



Fasting Ketone Bodies and Incident Type 2 Diabetes in the General Population

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With rising incidence and prevalence of type 2 diabetes, prevention including identification of prospective biomarkers becomes increasingly relevant. Although ketone bodies recently received a renewed interest as potential biomarkers, data linking these metabolites to diabetes risk are scarce. Therefore, the present prospective study investigated a potential association between fasting ketone bodies and incident type 2 diabetes in the general population. This study from the PREVEND cohort included 3,307 participants from the general population initially free of diabetes or impaired fasting glucose. Baseline fasting ketone body concentrations were measured by nuclear magnetic resonance spectroscopy. One hundred twenty-six participants (3.8%) developed type 2 diabetes during a median (interquartile range) follow-up of 7.3 (6.3–7.6) years. In Kaplan-Meier analysis, sex-stratified ketone body levels strongly positively associated with incident type 2 diabetes, which was confirmed in Cox regression analyses adjusted for several potential confounders. There was no significant interaction by sex. Both 3- β -hydroxybutyrate and acetoacetate+acetone individually associated with incident type 2 diabetes. In conclusion, fasting plasma ketone body levels are strongly positively associated with incident type 2 diabetes in the general population independent of several other recognized risk factors. These results may have important implications for diabetes prevention including dietary strategies.

Incidence and prevalence of type 2 diabetes are rising with high associated healthcare and societal costs (1,2). Preventive strategies to change this trajectory include

ARTICLE HIGHLIGHTS

- The identification of biomarkers that predict type 2 diabetes is increasingly relevant for personalized medicine strategies.
- Data regarding ketone bodies and incident type 2 diabetes are scarce.
- This study shows that ketone bodies, either combined or as individual subspecies, are strongly associated with incident type 2 diabetes in the general population, independent of potential confounders.
- These results may have important implications for diabetes prevention including dietary strategies.

identification of predictive biomarkers combined with early interventions (2).

Ketone bodies are an alternative energy source to glucose during fasting produced from fatty acids. Primarily, 3- β -hydroxybutyrate (3HB) and acetoacetate (AcAc) are formed, and, secondarily, acetone, a spontaneous breakdown product of AcAc (3). Insulin regulates ketogenesis, with low insulin levels stimulating it (3,4). Of note, in insulin resistance, the ability of insulin to suppress ketogenesis appears maintained (5).

In heart failure, higher circulating ketone body levels associated with better outcomes (4). Further, treatment with sodium–glucose cotransporter 2 inhibitors, which improve glycemic control and, very efficiently, diabetic complications, increased circulating ketone bodies (6,7). Although not part of contemporary nutritional guidelines, so-called ketogenic

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diets, high in fats and very low in carbohydrates, that result in measurably higher ketone body levels are vividly discussed as a potential strategy to prevent type 2 diabetes (8). However, data on a potential association between ketone bodies and incident type 2 diabetes in the general population are scarce. Therefore, the current study investigated the relationship between baseline plasma ketone bodies and de novo type 2 diabetes in a large general population cohort.

RESEARCH DESIGN AND METHODS

Prevention of REnal and Vascular ENd-stage Disease (PREVEND) is a prospective longitudinal cohort study from the north of the Netherlands (9). Briefly, from initially screened 8,592 participants (1997–1998), 6,893 returned for the second screening (2001–2003, baseline of the current study). We excluded subjects with nonfasting laboratory measurements, with missing data of ketone bodies or diabetes follow-up, with ketone body levels <2.5th percentile and >97.5th percentile, or with pre-existing diabetes (10) or impaired fasting glucose (11), leaving 3,307 participants. Type 2 diabetes was defined as fasting glucose of ≥ 7.0 mmol/L, nonfasting glucose of ≥ 11.1 mmol/L, self-report of type 2 diabetes diagnosis, or initiation of glucose-lowering medication (10). Impaired fasting glucose was defined according to World Health Organization criteria reflecting standard of care in the Netherlands (6.1–7.0 mmol/L) (11).

This study was approved by the local medical ethical committee (Groningen, the Netherlands, MEC96/01/022) and carried out in accordance with the Declaration of Helsinki. All participants provided written informed consent.

Outcome and End Point

The main predictor was circulating ketone body levels. The study end point was incident type 2 diabetes. Follow-up was defined as the time period between baseline measurements and type 2 diabetes diagnosis or end of the observation period.

General Participant Characteristics

Participants attended two outpatient visits during which baseline data were collected, including general participant characteristics such as lifestyle parameters and medication use. Longitudinal information of medication use was obtained from the pharmacy dispensing registry.

Laboratory Measurements

Venous plasma was drawn after an overnight fast. Glucose and total cholesterol were determined using dry chemistry (Eastman Kodak, Rochester, NY), urinary albumin and high sensitivity C-reactive (hsCRP) protein concentrations utilizing nephelometry (Dade Behring Diagnostic, Marburg, Germany), and insulin by immunoturbidimetry (Diazyme Laboratories, Poway, CA). Ketone bodies (AcAc, 3HB, acetone) and triglycerides were determined by nuclear magnetic resonance (NMR) spectroscopy at Labcorp (Morrisville, NC). NMR spectra were

collected on Vantera Clinical Analyzers (12), and concentrations were calculated using an optimized NMR LipoProfile test version (LP4 algorithm) as described (13). HDL cholesterol was assessed using a homogenous method (direct HDL; Abbott Laboratories, Abbot Park, IL). Serum creatinine was measured enzymatically, and serum cystatin C was measured by immunoassay (Gentian AS, Moss, Norway), both on a Roche Modular Analyzer (Roche Diagnostics, Mannheim, Germany). Estimated glomerular filtration rate (eGFR) was calculated by the Chronic Kidney Disease Epidemiology Collaboration (CKD-EPI) combined creatinine-cystatin C equation. Homeostatic model assessment of insulin resistance (HOMA-IR) was calculated as fasting plasma insulin (mU/L) \times fasting plasma glucose (mmol/L)/22.5. LDL cholesterol was determined using the National Institutes of Health equation (all participants had triglycerides below 800 mg/dL) (14).

Statistical Analysis

All statistical analyses were done using R Studio (RStudio Team, 2020). *P* values below 0.05 were considered significant. χ^2 test was used for categorical variables (total numbers [%]), Kruskal-Wallis test for skewed continuous variables (median [interquartile range (IQR)]). Normal distribution was checked by Shapiro-Wilk test. Multivariate linear regression with backward elimination was used to define baseline variables independently correlated to ketone bodies. Kaplan-Meier curves were constructed based on tertiles of ketone bodies; significance was determined utilizing the log-rank test. To assess the continuous relationship between ketone bodies and incident type 2 diabetes, log₂-transformed ketone body concentrations were used, adjusted for age and sex. Prospective associations between baseline ketone bodies and incident type 2 diabetes were explored with Cox regression analysis. Schoenfeld residuals test showed that the proportional hazard assumption was not violated. First, crude analysis (model 1) was carried out and hazard ratios (HR) (95% CI) were obtained for log₂-transformed ketone bodies. Subsequently, we adjusted the crude model stepwise for the indicated parameters. To explore differential associations of different ketone bodies with type 2 diabetes, Cox regression analyses were repeated. AcAc and acetone were combined because of the spontaneous formation of acetone from AcAc. Subgroup analyses with interaction tests were performed to determine HR across categories of baseline characteristics using, for continuous variables, median values as the cutoff.

Data and Resource Availability

The data sets generated during and/or analyzed during the current study are available from the corresponding author on reasonable request.

RESULTS

Out of 3,307 participants, 126 (3.8%) developed type 2 diabetes during a median follow-up [IQR] of 7.3 [6.3–7.6] years. The median ketone body level in all participants was 175.5 [139.5–241.1] μ mol/L. Among subjects developing

type 2 diabetes during follow-up, median ketone body levels were 200.1 [161.2–264.4] vs. 174.8 [138.9–239.4] $\mu\text{mol/L}$ in participants who stayed free of type 2 diabetes ($P < 0.001$).

Analysis of baseline participant level characteristics (Table 1) indicated that subjects in the higher tertiles of ketone bodies were older ($P < 0.001$) and past smokers ($P = 0.022$). BMI ($P < 0.001$), waist circumference ($P < 0.001$), glucose ($P < 0.001$), HOMA-IR ($P < 0.001$), triglycerides ($P < 0.001$), and systolic blood pressure ($P = 0.012$) were significantly increased in the medium and high tertiles, while HDL cholesterol ($P = 0.003$) was decreased. Subjects with higher ketone bodies had higher hsCRP ($P < 0.001$). Furthermore, participants in the low tertile had better kidney function (eGFR, $P < 0.001$) and less urinary albumin excretion ($P = 0.019$). Lastly, subjects with higher ketone bodies used lipid-lowering ($P = 0.015$) and antihypertensive medication ($P = 0.013$) more frequently. In linear regression with backward elimination (Supplementary Table 1), age (standardized β [95% CI] 5.39 [0.33, 10.46], $P = 0.037$), glucose (-4.74 [-8.46 , -1.02], $P = 0.013$), and total cholesterol (-3.79 [-7.44 , -0.13], $P = 0.042$) remained significantly associated with continuous fasting ketone body concentrations.

Kaplan-Meier analysis (Fig. 1) showed that higher tertiles of ketone bodies were significantly associated with incident type 2 diabetes ($P < 0.001$). Cox regression analysis (Table 2) demonstrated that high baseline fasting ketone body concentrations entailed higher type 2 diabetes incidence (model 1, $P < 0.001$). Adjusting for age and sex (model 2, $P = 0.001$), metabolic syndrome constituents and BMI (model 3, $P = 0.001$), HOMA-IR (model 4, $P = 0.001$), lipid-related biomarkers (model 5, $P = 0.001$), and renal function (model 6, $P = 0.002$) did not materially weaken this association. When adjusting baseline ketone bodies for changes in weight, smoking habits, and age during follow-up, the association with incident type 2 diabetes remained (HR 1.78 [1.27–2.48], $P = 0.001$). Neither total nor individual ketone bodies correlated with HOMA-IR ($r < 0.02$), and no significant interaction between HOMA-IR and ketone bodies for incident type 2 diabetes was detected ($P = 0.785$). Stratified analyses by several baseline-level characteristics revealed no significant interactions for the association between ketone bodies and incident diabetes (Supplementary Fig. 1). In addition, visualizing this prospective association continuously over the full range of ketone bodies (Fig. 2) showed an increase in the adjusted

Table 1—Baseline participant level characteristics according to tertiles of fasting ketone body levels

| | Low tertile ($n = 1,103$) ($<153.3 \mu\text{mol/L}$) | Medium tertile ($n = 1,103$) (>153.3 to $<211.5 \mu\text{mol/L}$) | High tertile ($n = 1,101$) ($>211.5 \mu\text{mol/L}$) | <i>P</i> value |
|--------------------------------------|--|---|---|----------------|
| Ketone bodies ($\mu\text{mol/L}$) | 126.7 [111.3–139.5] | 175.5 [162.0–192.5] | 284.3 [241.4–367.5] | <0.001 |
| Type 2 diabetes during follow-up (%) | 1.8 | 4.3 | 5.4 | <0.001 |
| Age (years) | 50.3 [43.2–58.7] | 53.3 [45.5–63.6] | 53.5 [45.4–63.9] | <0.001 |
| Female (%) | 54.5 | 54.6 | 54.5 | 0.999 |
| Intoxication | | | | |
| Alcohol use (%) | 73.5 | 75.2 | 77.3 | 0.121 |
| Smoking (%) | 28.5 | 26.9 | 28.5 | 0.640 |
| Past smoking (%) | 58.7 | 65.3 | 60.7 | 0.022 |
| Metabolic health | | | | |
| BMI (kg/m^2) | 25.5 [23.3–28.1] | 26.4 [24.1–29.2] | 26.1 [23.6–29.0] | <0.001 |
| Waist circumference (cm) | 89.0 [81.0–98.0] | 92.0 [84.0–100.0] | 91.0 [82.0–100.0] | <0.001 |
| Glucose (mmol/L) | 4.7 [4.4–5.1] | 4.8 [4.4–5.2] | 4.7 [4.4–5.1] | <0.001 |
| HOMA-IR | 1.6 [1.1–2.3] | 1.8 [1.3–2.8] | 1.7 [1.1–2.6] | <0.001 |
| hsCRP (mg/dL) | 1.0 [0.5–2.0] | 1.6 [0.7–3.3] | 1.7 [0.7–3.8] | <0.001 |
| Systolic blood pressure (mmHg) | 121.0 [111.0–134.0] | 122.0 [112.0–136.5] | 123.0 [111.0–137.0] | 0.012 |
| Diastolic blood pressure (mmHg) | 72.0 [66.0–79.0] | 73.0 [67.0–79.0] | 73.0 [67.0–79.5] | 0.056 |
| Lipid markers | | | | |
| Total cholesterol (mmol/L) | 5.3 [4.7–6.1] | 5.5 [4.8–6.2] | 5.4 [4.7–6.2] | 0.012 |
| HDL cholesterol (mmol/L) | 1.3 [1.1–1.5] | 1.2 [1.0–1.4] | 1.2 [1.0–1.5] | 0.003 |
| LDL cholesterol (mmol/L) | 3.5 [3.0–4.2] | 3.7 [3.1–4.3] | 3.6 [3.0–4.2] | 0.225 |
| Triglycerides (mg/dL) | 90.0 [65.8–124.0] | 108.5 [78.0–151.9] | 99.1 [71.5–146.5] | <0.001 |
| Renal function | | | | |
| Serum creatinine (mmol/L) | 70.0 [62.0–79.0] | 70.0 [61.0–79.0] | 71.0 [62.0–81.0] | 0.104 |
| eGFR (mL/min/1.73m^2) | 95.0 [85.1–104.9] | 93.7 [81.3–104.1] | 92.8 [80.7–102.6] | <0.001 |
| Urinary albumin excretion | 5.1 [3.1–9.2] | 5.7 [3.3–10.8] | 5.4 [3.2–11.2] | 0.019 |
| Medication use | | | | |
| Lipid lowering drugs (%) | 6.7 | 9.8 | 7.2 | 0.015 |
| Antihypertensives (%) | 17.3 | 22.3 | 20.3 | 0.013 |

Data are median [IQR] unless otherwise specified.

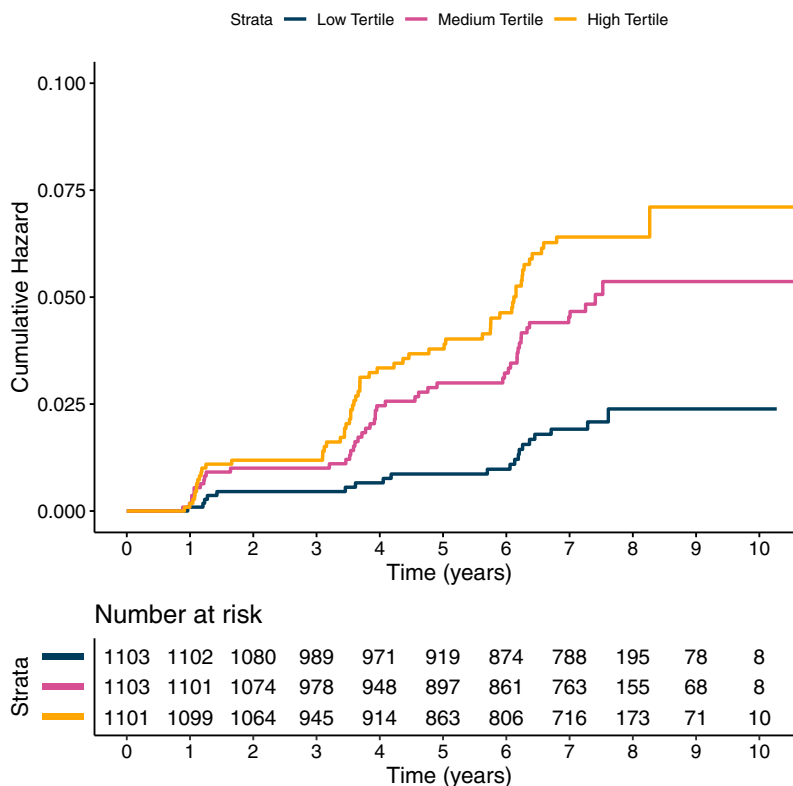


Figure 1—Kaplan-Meier analysis of type 2 diabetes incidence according to tertiles of ketone bodies (log-rank test, $P < 0.001$).

HR of type 2 diabetes with increasing fasting ketone body concentrations.

In separate Cox regression analyses either individually investigating levels of the ketone body subspecies AcAc + acetone and 3HB (Supplementary Table 2) or using very large triglyceride-rich lipoprotein particle concentration as a more objectifiable parameter for fasting (Supplementary Table 3), all models remained significant.

DISCUSSION

The results of this longitudinal prospective study demonstrate that fasting plasma ketone body levels strongly positively

associate with incident type 2 diabetes in the general population independent of several recognized risk factors. Of note, no differences were detected when separately considering individual ketone body subspecies (3).

During ketoacidosis, mainly occurring in absolute insulin deficiency such as type 1 diabetes, ketone body levels increase substantially because of increased hepatic production (15). In type 2 diabetes, circulating ketone bodies, assessed after an overnight fast, are usually also increased (16,17). In contrast, in young Finnish adults, fasting ketone bodies correlated negatively with HOMA-IR (18). However, in Finnish men, fasting ketone bodies and levels 2 h into an oral glucose tolerance

Table 2—Association of ketone bodies with incident type 2 diabetes in the general population including all participants (n = 3,307)

| | (Adjusted) hazard ratio [95% CI] | P value |
|--|----------------------------------|---------|
| Model 1: crude analysis | 1.62 [1.24, 2.10] | <0.001 |
| Model 2: adjusted for age and sex | 1.55 [1.19, 2.04] | 0.001 |
| Model 3: model 2 + BMI, waist circumference, blood pressure, hsCRP | 1.62 [1.21, 2.17] | 0.001 |
| Model 4: model 3 + HOMA-IR | 1.63 [1.21, 2.19] | 0.001 |
| Model 5: model 4 + lipid related biomarkers | 1.63 [1.21, 2.20] | 0.001 |
| Model 6: model 5 + renal function | 1.62 [1.19, 2.19] | 0.002 |

(Adjusted) hazard ratios [95% CI] are represented as doubling in baseline ketone body levels and were obtained utilizing Cox regression analysis. Model 1 is crude analysis; model 2 is adjusted for age and sex; model 3 is adjusted for model 2 + BMI, systolic blood pressure, waist circumference, and hsCRP; model 4 is adjusted for model 3 + HOMA-IR; model 5 is adjusted for model 4 + total cholesterol, HDL cholesterol, and triglycerides; and model 6 is model 5 + eGFR and urinary albumin excretion.

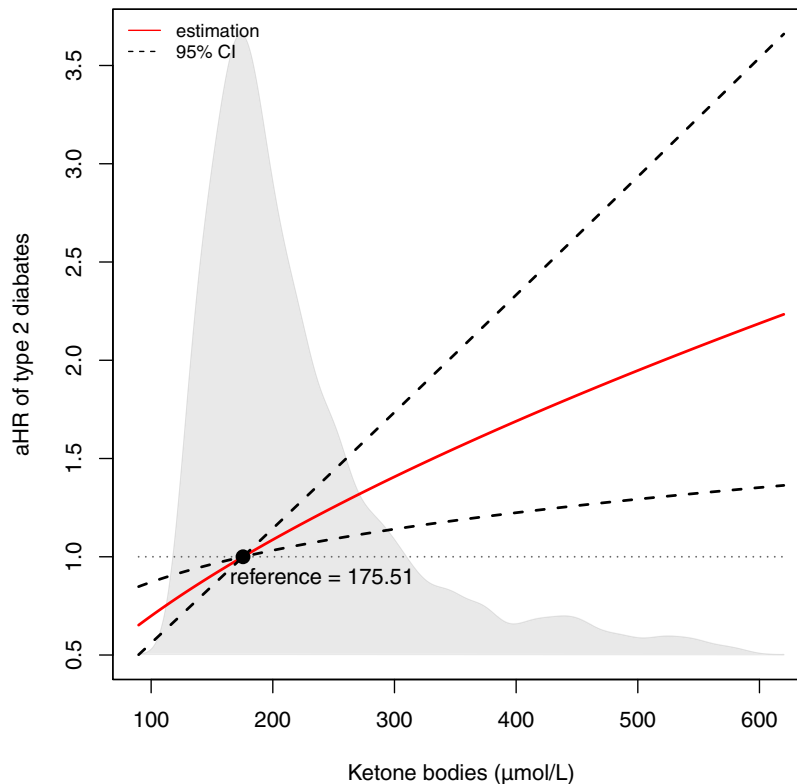


Figure 2—Adjusted hazard ratios (aHR) of type 2 diabetes at different concentrations of ketone bodies. The gray area represents the participant distribution.

test correlated positively with blood glucose (19). Similarly, our study comprising both males and females demonstrated a strong positive association between glucose and circulating ketone bodies. Causality of this association cannot be derived from both studies. However, ketone body infusion into fasted dogs resulted in hypoglycemia (20). Smaller studies in humans indicate a similar effect following ketone ester-containing drinks (21). Thus, increased circulating ketone bodies could represent an early response to maintain normoglycemia in subjects at risk for developing insulin resistance. Further studies are required to specifically address this point. Data on a prospective association of ketone bodies with incident type 2 diabetes are currently scarce and do not allow uniform conclusions. In the aforementioned Finnish study including only male participants ($n = 4,277$), AcAc associated with de novo type 2 diabetes ($P = 0.047$) in a model adjusted for age, BMI, smoking, and physical activity, while, surprisingly, 3HB was not associated with that outcome at all (19). This contrasts with our data demonstrating a firm association of both ketone bodies with incident type 2 diabetes without discernible interaction by sex. When expanding the results in Finnish cohorts to a metabolomics approach including 11,896 young participants, AcAc and 3HB were positively, albeit not significantly, associated with incident type 2 diabetes (22). However, fasting times varied highly, which could conceivably have contributed to offsetting the significance of these findings. A similar reasoning might apply to recent results from the UK Biobank

indicating a potential negative association of 3HB with incident type 2 diabetes, while the outcome was neutral for AcAc (23); this study deliberately used nonfasting conditions. Of note, all three studies measured metabolites on the same NMR platform (Nightingale Health Ltd.) (19,22,23). More research, ideally prospectively using nonfasting and fasting samples from the same participants, would be required to explore these points. Further, the impact of age seems important, since young adults developing insulin-resistant diabetes might differ with respect to metabolic signatures from middle-aged and older participants, when similar follow-up times are applied.

Ketone bodies are the eponymous biomarker of the increasingly popular so-called ketogenic diets that advise followers to consume more than 70% of calories derived from fat (24), which consistently results in high ketone body formation. However, scientific evidence for a superior efficacy of such an approach to prevent type 2 diabetes is low. Although, formally, the design of our study does not allow drawing firm conclusions on the impact of dietary interventions, it adds a cautionary note by demonstrating that high ketone body levels are associated with an opposite outcome than is intended by ketogenic diets. Interestingly, in the Inuit population traditionally following a ketogenic diet, a highly prevalent CPT1A mutation developed, which circumvents ketone body production (25). Such data might indicate that evolutionary chronically increased ketone body levels could be harmful.

Potential limitations of PREVENT are that dietary habits were not recorded, free fatty acids were not determined, and participants are from a relatively homogenous, predominantly White population, preventing conclusions with respect to other ethnicities. In addition, HbA_{1c} levels were not available to establish a diagnosis of type 2 diabetes, and ketone body concentrations were only measured at baseline and not during follow-up. Strengths of our work are the inclusion of a relatively large number of well-characterized subjects, the availability of various biomarkers, and a close and thorough follow-up.

In conclusion, this study demonstrates that fasting ketone bodies strongly and independently associate with incident type 2 diabetes in the general population. Thereby, these data may have important implications for the identification and potential stratification of subjects at risk for developing type 2 diabetes, as well as for considering intervention strategies against the obesity epidemic with its cardiometabolic sequelae.

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Author Contributions. T.S.-T. performed data acquisition, analysis and interpretation, and drafting of the manuscript; M.H.d.B. performed data acquisition and interpretation, and critical revision of the manuscript; E.G. performed data acquisition and interpretation, and critical revision of the manuscript; R.T.G. performed data acquisition and interpretation, and critical revision of the manuscript; R.P.F.D. performed data acquisition and interpretation, and critical revision of the manuscript; M.A.C. performed data acquisition and interpretation, and critical revision of the manuscript; S.J.L.B. performed data acquisition and interpretation, and critical revision of the manuscript; and U.J.F.T. performed conception and design of the study, data interpretation, and drafting of the manuscript. U.J.F.T. 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.

References

- Chatterjee S, Khunti K, Davies MJ. Type 2 diabetes. *Lancet* 2017;389:2239–2251
- Jonas DE, Crotty K, Yun JDY, et al. Screening for prediabetes and type 2 diabetes: updated evidence report and systematic review for the US Preventive Services Task Force. *JAMA* 2021;326:744–760
- Laffel L. Ketone bodies: a review of physiology, pathophysiology and application of monitoring to diabetes. *Diabetes Metab Res Rev* 1999;15:412–426
- Yurista SR, Chong CR, Badimon JJ, Kelly DP, de Boer RA, Westenbrink BD. Therapeutic potential of ketone bodies for patients with cardiovascular disease: JACC state-of-the-art review. *J Am Coll Cardiol* 2021;77:1660–1669
- Soeters MR, Sauerwein HP, Faas L, et al. Effects of insulin on ketogenesis following fasting in lean and obese men. *Obesity (Silver Spring)* 2009;17:1326–1331
- Vallon V, Verma S. Effects of SGLT2 inhibitors on kidney and cardiovascular function. *Annu Rev Physiol* 2021;83:503–528
- Cowie MR, Fisher M. SGLT2 inhibitors: mechanisms of cardiovascular benefit beyond glycaemic control. *Nat Rev Cardiol* 2020;17:761–772
- Tinguely D, Gross J, Kosinski C. Efficacy of ketogenic diets on type 2 diabetes: a systematic review. *Curr Diab Rep* 2021;21:32
- Jia C, Anderson JLC, Gruppen EG, et al. High-density lipoprotein anti-inflammatory capacity and incident cardiovascular events. *Circulation* 2021;143:1935–1945
- American Diabetes Association. 2. Classification and diagnosis of diabetes: *Standards of Medical Care in Diabetes-2020*. *Diabetes Care* 2020;43(Suppl. 1):S14–S31
- Alberti KG, Zimmet PZ. Definition, diagnosis and classification of diabetes mellitus and its complications. Part 1: diagnosis and classification of diabetes mellitus provisional report of a WHO consultation. *Diabet Med* 1998;15:539–553
- Matyus SP, Braun PJ, Wolak-Dinsmore J, et al. NMR measurement of LDL particle number using the Vantera Clinical Analyzer. *Clin Biochem* 2014;47:203–210
- Garcia E, Shalaurova I, Matyus SP, et al. Ketone bodies are mildly elevated in subjects with type 2 diabetes mellitus and are inversely associated with insulin resistance as measured by the Lipoprotein Insulin Resistance Index. *J Clin Med* 2020;9:321
- Sampson M, Ling C, Sun Q, et al. A new equation for calculation of low-density lipoprotein cholesterol in patients with normolipidemia and/or hypertriglyceridemia. *JAMA Cardiol* 2020;5:540–548
- Fazeli Farsani S, Brodovicz K, Soleymanlou N, Marquard J, Wissinger E, Maiese BA. Incidence and prevalence of diabetic ketoacidosis (DKA) among adults with type 1 diabetes mellitus (T1D): a systematic literature review. *BMJ Open* 2017;7:e016587
- Avogaro A, Crepaldi C, Miola M, et al. High blood ketone body concentration in type 2 non-insulin dependent diabetic patients. *J Endocrinol Invest* 1996;19:99–105
- Ferrannini E, Baldi S, Frascerra S, et al. Shift to fatty substrate utilization in response to sodium-glucose cotransporter 2 inhibition in subjects without diabetes and patients with type 2 diabetes. *Diabetes* 2016;65:1190–1195
- Würtz P, Mäkinen VP, Soininen P, et al. Metabolic signatures of insulin resistance in 7,098 young adults. *Diabetes* 2012;61:1372–1380
- Mahendran Y, Vangipurapu J, Cederberg H, et al. Association of ketone body levels with hyperglycemia and type 2 diabetes in 9,398 Finnish men. *Diabetes* 2013;62:3618–3626
- Felts PW, Crofford OB, Park CR. Effect of infused ketone bodies on glucose utilization in the dog. *J Clin Invest* 1964;43:638–646
- Soto-Mota A, Norwitz NG, Evans RD, Clarke K. Exogenous d-β-hydroxybutyrate lowers blood glucose in part by decreasing the availability of L-alanine for gluconeogenesis. *Endocrinol Diabetes Metab* 2022;5:e00300
- Ahola-Olli AV, Mustelin L, Kalimeri M, et al. Circulating metabolites and the risk of type 2 diabetes: a prospective study of 11,896 young adults from four Finnish cohorts. *Diabetologia* 2019;62:2298–2309
- Bragg F, Trichia E, Aguilar-Ramirez D, Bešević J, Lewington S, Emberson J. Predictive value of circulating NMR metabolic biomarkers for type 2 diabetes risk in the UK Biobank study. *BMC Med* 2022;20:159
- Ludwig DS. The ketogenic diet: evidence for optimism but high-quality research needed. *J Nutr* 2020;150:1354–1359
- Clemente FJ, Cardona A, Inchley CE, et al. A selective sweep on a deleterious mutation in CPT1A in Arctic populations. *Am J Hum Genet* 2014;95:584–589