2D and T2D patients. The beneficial effects of exercise and physical activity on improving insulin sensitivity in healthy adults and elderly individuals have also been reported by other studies (30). In another study, weight loss induced by 6 months of exercise training ranged from improved insulin sensitivity in the elderly individuals to normal values in the young individuals (31). On the basis of this evidence, it is likely that the beneficial roles of exercise training on blood glucose may be mostly attributed to improvements in insulin sensitivity than to changes in insulin resistance. The mentioned finding requires further examination. It is also possible that

decrease in blood glucose in the study population is rooted in altering or improving cardiovascular risk factors such as triglyceride or HDL as well as decreasing body fat percentage. Lack of measurement of cardiovascular risk factors is limitation of the present study. Reduced blood glucose in response to aerobic training in the absence of altered insulin resistance may be due to changes of glucose transporters. In this regard, exercise training has been suggested to reduce blood glucose, independent of insulin resistance, by increasing the number of glucose transporters such as GLUT4 in skeletal muscle and adipose tissues (32). Clinical studies have also revealed that regular exercise training is able to improve glycemic profile or decrease blood glucose by enhancing AMPK activity in skeletal muscle (33), enhancing GLUT4 translocation and expression (34), decreasing hepatic glucose release induced by decreased phosphoenolpyruvate carboxykinase expression (35), weight loss (36), and maintenance of beta-cell mass (37), or other unknown factors affecting insulin sensitivity.

Finally, despite the lack of measurement of inflammatory or anti-inflammatory mediators affecting insulin function and glycemic profile as limitations and weaknesses of the study, improvement of glucose and insulin in response to 6 weeks of aerobic training in the absence of insulin and insulin resistance change are the strengths of the present study. Improved glucose and reduced HbA1C are reported in the present study, while Garcia et al (2022) noted that exercise training longer than 24 weeks with at least 60 min exercise in the form high-intensity concurrent may serve as a supportive therapy to glycemic profile and metabolic control (38). Improved HbA1C may also be attributed to weight loss or improvement in anthropometric parameters in response to aerobic training in obese individuals studied. As Chou et al (2012) based on their findings collected from 90,958 individuals between 2008 and 2019 have pointed out that normal exercise training,

coupled with a normal WHR was significantly associated with lower HbA1c among non-diabetic people in Taiwan (39). Yan et al (2022) also stated based on their Data of 2559 participants were included (1273 females and 1286 males) from the 2015-2019 Korea National Nutrition and Health Nutrition Examination that HbA1c were more likely to be controlled when walking or resistance exercises were performed for  $\geq 5$  days a week in male or women (40).

## Conclusions

Aerobic training for 6 weeks in the absence of significant changes in insulin resistance improved blood glucose and HbA1C in obese men. Based on the available evidence, exercise training is likely to indirectly affect blood

glucose levels by affecting other hormonal mediators or lipid profiles. In addition, despite no significant decrease insulin resistance in response to exercise training but this decrease is considerable from a clinical perspective.

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## Conflict of Interest

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