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Associations between systemic low-grade inflammation and body weight, therapeutical management, and comorbidities in type 2 diabetes

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TITLE PAGE

Full Title: Associations between systemic low-grade inflammation and body weight, therapeutical management, and comorbidities in type 2 diabetes

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STRUCTURED ABSTRACT

Objectives: To investigate low-grade inflammation in type 2 diabetes and explore associations to clinical aspects as well as micro- and macrovascular complications.

Design: Cross-sectional analysis

Setting: The out-patient diabetes clinic at the department of endocrinology at Aalborg University Hospital, Denmark

Participants: 100 participants with type 2 diabetes confirmed by a HbA1C ≥ 6.5% for a minimum of one year and 21 healthy controls

Outcome measures: Plasma levels of 27 inflammation-related biomarkers measured by immunoassay. Associations with micro-and macrovascular complications, body weight, glycemic control, medication, and sex were investigated in the diabetes cohort.

Results: Plasma levels of TNF-α, eotaxin, MCP-1, MDC, MIP-1β, and CRP were elevated in type 2 diabetes ($p<0.05$), while IL-7 was decreased ($p<0.001$). IL-12/IL-23p40, IL-15 and CRP levels were increased with body weight ($p<0.05$), while IL-12/IL-23p40 and eotaxin were increased with elevated HbA1c levels ($p<0.03$). DPP-4 inhibitor therapy was associated with lower levels of IL-18, IP-10, and MDC ($p<0.03$), while females had higher levels of MDC ($p=0.012$). Individuals with ≥3 diabetic complications had elevated levels of IL-6, IL-10, IL-12/IL-23p40, IL-15, and CRP compared to those with ≤3 ($p<0.05$).

Conclusion: The level of low-grade inflammation in type 2 diabetes is associated with obesity, glycemic regulation, therapeutical management, sex, and complications. Our results underline the importance of addressing inflammatory issues in type 2 diabetes, as these may predispose for crippling comorbidities.

Strengths and limitations of this study:

- Analysis of a broad palette of inflammatory biomarkers in plasma in 100 participants with type 2 diabetes and 21 healthy controls
- High degree of heterogeneity of our cohort, which allows for generalization to the population of type 2 diabetes
- Well-characterized cohort in regard to micro- and macrovascular comorbidities
- This study is based on secondary analysis and thus inclusion and exclusion criteria were not designed specifically with the investigation of inflammatory biomarkers in mind

1 INTRODUCTION

Tight glycemic regulation is vital for balancing the existing energy demand in tissues by combining resources originating from the nutritional supply and release from internal storages. Low blood glucose is potentially life-threatening, while long-term elevated levels have several metabolic consequences, including sorbitol production, mitochondrial dysfunction, and formation of advanced glycation end products (1). Chronic hyperglycemia can be caused either by insulin deficiency, as seen in type 1 diabetes, or by a combination of generalized insulin resistance in peripheral tissues and insufficient insulin production resulting in type 2 diabetes. The latter is the most prevalent diabetes type accounting for up to 90% of the cases (2).

The pathogenesis of type 2 diabetes is highly complex and multifactorial, and many aspects of the disease require further elucidation. However, it is clear that obesity along with a sedentary lifestyle is a substantial risk factor for development of insulin resistance and type 2 diabetes through stress-induced inflammation in adipose tissue leading to insensitivity of the insulin receptor (3). In recent years, the previous view on adipose tissue as a mere storage of fat has been disproved, and it is now accepted that especially visceral adipose tissue possesses important endocrine and inflammatory properties. As an example, adipocytes activated by expansion-associated hypoxia secrete cytokines and so-called adipokines, many of which are pro-inflammatory in nature (4). As the prevalence of both obesity and type 2 diabetes continue to rise worldwide (2), a better understanding of the inflammatory link between these lifestyle-associated conditions is crucial.

In addition to obesity-induced inflammation, excess glucose availability in diabetes causes alterations in normal homeostasis, facilitating the progression of proinflammatory cytokine release to the microenvironment. Low-grade systemic inflammation is thus regarded as an accompanying condition in type 2 diabetes (5). Increased levels of proinflammatory biomarkers such as interleukin (IL) 6 and C-reactive protein (CRP) have been shown to be associated with an increased risk of type 2 diabetes development in several prospective studies (6,7). This suggests that the pathogenetic mechanisms in type 2 diabetes is influenced by systemic low-grade inflammation. It is, however, unclear whether this proinflammatory state remains during the course of the disease or if it increases or diminishes over time. In addition, standard medical treatment in type 2 diabetes such as statins and dipeptidyl peptidase-4 (DPP-4) inhibitors have immunomodulating properties and may thus influence the inflammatory response (8,9).

The low-grade systemic inflammation in type 2 diabetes is clinically essential, because it is associated with the development and progression of long-term complications such as nephropathy, neuropathy and retinopathy (10–12). Moreover, low-grade inflammation is associated with cardiovascular disease in diabetes (13), which is the primary cause of morbidity and mortality in individuals with type 2 diabetes (14).

The aim of this study was to investigate the level of low-grade systemic inflammation in a cohort of individuals with type 2 diabetes with varying disease duration. Furthermore, we aimed to explore if presence

of inflammation was more prevalent in clinically relevant subgroups of the type 2 diabetes cohort, and whether elevated systemic inflammation was associated with number of diabetic comorbidities. We hypothesized that individuals with type 2 diabetes exhibited higher levels of pro-inflammatory biomarkers than healthy controls, and that levels of pro-inflammatory biomarkers were associated with obesity, and glycemic control. Further, we hypothesized that the number of diabetes-related micro- and macrovascular complications and therapeutic management were associated with the level of low-grade systemic inflammation.

2 METHODS

2.1 Study population

All individuals with type 2 diabetes scheduled for regular health visits at the out-patient diabetes clinic at the department of endocrinology at Aalborg University Hospital, Denmark were informed about the study and screened for eligibility after signing of the informed consent form, and 100 participants were included for cross-sectional analysis. Inclusion criteria included Northern European descent, age above 18 years, a verified diagnosis of type 2 diabetes with HbA1C ≥ 6.5% for a minimum of one year, and stable diabetes treatment. People with other endocrinological or neurological diseases were excluded. Prior to study initiation, the protocol was approved by The North Denmark Region Committee on Health Research Ethics, Denmark (N-20170045). The primary outcome of the study was cardiac vagal tone and the results have been published elsewhere (15). The control cohort consisted of sex-matched healthy volunteers (n=21) recruited for a randomized controlled trial (N-20090008) likewise conducted by our research group.

2.2 Blood samples

Morning blood samples were drawn from the cubital vein after a fasting period of a minimum of six hours. For analysis of inflammatory biomarkers, blood was collected in EDTA tubes and centrifuged for 10 minutes at 1000 g. Isolated plasma was aliquoted in appropriate volumes and stored in a biobank at -80°C until the complete data set was collected. All samples were thawed just prior to analysis. Samples from both cohorts were analyzed consecutively to minimize interplate variability. For analysis of hemoglobin A1c (HbA1c), blood was collected in lithium heparin tubes and analyzed by routine biochemical procedures.

2.3 Inflammatory biomarkers

Biomarker concentrations in plasma samples were analyzed using the V-PLEX Neuroinflammation Panel 1 Human Kit (Meso Scale Diagnostics® [MSD], Gaithersburg, MD, USA) on a MESO QuickPlex SQ 120 instrument (MSD) according to the manufacturer´s specifications. Sample values below the detection limit of the assay were assigned a value of the detection limit divided by √2 (16). If more than 30% of the measured samples for any given biomarker were below the detection limit, the biomarker was excluded from the analysis. Likewise, samples with a coefficient of variation (CV) >30% between duplicate measurements were excluded from the analysis (Supplementary Table 1). Biomarkers on the panel included: IL-1α, IL-1β,

IL-2, IL-4, IL-5, IL-6, IL-7, IL-8, IL-10, IL-12/IL-23p40, IL-13, IL-15, IL-16, IL-17A, interferon (IFN)-γ, tumor necrosis factor (TNF)-α, TNF-β, eotaxin, eotaxin-3, IFN-γ-induced protein (IP)-10, monocyte chemoattractant protein (MCP)-1, MCP-4, macrophage-derived chemokine (MDC), macrophage inflammatory protein (MIP)-1α, MIP-1β, thymus and activation regulated chemokine (TARC), CRP.

2.4 Assessment of diabetic comorbidities

All participants in the type 2 diabetes cohort underwent investigations concerning common diabetic comorbidities: 1) *Peripheral neuropathy*: Signs of peripheral neuropathy was investigated by vibration perception threshold (VPT) at the dorsum of the first phalanx using a biothesiometer (Bio-Medical Instruments). The measurement was done three consecutive times bilaterally, and the final vibration perception threshold was calculated as the mean value of both feet. Results above 18 volts were considered abnormal and thus as signs of diabetic peripheral neuropathy. 2) *Nephropathy*: Morning urine samples were collected by participants at home and handed over to study personnel for standard biochemical analysis. Diabetic nephropathy was defined as a urine albumin/creatinine ratio above 30 mg/g, which is a standard cut-off for early diabetic nephropathy and microalbuminuria. 3) *Retinopathy*: Participants were asked if they had ever been diagnosed with proliferative or non-proliferative retinopathy 4) *Cardiac autonomic neuropathy*: Electrocardiographic recordings by the VAGUS™ device (Medicus Engineering Aps, Aarhus, Denmark) were applied for evaluation of cardiac autonomic neuropathy. Recordings were made during rest, postural change, deep breathing, and the Valsalva maneuver. Abnormal results in one or more exercises were considered as signs of cardiac autonomic neuropathy.

2.5 Data handling and statistics

Distribution of raw and log-transformed data was evaluated by Shapiro-Wilk test of normality. Pairwise comparisons among groups were achieved by independent samples t-test or Mann-Whitney U based on data distribution. For volcano plots, the fold difference was calculated as the $\log_2$-ratio between two group means. Multiple regression analyses were performed to investigate the association between clinical parameters and inflammatory biomarkers. The independent variables included obesity (BMI<30 versus BMI>30), blood glucose level (HbA1c<55 versus HbA1c>55), DPP-4 inhibitor therapy, GLP-1 receptor agonist therapy, and sex. Additionally, two models were applied in which associations were adjusted for the remaining clinical variables, and total plasma cholesterol or statin therapy. An α-level of 0.05 was applied for all analyses. The STATA software (StataCorp LLC, version 15.1) was applied for all statistical analyses.

2.6 Patient and public involvement

Patients or members of the public were not included in the design, conduction, reporting, or dissemination plans of this project.

3 RESULTS

3.1 Study population

Two subjects in the type 2 diabetes group were excluded due to hemolysis of collected blood samples. Individuals in the diabetes group were older, had higher BMI, and higher HbA1c compared to the healthy controls ($p<0.001$). On the contrary, healthy controls had higher total cholesterol ($p<0.001$), high-density lipoprotein (HDL) ($p=0.006$), and low-density lipoprotein (LDL) ($p<0.001$) compared to individuals in the type 2 diabetes cohort of which 66% were on lipid-lowering statin therapy. A full demographic overview can be found in Table 1.

	Healthy (n=21)	**Type 2 diabetes** (n=98)	**p-value**
Basic demography			
Age (years)	51 ± 6	65 (56-71)	**<0.001**
Sex (% of males)	71	63	0.478
BMI (kg/m$^{2)}$	25.6 (23.7-28.0)	31.4 ± 5.6	**<0.001**
Current smokers (%)	19	5	**0.028**
Disease duration (y)	-	10 (5-17)	-
Vital signs			
Systolic BP (mmHg)	129 ±15	137 (128-147)	**0.021**
Diastolic BP (mmHg)	76 ± 11	77 ± 9	0.720
Pulse (beats/min)	66 ± 7	69.8 ± 10	0.110
Biochemistry			
Hba1c			
(mmol/mol)	33 (33-37)	55 (48-61.5)	**<0.001**
(%)	5.2 (5.2-5.5)	7.2 (6.5-7.8)	**<0.001**
Cholesterol (mmol/l)	5.4 ± 0.9	3.9 ± 0.9	**<0.001**
HDL (mmol/l)	1.6 ± 0.4	1.2 (1.0-1.5)	**0.006**
LDL (mmol/l)	3.3 ± 0.9	1.9 ± 0.7	**<0.001**
Triglycerides (mmol/l)	1.2 ± 0.5	1.4 (1.0-2.0)	**0.023**
Medication			
DPP-4 inhibitor (%)	-	18	-
SGLT-2 inhibitor (%)	-	23	-
GLP-1 receptor agonist (%)	-	23	-
Statins (%)	-	66	-

Table 1: Demographic and clinical characteristics among groups. Results displayed as either mean ± SD or median (1st-3rd quartiles) based on distribution of the data. Boldface font indicates statistical significance

(p<0.05). BMI: Body mass index; HDL: High-density lipoprotein; LDL: Low-density lipoprotein; DPP-4: Dipeptidyl peptidase-4; SGLT: Sodium-glucose transport protein; GLP: Glucagon-like peptide.

3.2 Inflammatory biomarkers in plasma

Plasma levels of 27 inflammatory biomarkers were measured in individuals with type 2 diabetes and healthy controls. Eleven biomarkers were excluded from the statistical analyses due to being undetectable or of insufficient measurement quality due to low levels (Supplementary Table 1). The remaining 16 biomarkers (IL-6, IL-7, IL-8, IL-10, IL-12/IL-23p40, IL-15, IL-16, IFN-γ, TNF-α, eotaxin, IP-10, MCP-1, MDC, MIP-1β, TARC, CRP) were measured in ≥95% of the samples. The concentrations of TNF-α (p = 0.003) and CRP (p=0.030) were significantly higher in the type 2 diabetes cohort compared to the control cohort (Figure 1). Similarly, 4 chemokines (eotaxin (p=0.001), MCP-1 (p=0.018), MDC (p=0.005), and MIP-1β (p=0.047)) showed elevated levels in the diabetes cohort. In contrast, the level of cytokine IL-7 was significantly lower in participants with type 2 diabetes compared to healthy controls (p<0.001). Plasma concentrations of all measured biomarkers are presented in supplementary Table 2. When subdividing the type 2 diabetes cohort according to disease duration only IL-10 was significantly different (p=0.008) between groups with a modestly increased level found in subjects with disease duration above ten years (Table 2).

	Short-term disease duration	Long-term disease duration	p-value
IL-6	0.8 (0.6-1.1)	0.9 (0.6-1.4)	0.480
IL-7	7.6 (5.7-10.1)	8.3 (6.4-10.7)	0.442
IL-8	12.5 (9.2-16.8)	13.1 (9.4-16.5)	0.970
IL-10	0.3 (0.2-0.3)	0.3 (0.2-0.4)	**0.008**
IL-12/IL-23p40	107.5 (80.3-142.6)	104.9 (83.0-155.3)	0.740
IL-15	2.6 (2.2-2.8)	2.8 (2.4-3.0)	0.170
IL-16	208.7 ± 51.8	206.6 ± 46.9	0.835
IFN-γ	4.7 (3.0-7.7)	5.4 (3.7-7.8)	0.313
TNF-α	1.5 ± 0.4	1.6 ± 0.5	0.246
Eotaxin	326.7 (264.4-447.5)	350.6 (258.2-418.9)	0.860
IP-10	590.7 (436.2-689.7)	608.2 ± 213.3	0.950
MCP-1	327.9 ± 104.3	317.8 (229.3-379.6)	0.604
MDC	1136.4 ± 375.1	1013.8 (881.6-1241.6)	0.513
MIP-1β	162.0 ± 44.3	162.1 ± 53.3	0.992
TARC	287.3 (168.1-404.2)	267.7 (169.3-398.6)	0.763
CRP (ng/mL)	2941.6 (1050.8-5236.5)	2025 (966.1-4686.6)	0.587

Table 2: Plasma concentrations of inflammatory factors in type 2 diabetes with short-term disease duration (<10 years, n=44) and long-term disease duration (>10 years, n=50). Results (in pg/mL, unless otherwise stated) displayed as either mean ± SD or median (1^{st}-3^{rd} quartiles) based on distribution of the data. Boldface font indicates statistical significance ($p<0.05$).

3.3 Inflammatory biomarkers in subgroups

Obesity significantly predicted concentration of five inflammatory biomarkers (IL-12/IL-23p40, IL-15, IFN-γ, MDC, and CRP) (Table 3). When adjusting for HbA1c, sex, and total plasma cholesterol or statin use, IL-12/IL-23p40, IL-15, and CRP remained statistically significant predicted by obesity. HbA1c significantly predicted eotaxin and IL-12/IL-23p40 levels after adjusting for confounders. Lower levels of IL-8, IP-10, and MDC were predicted by DPP-4 inhibitor therapy, while higher levels of TNF-α were predicted by GLP-1 receptor agonist therapy. Lastly, levels of MDC were predicted by sex with lower levels found in male subjects compared to females.

	UNADJUSTED MODEL			ADJUSTED MODEL 1			ADJUSTED MODEL 2		
	R^2	Effect size	p-value	R^2	Effect size	p-value	R^2	Effect size	p-value
A. Obesity									
IL-12/IL-23p40	0.11	45.8 (19.1 - 72.6)	**0.001**	0.32	44.9 (6.2 - 70.6)	**<0.001**	0.27	41.5 (21.2 - 63.1)	**0.001**
IL-15	0.04	0.2 (0.0 - 0.5)	**0.038**	0.44	0.2 (0.0 - 0.5)	0.086	0.26	0.2 (0.0 - 0.5)	**0.045**
IFN-γ	0.05	3.6 (0.5 - 6.7)	**0.024**	0.38	2.8 (-0.3 - 7.0)	0.096	0.22	3.3 (-0.2 - 7.3)	0.111
MDC	0.06	190.6 (35.4 - 345.9)	**0.017**	0.43	104.5 (38.6 - 299.4)	0.131	0.28	141.7 (-59.4 - 314.4)	0.119
CRP	0.14	2896.5 (1412.0 - 4380.9)	**<0.001**	0.50	2223.5 (875.9 - 4034.3)	**0.012**	0.42	3081.9 (1161.3 - 4640.9)	**<0.001**
B. Blood glucose									
IL-8	0.04	2.9 (0.1 - 5.7)	**0.043**	0.50	1.9 (-1.1 - 5.3)	0.352	0.26	2.5 (0.3 - 4.7)	0.062
IL-12/IL-23p40	0.03	26.1 (-1.3 – 53.4)	0.062	0.47	25.9 (4.2 - 50.9)	0.168	0.40	29.2 (5.1 - 52.7)	**0.014**
TNF-α	0.06	0.2 (0.0 - 0.4)	**0.020**	0.32	0.1 (-0.0 - 0.3)	0.158	0.21	0.2 (0.0 - 0.4)	0.067
Eotaxin	0.05	58.9 (8.7 - 109.1)	**0.022**	0.46	66.3 (35.7 - 108.7)	**0.001**	**0.22**	54.8 (-0.1 - 98.1)	**0.028**
C. DPP-4 inhibitor therapy									
IL-8	0.05	-4.0 (-7.5 - -0.5)	**0.028**	0.62	-2.8 (-23.5 – 5.7)	0.683	0.32	-3.8 (-7.5 - -1.2)	**0.023**
IP-10	0.08	-175.9 (-303.7- -48.2)	**0.007**	0.58	-272.1 (-655.4 - -146.2)	0.334	0.45	-201.5 (-298.6 - -87.1)	**0.001**
MDC	0.06	-236.8 (-433.1- -40.4)	**0.019**	0.65	-258.5 (-484.1 - -138.2)	**0.003**	0.50	-256.6 (-487.1 - -154.9)	**0.003**
TARC	0.11	165.7 (69.3 – 262.0)	**0.001**	0.76	98.9 (-102.5 – 220.6)	0.350	0.48	103.3 (9.6 - 257.9)	0.102
D. GLP-1 receptor agonist therapy									
IL-8	0.05	3.8 (0.5 – 7.1)	**0.023**	0.60	0.6 (-3.4 – 5.1)	0.765	0.33	1.0 (-1.8 – 5.0)	0.623
IL-16	0.04	-23.5 (-46.5 - -0.6)	**0.044**	0.04	-22.7 (-48.0 – 2.5)	0.077	0.04	-24.0 (-49.3 – 1.4)	0.064
TNF-α	0.11	0.4 (0.2 – 0.6)	**0.001**	0.16	0.3 (0.0 – 0.5)	**0.032**	0.16	0.3 (0.0 – 0.5)	**0.025**

E. Sex									
MDC	0.1	-238.5 (-395.1 - -81.9)	**0.003**	0.57	-336.2 (-545.1 - -72.0)	**0.012**	0.46	-257.6 (-4.62.4 - 0.20)	0.451

Table 3: Multiple regression analysis of plasma concentrations (dependent variable) between A) type 2 diabetes+BMI<30 (n=40) and Type 2 diabetes+BMI>30 (n=58), B) type 2 diabetes with HbA1c<55(n=47) and type 2 diabetes with HbA1c>55 (n=51), C) type 2 diabetes (n=80) and type 2 diabetes treated with DPP-4 inhibitors (n=18), D) type 2 diabetes (n=75) and type 2 diabetes treated with GLP-1 receptor agonists (n=23), and D) male type 2 diabetes (n=62) and female type 2 diabetes (n=36) with overall R-squared value and effect size (95% CI) of BMI, HbA1c, DPP-4 inhibitor therapy, GLP-1 receptor agonist therapy, or sex displayed. Total plasma cholesterol, BMI, HbA1c, and sex were included in the adjusted model 1 as appropriate, while statin use, BMI, HbA1c, and sex were included in the adjusted model 2 as appropriate. Only analytes with significant results are shown. Boldface font indicated statistical significance ($p<0.05$)

3.4 Diabetic comorbidities

When subdividing the type 2 diabetes cohort into groups according to number of diabetic comorbidities, five biomarkers (IL-6, IL-10, IL12/IL-23p40, IL-15, and CRP) were significantly elevated in participants with three or more comorbidities compared to those with fewer or none (Figure 2).

4 DISCUSSION

In this study, we investigated the level of systemic low-grade inflammation in a cohort of individuals diagnosed with type 2 diabetes. Elevated levels of several inflammatory biomarkers were found in comparison to healthy controls, evident in both short- and long-term disease duration. Moreover, in the type 2 diabetes cohort, obesity, hyperglycemia and female sex were found to be predictors of elevated levels of various inflammatory biomarkers. Lastly, we were able to establish a connection between the number of common diabetic comorbidities and elevated levels of inflammatory biomarkers including CRP.

4.1 Inflammatory biomarkers in plasma

Increased levels of TNF-α and CRP have previously been reported in adults with type 2 diabetes (13,17). CRP production is induced by the presence of both TNF-α and IL-6 (18). Our data support these findings, as we showed concurrent increases in both TNF-α and CRP in the type 2 diabetes cohort regardless of disease duration in comparison to healthy controls.

Eotaxin has been linked to the development of atherosclerosis by facilitating monocyte infiltration in smooth muscle cells under the influence of proinflammatory mediators (19), and elevated levels of this chemokine have previously been reported in type 1 diabetes individuals with complications compared to individuals with no diabetic complications as well as healthy controls (20). Accordingly, our statistical analysis revealed significant increases in several chemokines (eotaxin, MCP-1, MDC, and MIP-1β) in individuals with type 2 diabetes.

The majority of research regarding IL-7 has been conducted in type 1 diabetes, where elevated levels are shown compared to healthy (21). IL-7 is highly involved in T cell function and proliferation, and a role of this cytokine in mediating expansion of insulin-producing β-cell-autoreactive T cells have been proposed thus implicating IL-7 in the pathogenesis of type 1 diabetes (22). The decreased levels in type 2 diabetes compared to healthy controls found in this study were somewhat surprising but may reflect the lack of T-cell activation the pathology of type 2 diabetes.

IL-10 is generally regarded as an anti-inflammatory cytokine with the ability to dampen the immune response, and previous data have shown downregulation of IL-10 in both type 2 diabetes and obesity *per se* (23). This contrasts our findings, which showed no differences in the overall diabetes cohort but an increase in individuals with long disease duration. This observation could reflect manifestations of compensatory mechanisms toward a long-term elevated inflammatory environment attempting to elicit an anti-

inflammatory response. However, pro-inflammatory factors (e.g. TNF-α) were elevated regardless of disease duration suggesting that any attempt of balancing the immune response remain challenging in the presence of type 2 diabetes.

4.2 Inflammatory biomarkers in subgroups

In our type 2 diabetes cohort, obesity (BMI>30) significantly predicted the levels of IL-12/IL-23p40 and CRP, while eotaxin level was predicted by glycemic regulation (HbA1c). In the unadjusted model, TNF-α was likewise predicted by HbA1c. This association was, however, abolished when the model was adjusted for confounders. Previously it has been shown that TNF-α release is upregulated in connection with obesity and has been linked to the progression of insulin resistance (24,25). The fact that TNF-α was not predicted by obesity in our cohort is thus surprising. However, elevated levels of TNF-α in adipose tissue, but not in plasma have previously been reported (26), which could also be the case in our cohort. In animal models, TNF-α antagonist treatment improves insulin resistance in obesity (27). A clinical study, however, failed to show the same effect in humans (28). Regarding eotaxin, this chemokine has been linked to the development of cardiovascular disease, which is likewise a complication to long-term hyperglycemia, and our findings of increased levels in dysregulated individuals could therefore be a plausible sign of atherosclerosis (19).

Lower levels of three chemokines (IL-8, IP-10 and MDC) were all predicted by DPP-4 inhibitor therapy. DPP-4 inhibitor therapy is known to improve glycemic control via prevention of breakdown of the incretin hormone GLP-1. In addition, several cytokines and chemokines are also substrates of the DPP-4 enzyme, and DPP-4 inhibitor therapy thus possesses immunomodulating properties possibly facilitating low-grade systemic inflammation in diabetes (9). Potentially this could explain why promising *in vitro* anti-inflammatory actions of DPP-4 inhibitors have failed to show convincingly results in humans (29). Surprisingly, we found lower levels of three DPP-4 substrates (IL-8, IP-10, and MDC) in connection with DPP-4 inhibitor therapy. Though seemingly in contrast with the expected result, similar observations have previously been reported (30), underlining the need for further research in the immunomodulating effects of DPP-4 inhibitor therapy.

GLP-1 receptor agonist therapy, which share the same pharmacodynamic endpoint as DPP-4 inhibitor therapy, is known to possess anti-inflammatory properties independent of improved glycemic control (31). However, our results showed an approximately 25% increase in proinflammatory TNF-α levels in connection with GLP-1 receptor agonist therapy. This finding is unexpected and in contrast with a previous pilot study showing that liraglutide significantly decreased TNF-α levels in a type 2 diabetes cohort (32). Preclinical studies have likewise shown inhibitory effects of liraglutide on TNF-α expression (33). Other preclinical studies, however, have reported decreased proinflammatory effects of TNF-α through inhibition of the NK-

κB pathway after GLP-1 receptor agonist therapy (34). If this is the case, this would neutralize the proinflammatory pathways caused by increased TNF-α levels seen in this study.

We showed that the level of the chemokine MDC was predicted by sex with higher levels seen in females compared to males. Different obesity-related inflammatory pathways between men and women with metabolic syndrome have previously been shown. Increased levels of pro-inflammatory mediators seem to facilitate low-grade systemic inflammation in males, while an insufficient anti-inflammatory milieu appears to be dominant in females (35). These findings suggest that any inflammation-modulating therapy in obesity should be differentiated according to sex and underlying mechanisms. In our type 2 diabetes cohort, however, this pattern was not recreated, indicating that the crucial factor may be aspects related to the metabolic syndrome rather than hyperglycemia.

Apart from obesity, hyperglycemia, and sex, other factors such as current smoking status and specific medical therapy may likewise influence the level of inflammation in type 2 diabetes (36,37). In our cohort only 5% were smokers, which is surprisingly low, giving the fact that smoking is a substantial risk factor for development of type 2 diabetes (36). The result may reflect successful free smoking cessation programs, as 40% of our participants reported to be previous smokers. The degree of a persistent pro-inflammatory effect of nicotine following smoking cessation is debated (38), but could potentially be influencing the results in the current study. Moreover, the high proportion of previous smokers could indicate that our cohort consisted of individuals with a high degree of determination and self-efficacy. Such selection bias is potentially also reflected in the median HbA1c of 55 mmol/mol, which is lower in comparison to other cohorts (13,39).

In our cohort, 66% received lipid-lowering statin therapy, which is known to possess anti-inflammatory properties (8), which again could impact the level of investigated inflammatory biomarkers. Consequently, the reported elevated levels of several biomarkers compared to the healthy control cohort could be artificially low due to the anti-inflammatory effect of statins. Potentially this could explain why no pro-inflammatory biomarkers were increased in individuals with longer disease duration as these individuals were more likely to be on statin therapy.

4.3 Diabetic comorbidities

It has previously been established that low-grade systemic inflammation plays a role in progression of diabetic complications (10–12). We support those findings by showing that IL-6, IL-10, IL-12/IL-23p40, IL-15, and CRP were elevated in individuals with multiple diabetic comorbidities compared to those with fewer or none. In the literature, IL-6 elevation has in particular been associated with diabetic complications (40–43). Likewise, increased levels of CRP has previously been linked to development and severity of diabetic complications (41,44). In addition, the observed elevated levels of IL-10 were primarily found in subjects with longer disease duration, which could reflect that diabetes comorbidities typically become more

prevalent with increasing exposure to glycemic fluctuations and disease duration (45). Furthermore, IL-12 has previously been shown to be involved in the pathogenesis of several diabetic micro- and macrovascular comorbidities (46). Interestingly, a study in obese and insulin resistant IL-12 knockout mice showed that IL-12 disruption increased angiogenesis and restored peripheral blood flow perfusion through attenuation of oxidative stress and increased levels of angiogenic factors (47). In humans, a monoclonal antibody (Ustekinumab) targeting IL-12/IL-23p40 is currently used as a safe and effective treatment of psoriasis (48). Our data raise the intriguing possibility of applying this drug as a novel treatment option for diabetic micro- and macrovascular complications but needs to be investigated in future randomized controlled trials. Finally, circulating levels of IL-15 have been shown to be influenced by fat mass and physical activity (49). Furthermore, IL-15 improve lipid deposition and insulin sensitivity by activation of the GLUT-4 transporter in skeletal muscles. Hence, IL-15 has been proposed as a novel therapeutic option for treating obesity and type 2 diabetes (50). The increased levels of IL-15 in individuals with three or more comorbidities found in this study seem to contradict the beneficial effects normally attributed to this cytokine, and confirmation in additional studies are encouraged.

4.4 Strengths and limitations

The strength of this study is the high degree of heterogeneity of our cohort, obtained by systematically screening all people in our out-patient diabetes clinic, thereby facilitating generalization to the larger population of type 2 diabetes. However, selection bias in which individuals with low symptom burdens are more likely to participate cannot be ruled out. Contrary, a majority of patients with complications, who regard participation in a clinical trial as a possibility to receive extra attention from health care professionals, is likewise conceivable. It should also be noted that because this study is based on secondary analyses, the inclusion and exclusion criteria were not designed to exclude participants with comorbidities or medication use, which could impact the levels of the investigated inflammatory factors. Lastly, registration of retinopathy was restricted to participant recollection and reporting. Objective measures or consultation in patient records would have improved the validity of this outcome.

4.5 Conclusion

We showed that individuals with type 2 diabetes exhibit higher degrees of various inflammatory factors in plasma, and that obesity and glycemic dysregulation are associated with the level of specific inflammatory factors. Furthermore, a considerable increase in several inflammatory factors was seen in people with multiple diabetic comorbidities. Regarding medication, DPP-4 inhibitor therapy was associated with decreased levels of several chemokines, while increased TNF-α levels were observed in association with GLP-1 receptor agonist therapy. Taken together, our results show that individuals with type 2 diabetes have systemic low-grade inflammation. Although the cross-sectional nature of our study hinders the ability to look at the causality between systemic low-grade inflammation and diabetic complications, it is intriguing to

speculate whether dampening of the inflammatory state could protect against development of comorbidities in type 2 diabetes.

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AUTHOR CONTRIBUTIONS

Study design and original idea by CB and BB. ALW collected the data. TO, ALW, FP, BB, JS, and CB analysed and interpreted the data. TO wrote the first draft, but all authors contributed to the final manuscript. CB are the guarantor of the work, has full access to the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis. The data that support the findings of this study are available from the corresponding author upon reasonable request.

COMPETING INTERESTS

None

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DATA SHARING STATEMENT

Deidentified participant data are available upon reasonable request from the corresponding author.

ETHICS APPROVAL

The protocol was approved by The North Denmark Region Committee on Health Research Ethics, Denmark (N-20170045)

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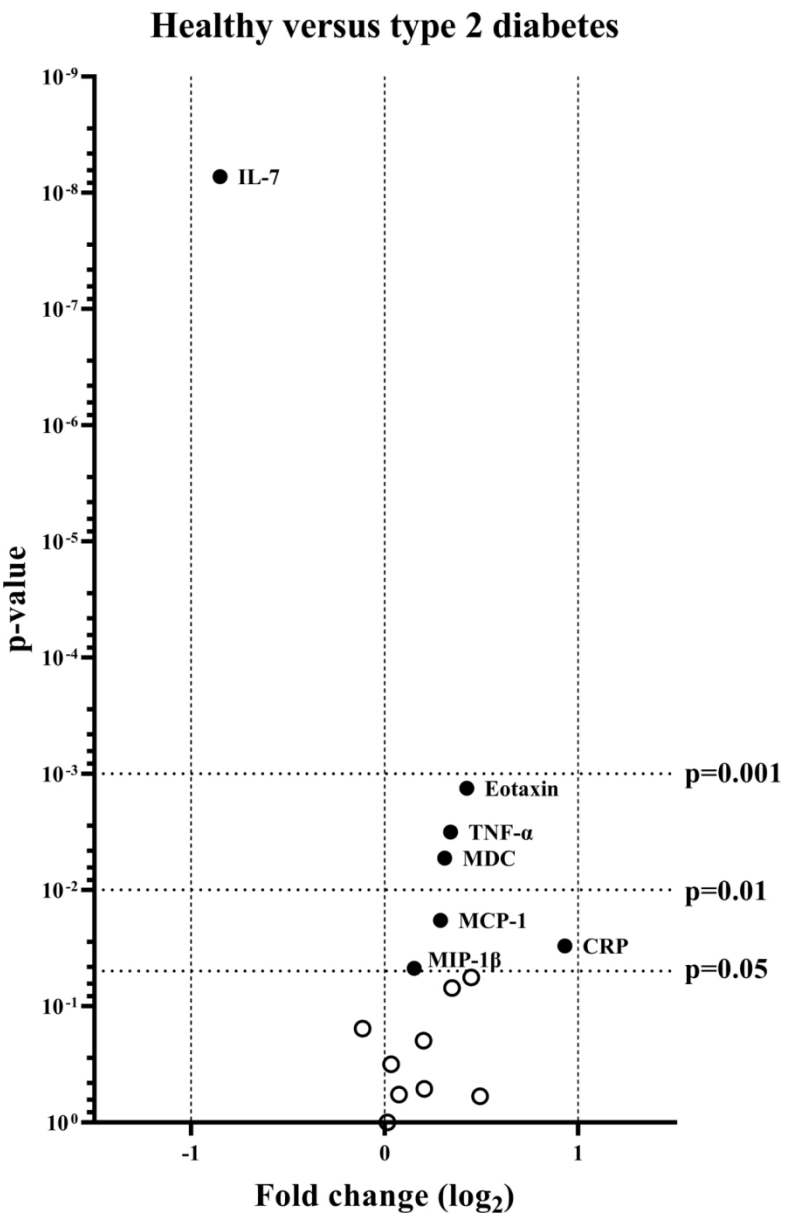
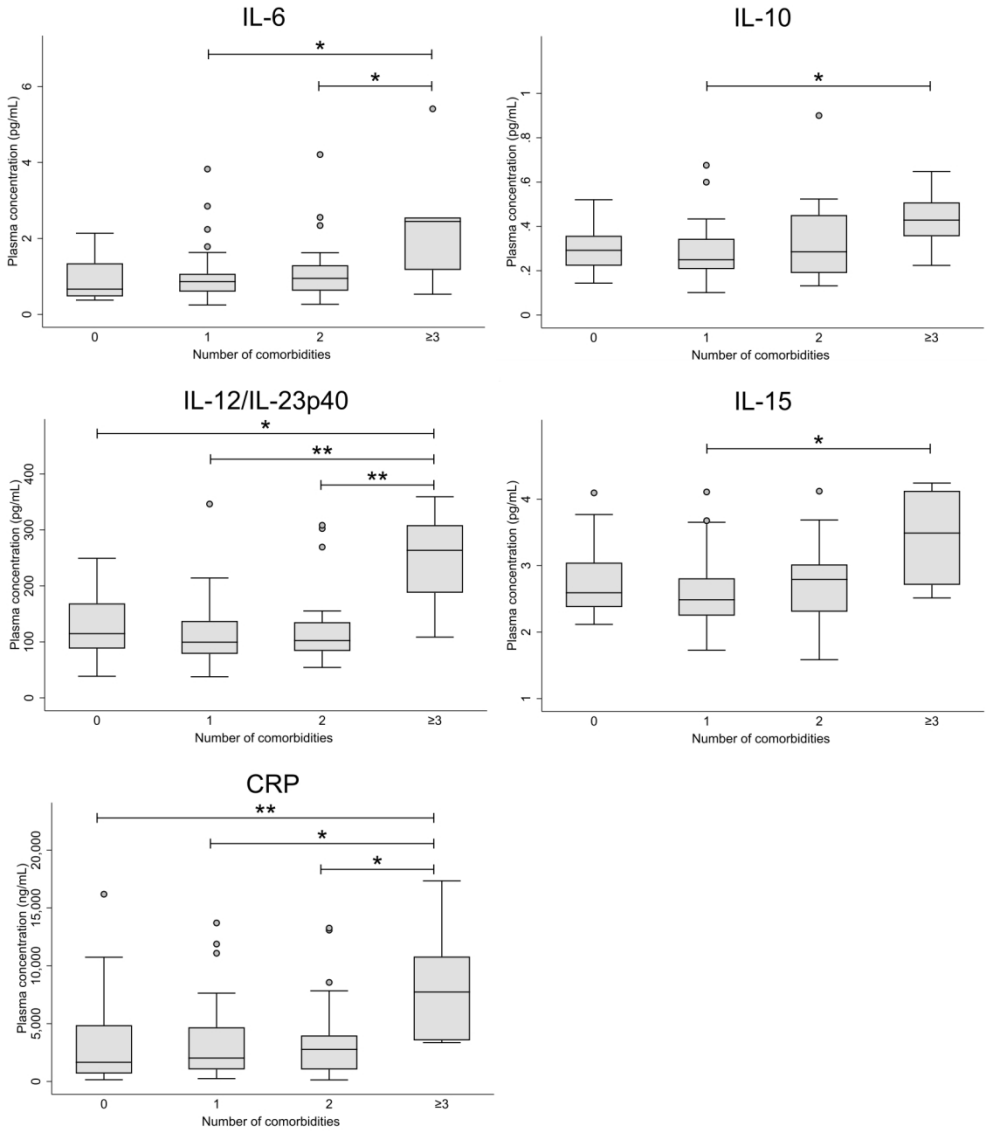
FIGURE LEGENDS

Figure 1: Volcano plot displaying pairwise comparisons of inflammatory factors in type 2 diabetes and healthy controls. Vertical dashed lines indicate threshold for two-fold differences among groups. Horizontal dashed lines indicate p-value thresholds of 0.05, 0.01, and 0.001, respectively. ● p-value < 0.05, ○ above significance threshold. Only significant analytes are labeled.

Figure 2: Box plots displaying plasma concentrations of selected biomarkers in individuals with type 2 diabetes and 0 (n=20), 1 (n=43), 2 (n=28), or 3 or more (n=7) diabetic comorbidities (retinopathy, nephropathy, neuropathy, cardiac autonomic neuropathy). *p<0.05, **p<0.01



278x429mm (118 x 118 DPI)



Box plots displaying plasma concentrations of biomarkers in individuals with type 2 diabetes and 0 (n=20), 1 (n=43), 2 (n=28), or 3 or more (n=7) diabetic comorbidities (retinopathy, nephropathy, neuropathy, cardiac autonomic neuropathy). Only analytes with p-values below 0.05 are shown. *p<0.05, **p<0.01

301x342mm (150 x 150 DPI)

SUPPLEMENTARY TABLES

	% of samples with estimated values† (T2D/healthy)	**% of excluded samples‡** (T2D/healthy)	**Number of readings above 3 SD from group mean** (T2D/healthy)
IL-1α§	95/95	3/5	-
IL-1β§	93/95	3/0	-
IL-2§	19/29	30/29	-
IL-4§	14/14	51/43	-
IL-5§	32/19	23/14	-
IL-6	**0/0**	**0/0**	**2/0**
IL-7	**0/0**	**1/0**	**1/0**
IL-8	**0/0**	**0/0**	**2/0**
IL-10	**0/0**	**0/0**	**1/0**
IL-12/IL-23p40	**0/0**	**0/0**	**1/0**
IL-13§	82/100	10/0	-
IL-15	**0/0**	**1/0**	**2/0**
IL-16	**0/0**	**1/0**	**1/0**
IL-17A§	0/0	17/19	-
IFN-γ	**0/0**	**0/0**	**2/0**
TNF-α	**0/0**	**0/0**	**2/0**
TNF-β§	21/5	33/19	-
Eotaxin	**0/0**	**1/0**	**0/0**
Eotaxin-3§	0/0	15/10	-
IP-10	**0/0**	**1/0**	**3/0**
MCP-1	**0/0**	**1/0**	**0/0**
MCP-4§	0/0	1/10	-
MDC	**0/0**	**1/0**	**1/0**
MIP-1α§	0/0	10/5	-
MIP-1β	**0/0**	**1/5**	**2/0**
TARC	**0/0**	**1/0**	**2/0**
CRP	**0/0**	**0/0**	**3/1**

Supplementary table 1: Overview of MSD multiplex analysis and data handling. † calculated as the lower detection limit divided by the square root of two, ‡ excluded due to a coefficient of variance above 30%

between duplicates, § excluded from further analysis due to insufficient data quality. Boldface font indicates analytes included in the analysis.

	Healthy (n=21)	**Type 2 diabetes** (n=98)	**p-value**
IL-6	0.6 (0.4-0.9)	0.9 (0.6-1.3)	0.056
IL-7	15.5 ± 5.0	8.2 (5.9-10.2)	**<0.001**
IL-8	12.1 ± 3.8	12.4 (8.8-16.7)	0.514
IL-10	0.2 (0.2-0.3)	0.3 (0.2-0.4)	0.198
IL-12/IL-23p40	100.9 ± 45.5	107.5 (82.9-145.8)	0.070
IL-15	2.7 ± 0.4	2.6 (2.3-3.0)	0.999
IL-16	225.0 ± 53.9	208.0 ± 48.4	0.156
IFN-γ	5.1 ± 2.4	5.2 (3.1-7.7)	0.594
TNF-α	1.2 ± 0.2	1.5 (1.3-1.8)	**0.003**
Eotaxin	267.6 ± 74.3	339.9 (259.8-434.1)	**0.001**
IP-10	539.4 (397.7-767.9)	575.9 (443.6-725.4)	0.576
MCP-1	243.3 (215.9-287.8)	323.1 ± 105.0	**0.018**
MDC	912.3 ± 255.5	1059.7 (887.9-1279.2)	**0.005**
MIP-1β	131.5 (102.0-167.8)	161.9 ± 48.3	**0.047**
TARC	218.6 (120.7-531.7)	275.4 (168.6-412.4)	0.316
CRP (ng/mL)	871.3 (528.6-3353.3)	2769.3 (1037.6-5236.5)	**0.030**

Supplementary table 2: Plasma concentrations of inflammatory factors. Results (in pg/mL, unless otherwise stated) displayed as either mean ± SD or median (1^{st}-3^{rd} quartiles) based on distribution of the data. Boldface font indicates statistical significance ($p<0.05$).

STROBE Statement—Checklist of items that should be included in reports of ***cross-sectional studies***

	Item No	Recommendation	Page No
Title and abstract	1	(*a*) Indicate the study's design with a commonly used term in the title or the abstract	2
		(*b*) Provide in the abstract an informative and balanced summary of what was done and what was found	2
Introduction			
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported	3
Objectives	3	State specific objectives, including any prespecified hypotheses	4
Methods			
Study design	4	Present key elements of study design early in the paper	4
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection	4
Participants	6	(*a*) Give the eligibility criteria, and the sources and methods of selection of participants	4
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable	4-5
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group	4-5
Bias	9	Describe any efforts to address potential sources of bias	4-5
Study size	10	Explain how the study size was arrived at	Secondary analysis
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why	5
Statistical methods	12	(*a*) Describe all statistical methods, including those used to control for confounding	5
		(*b*) Describe any methods used to examine subgroups and interactions	5
		(*c*) Explain how missing data were addressed	5
		(*d*) If applicable, describe analytical methods taking account of sampling strategy	n/a
		(*e*) Describe any sensitivity analyses	n/a
Results			
Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed	Secondary analysis
		(b) Give reasons for non-participation at each stage	n/a
		(c) Consider use of a flow diagram	n/a
Descriptive data	14*	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders	Table 1
		(b) Indicate number of participants with missing data for each variable of interest	Supp. material

Outcome data	15*	Report numbers of outcome events or summary measures	
Main results	16	(*a*) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included	Table 2, Table 3
		(*b*) Report category boundaries when continuous variables were categorized	n/a
		(*c*) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period	n/a
Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses	n/a
Discussion			
Key results	18	Summarise key results with reference to study objectives	11
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias	14
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence	14-15
Generalisability	21	Discuss the generalisability (external validity) of the study results	14-15
Other information			
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based	15

*Give information separately for exposed and unexposed groups.

Note: An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available on the Web sites of PLoS Medicine at http://www.plosmedicine.org/, Annals of Internal Medicine at http://www.annals.org/, and Epidemiology at http://www.epidem.com/). Information on the STROBE Initiative is available at www.strobe-statement.org.

BMJ Open

Low-grade inflammation in type 2 diabetes: A cross-sectional study from a Danish diabetes out-patient clinic

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Primary Subject Heading:	Diabetes and endocrinology
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TITLE PAGE

Full Title: Low-grade inflammation in type 2 diabetes: A cross-sectional study from a Danish diabetes outpatient clinic

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STRUCTURED ABSTRACT

Objectives: To investigate low-grade inflammation in type 2 diabetes and explore associations to clinical aspects as well as micro- and macrovascular complications.

Design: Cross-sectional analysis

Setting: The out-patient diabetes clinic at the department of endocrinology at Aalborg University Hospital, Denmark

Participants: 100 participants with type 2 diabetes confirmed by a HbA1C ≥ 6.5% for a minimum of one year and 21 healthy controls

Outcome measures: Plasma levels of 27 inflammation-related biomarkers measured by immunoassay. Associations with micro-and macrovascular complications, body weight, glycemic control, medication, and sex were investigated in the diabetes cohort.

Results: Plasma levels of TNF-α and eotaxin, were elevated in type 2 diabetes ($p<0.05$), while IL-7 was decreased ($p<0.001$). IL-12/IL-23p40, IL-15, MDC, and CRP levels were increased with body weight ($p<0.05$), while eotaxin and TNF-α were increased with elevated HbA1c levels ($p<0.04$). DPP-4 inhibitor therapy was associated with lower levels of IP-10, MDC, and TARC ($p<0.02$), while females had higher levels of MDC ($p=0.027$). Individuals with ≥3 diabetic complications had elevated levels of IL-6, IL-10, IL-12/IL-23p40, IL-15, and CRP compared to those with ≤3 ($p<0.05$).

Conclusion: The level of low-grade inflammation in type 2 diabetes is associated with obesity, glycemic regulation, therapeutical management, sex, and complications. Our results underline the importance of addressing inflammatory issues in type 2 diabetes, as these may predispose for crippling comorbidities.

Strengths and limitations of this study:

- Analysis of a broad palette of inflammatory biomarkers in plasma in 100 participants with type 2 diabetes and 21 healthy controls
- High degree of heterogeneity of our cohort, which allows for generalization to the population of type 2 diabetes
- Well-characterized cohort in regard to micro- and macrovascular comorbidities
- The cross-sectional design is a limitation of the study and hinders any assumptions of causality
- This study is based on secondary analysis and thus inclusion and exclusion criteria were not designed specifically with the investigation of inflammatory biomarkers in mind

1 INTRODUCTION

Tight glycemic regulation is vital for balancing the existing energy demand in tissues by combining resources originating from the nutritional supply and release from internal storages. Low blood glucose is potentially life-threatening, while long-term elevated levels have several metabolic consequences, including sorbitol production, mitochondrial dysfunction, and formation of advanced glycation end products (1). Chronic hyperglycemia can be caused either by insulin deficiency, as seen in type 1 diabetes, or by a combination of generalized insulin resistance in peripheral tissues and insufficient insulin production resulting in type 2 diabetes. The latter is the most prevalent diabetes type accounting for up to 90% of the cases (2).

The pathogenesis of type 2 diabetes is highly complex and multifactorial, and many aspects of the disease require further elucidation. However, it is clear that obesity along with a sedentary lifestyle is a substantial risk factor for development of insulin resistance and type 2 diabetes through stress-induced inflammation in adipose tissue leading to insensitivity of the insulin receptor (3). In recent years, the previous view on adipose tissue as a mere storage of fat has been disproved, and it is now accepted that especially visceral adipose tissue possesses important endocrine and inflammatory properties. As an example, adipocytes activated by expansion-associated hypoxia secrete cytokines and so-called adipokines, many of which are pro-inflammatory in nature (4). As the prevalence of both obesity and type 2 diabetes continue to rise worldwide (2), a better understanding of the inflammatory link between these lifestyle-associated conditions is crucial.

In addition to obesity-induced inflammation, excess glucose availability in diabetes causes alterations in normal homeostasis, facilitating the progression of proinflammatory cytokine release to the microenvironment. Low-grade systemic inflammation is thus regarded as an accompanying condition in type 2 diabetes (5). Increased levels of proinflammatory biomarkers such as interleukin (IL) 6 and C-reactive protein (CRP) have been shown to be associated with an increased risk of type 2 diabetes development in several prospective studies (6,7). This suggests that the pathogenetic mechanisms in type 2 diabetes is influenced by systemic low-grade inflammation. It is, however, unclear whether this proinflammatory state remains during the course of the disease or if it increases or diminishes over time. In addition, standard medical treatment in type 2 diabetes such as statins and dipeptidyl peptidase-4 (DPP-4) inhibitors have immunomodulating properties and may thus influence the inflammatory response (8,9).

The low-grade systemic inflammation in type 2 diabetes is clinically essential, because it is associated with the development and progression of long-term complications such as nephropathy, neuropathy and retinopathy (10–12). Moreover, low-grade inflammation is associated with cardiovascular disease in diabetes (13), which is the primary cause of morbidity and mortality in individuals with type 2 diabetes (14).

The aim of this study was to investigate the level of low-grade systemic inflammation in a cohort of individuals with type 2 diabetes with varying disease duration. We hypothesized that individuals with type 2 diabetes exhibited higher levels of pro-inflammatory biomarkers than healthy controls, and accordingly, the primary endpoint was differences in circulating inflammatory biomarkers in healthy and people with type 2 diabetes. Furthermore, we hypothesized that levels of pro-inflammatory biomarkers in type 2 diabetes were associated with disease duration, obesity, glycemic control, therapeutical management, and presence of diabetes-related micro- and macrovascular complications. The secondary endpoints were thus to investigate associations between inflammatory biomarkers and clinical characteristics of type 2 diabetes.

2 METHODS

2.1 Study population

All individuals with type 2 diabetes scheduled for regular health visits at the out-patient diabetes clinic at the department of endocrinology at Aalborg University Hospital, Denmark were informed about the study and screened for eligibility after signing of the informed consent form, and 100 participants were included for cross-sectional analysis. Inclusion criteria included Northern European descent, age above 18 years, a verified diagnosis of type 2 diabetes with HbA1C ≥ 6.5% for a minimum of one year, and stable diabetes treatment. People with other endocrinological or neurological diseases were excluded. Prior to study initiation, the protocol was approved by The North Denmark Region Committee on Health Research Ethics, Denmark (N-20170045). The primary outcome of the study was cardiac vagal tone and the results have been published elsewhere (15). The control cohort consisted of sex-matched healthy volunteers (n=21) recruited for a randomized controlled trial (N-20090008) likewise conducted by our research group.

2.2 Blood samples

Morning blood samples were drawn from the cubital vein after a fasting period of minimum six hours. For analysis of inflammatory biomarkers, blood was collected in EDTA tubes and centrifuged for 10 minutes at 1000 g. Isolated plasma was aliquoted in appropriate volumes and stored in a biobank at -80°C until the complete data set was collected. All samples were thawed just prior to analysis. Samples from both cohorts were analyzed consecutively to minimize interplate variability. For analysis of hemoglobin A1c (HbA1c), blood was collected in lithium heparin tubes and analyzed by routine biochemical procedures.

2.3 Inflammatory biomarkers

Biomarker concentrations in plasma samples were analyzed using the V-PLEX Neuroinflammation Panel 1 Human Kit (Meso Scale Diagnostics® [MSD], Gaithersburg, MD, USA) on a MESO QuickPlex SQ 120 instrument (MSD) according to the manufacturer´s specifications. Sample values below the detection limit of the assay were assigned a value of the detection limit divided by √2 (16). If more than 30% of the measured samples for any given biomarker were below the detection limit, the biomarker was excluded from the analysis. Likewise, samples with a coefficient of variation (CV) >30% between duplicate measurements

were excluded from the analysis (Supplementary Table 1). Biomarkers on the panel included: IL-1α, IL-1β, IL-2, IL-4, IL-5, IL-6, IL-7, IL-8, IL-10, IL-12/IL-23p40, IL-13, IL-15, IL-16, IL-17A, interferon (IFN)-γ, tumor necrosis factor (TNF)-α, TNF-β, eotaxin, eotaxin-3, IFN-γ-induced protein (IP)-10, monocyte chemoattractant protein (MCP)-1, MCP-4, macrophage-derived chemokine (MDC), macrophage inflammatory protein (MIP)-1α, MIP-1β, thymus and activation regulated chemokine (TARC), and CRP.

2.4 Assessment of diabetic comorbidities

All participants in the type 2 diabetes cohort underwent investigations concerning common diabetic comorbidities: 1) *Peripheral neuropathy*: Signs of peripheral neuropathy was investigated by vibration perception threshold (VPT) at the dorsum of the first phalanx using a biothesiometer (Bio-Medical Instruments). The measurement was done three consecutive times bilaterally, and the final vibration perception threshold was calculated as the mean value of both feet. Results above 18 volts were considered abnormal and thus as signs of diabetic peripheral neuropathy. 2) *Nephropathy*: Morning urine samples were collected by participants at home and handed over to study personnel for standard biochemical analysis. Diabetic nephropathy was defined as a urine albumin/creatinine ratio above 30 mg/g, which is a standard cut-off for early diabetic nephropathy and microalbuminuria. 3) *Retinopathy*: Participants were asked if they had ever been diagnosed with proliferative or non-proliferative retinopathy 4) *Cardiac autonomic neuropathy*: Electrocardiographic recordings by the VAGUS™ device (Medicus Engineering Aps, Aarhus, Denmark) were applied for evaluation of cardiac autonomic neuropathy. Recordings were made during rest, postural change, deep breathing, and the Valsalva maneuver. Abnormal results in one or more exercises were considered as signs of cardiac autonomic neuropathy.

2.5 Data handling and statistics

Distribution of raw and log-transformed data was evaluated by Shapiro-Wilk test of normality. Pairwise comparisons among groups were achieved by independent samples t-test or Mann-Whitney U based on data distribution. Differences in inflammatory biomarkers between healthy and type 2 diabetes were investigated firstly by pairwise comparisons and secondly by a logistic regression model including age and BMI as confounders, as these factors were different between groups and known to influence systemic low-grade inflammation. For the volcano plot, the fold difference was calculated as the $\log_2$-ratio between two group means. Differences in inflammatory biomarkers between people with short- and long-term disease duration were likewise investigated by a logistic regression model including age and BMI as confounders. Multiple logistic regression analyses were performed to investigate the association between clinical parameters and inflammatory biomarkers. The independent variables included obesity (BMI<30 versus BMI>30), blood glucose level (HbA1c<55 versus HbA1c>55), DPP-4 inhibitor therapy, GLP-1 receptor agonist therapy, and sex. Additionally, two models were applied in which associations were adjusted for the remaining clinical variables, and total plasma cholesterol or statin therapy, all of which may have an impact on the systemic

inflammatory status. Differences in inflammatory biomarkers between people with 0, 1, 2 og ≥3 comorbidities were investigated by a Bonferroni-corrected ANOVA and subsequently the Dunn's Test. An α-level of 0.05 was applied for all analyses. The STATA software (StataCorp LLC, version 15.1) was applied for all statistical analyses.

2.6 Patient and public involvement

Patients or members of the public were not included in the design, conduction, reporting, or dissemination plans of this project.

3 RESULTS

3.1 Study population

Two subjects in the type 2 diabetes group were excluded due to hemolysis of collected blood samples. Individuals in the diabetes group were older, had higher BMI, and higher HbA1c compared to the healthy controls (p<0.001). On the contrary, healthy controls had higher total cholesterol (p<0.001), high-density lipoprotein (HDL) (p=0.006), and low-density lipoprotein (LDL) (p<0.001) compared to individuals in the type 2 diabetes cohort of which 66% were on lipid-lowering statin therapy. A full demographic overview can be found in Table 1.

	Healthy (n=21)	**Type 2 diabetes** (n=98)	**p-value**
Basic demography			
Age (years)	52 (48-55)	65 (56-71)	**<0.001**
Sex (% of males)	71	63	0.478
BMI (kg/m$^{2)}$	25.6 (23.7-28.0)	31.4 (27.5-34.5)	**<0.001**
Current smokers (%)	19	5	**0.028**
Disease duration (y)	-	10 (5-17)	-
Vital signs			
Systolic BP (mmHg)	128 (119-137)	137 (128-147)	**0.021**
Diastolic BP (mmHg)	76 ± 11	77 ± 9	0.720
Pulse (beats/min)	66 ± 7	69.8 ± 10	0.110
Biochemistry			
Hba1c			
(mmol/mol)	33 (33-37)	55 (48-61.5)	**<0.001**
(%)	5.2 (5.2-5.5)	7.2 (6.5-7.8)	**<0.001**
Cholesterol (mmol/l)	5.4 ± 0.9	3.9 ± 0.9	**<0.001**
eGFR (mL/min/1.73 m^2)			

>90 (%)	62	46	0.197
40-90 (%)	38	52	0.264
<40 (%)	0	<1	0.507
HDL (mmol/l)	1.5 (1.3-1.8)	1.2 (1.0-1.5)	**0.006**
LDL (mmol/l)	3.3 ± 0.9	1.9 ± 0.7	**<0.001**
Triglycerides (mmol/l)	1.1 (0.7-1.4)	1.4 (1.0-2.0)	**0.023**
Medication			
Antihypertensives (%)	-	67	-
DPP-4 inhibitor (%)	-	18	-
Metformin (%)	-	78	-
SGLT-2 inhibitor (%)	-	23	-
GLP-1 receptor agonist (%)	-	23	-
Statins (%)	-	66	-

Table 1: Demographic and clinical characteristics among groups. Results displayed as either mean ± SD or median (1^{st}-3^{rd} quartiles) based on distribution of the data. Boldface font indicates statistical significance ($p<0.05$). Antihypertensive medication includes ACE inhibitors, angiotensin II receptor antagonists, calcium channel blockers, beta blockers, diuretics, and I1-imidazoline receptor antagonists. BMI: Body mass index; eGFR: Estimated glomerular filtration rate; HDL: High-density lipoprotein; LDL: Low-density lipoprotein; DPP-4: Dipeptidyl peptidase-4; SGLT: Sodium-glucose transport protein; GLP: Glucagon-like peptide.

3.2 Inflammatory biomarkers in type 2 diabetes compared to healthy

Plasma levels of 27 inflammatory biomarkers were measured in individuals with type 2 diabetes and healthy controls. Eleven biomarkers were excluded from the statistical analyses due to being undetectable or of insufficient measurement quality due to low levels (Supplementary Table 1). The remaining 16 biomarkers (IL-6, IL-7, IL-8, IL-10, IL-12/IL-23p40, IL-15, IL-16, IFN-γ, TNF-α, eotaxin, IP-10, MCP-1, MDC, MIP-1β, TARC, CRP) were measured in ≥95% of the samples. The concentrations of TNF-α ($p = 0.003$) and CRP ($p=0.030$) were significantly higher in the type 2 diabetes cohort compared to the control cohort (Figure 1). Similarly, 4 chemokines (eotaxin ($p=0.001$), MCP-1 ($p=0.018$), MDC ($p=0.005$), and MIP-1β ($p=0.047$)) showed elevated levels in the diabetes cohort. In contrast, the level of cytokine IL-7 was significantly lower in participants with type 2 diabetes compared to healthy controls ($p<0.001$). After adjustment for age and BMI, only IL-7,eotaxin, and TNF-α remained significantly different. Plasma concentrations of all measured biomarkers are presented in supplementary Table 2. When subdividing the type 2 diabetes cohort according to disease duration, only IL-10 was significantly different ($p=0.008$) between groups, even after adjustment for age and BMI, with a modestly increased levels found in subjects with disease duration above ten years.

(Table 2).

		UNADJUSTED MODEL		ADJUSTED MODEL	
		OR (95% CI)	**p-value**	**OR (95% CI)**	**p-value**
Cytokines	IL-7	1.03 (0.93-1.15)	0.565	1.04 (0.93-1.18)	0.466
	IL-12 /IL-23p40	1.00 (1.00-1.00)	0.446	1.00 (0.99-1.01)	0.717
	IL-15	1.51 (0.74-3.10)	0.256	1.32 (0.62-2.79)	0.471
	IL-16	1.00 (1.00-1.00)	0.832	1.00 (1.00-1.00)	0.813
Chemokines	Eotaxin	1.00 (1.00-1.00)	0.887	1.00 (1.00-1.00)	0.687
	IP-10	1.00 (1.00-1.00)	0.512	1.00 (1.00-1.00)	0.244
	MCP-1	1.00 (1.00-1.00)	0.864	1.00 (1.00-1.00)	0.523
	MDC	1.00 (1.00-1.00)	0.810	1.00 (1.00-1.00)	0.319
	MIP-1β	1.00 (0.99-1.01	0.992	1.00 (0.99-1.01)	0.916
	TARC	1.00 (1.00-1.00)	0.719	1.00 (1.00-1.00)	0.260
Pro-inflammatory cytokines	IL-6	1.34 (0.79-2.27)	0.271	1.21 (0.70-2.09)	0.504
	IL-8	1.00 (0.94-1.06)	0.983	1.00 (0.94-1.06)	0.904
	IL-10	111.85 (2.86-4377.78)	**0.012**	103.97 (2.30-4699.58)	**0.017**
	IFN-γ	1.02 (0.97-1.08)	0.438	1.02 (0.96-1.09)	0.447
	TNF-α	1.69 (0.70-4.12)	0.246	1.78 (0.69-4.62)	0.234
Vascular injury	CRP	1.00 (1.00-1.00)	0.697	1.00 (1.00-1.00)	0.713

Table 2: Odds ratio (OR) for associations between plasma concentrations of inflammatory factors (cytokines (n=4), chemokines (n=6), pro-inflammatory cytokines (n=5), vascular injury (n=1)) in type 2 diabetes with short-term disease duration (<10 years, n=44) and long-term disease duration (>10 years, n=50) unadjusted and adjusted for age and BMI. Boldface font indicates statistical significance (p<0.05).

3.3 Inflammatory biomarkers in subgroups of type 2 diabetes

Obesity was significantly associated with concentration of five inflammatory biomarkers (IL-12/IL-23p40, IL-15, IFN-γ, MDC, and CRP) (Table 3 – only analytes with p-value below 0.05 shown). When adjusting for

HbA1c, sex, and total plasma cholesterol or statin use, IL-12/IL-23p40, IL-15, and CRP remained statistically significant associated with obesity. HbA1c was significantly associated with eotaxin and IL-12/IL-23p40 levels after adjusting for confounders, and levels of MDC were associated with sex with lower levels found in male subjects compared to females. Lower levels of IL-8, IP-10, and MDC were associated with DPP-4 inhibitor therapy, while higher levels of TNF-α were associated with GLP-1 receptor agonist therapy. Lastly, SGLT2 inhibitor therapy was associated with lower levels of MDC.

	UNADJUSTED MODEL		ADJUSTED MODEL 1		ADJUSTED MODEL 2	
	OR (95% CI)	**p-value**	**OR (95% CI)**	**p-value**	**OR (95% CI)**	**p-value**
A. Obesity						
IL-12/IL-23p40	1.01 (1.00-1.02)	**0.003**	1.01 (1.00-1.02)	**0.007**	1.01 (1.00-1.02)	**0.007**
IL-15	2.32 (1.05-5.11)	**0.038**	2.30 (1.02-5.15)	**0.043**	2.30 (1.02-5.16)	**0.043**
IFN-γ	1.12 (1.00-1.25)	**0.041**	1.10 (0.99-1.23)	0.087	1.10 (0.99-1.22)	0.091
MDC	1.00 (1.00-1.00)	**0.029**	1.00 (1.00-1.00)	0.051	1.00 (1.00-1.00)	**0.049**
CRP	1.00 (1.00-1.00)	**0.001**	1.00 (1.00-1.00)	**0.001**	1.00 (1.00-1.00)	**0.001**
B. Blood glucose						
IL-8	1.08 (1.00-1.15)	**0.037**	1.07 (0.99-1.14)	0.076	1.07 (1.00-1.15)	0.055
TNF-α	3.25 (1.21-8.73)	**0.019**	2.64 (0.95-7.34)	0.062	3.09 (1.11-8.58)	**0.031**
Eotaxin	1.00 (1.00-1.01)	**0.031**	1.00 (1.00-1.01)	**0.027**	1.00 (1.00-1.01)	**0.025**
C. Sex						
MDC	1.00 (1.00-1.00)	**0.009**	1.00 (1.00-1.00)	**0.021**	1.00 (1.00-1.00)	**0.027**
D. DPP-4 inhibitor therapy						
IL-8	0.88 (0.79-0.99)	**0.040**	0.89 (0.79-1.00)	0.052	0.89 (0.79-1.00)	0.051
IP-10	1.00 (1.00-1.00)	**0.013**	0.99 (0.99-1.00)	**0.008**	0.99 (0.99-1.00)	**0.008**
MDC	1.00 (1.00-1.00)	**0.027**	1.00 (1.00-1.00)	**0.011**	1.00 (1.00-1.00)	**0.011**
TARC	1.00 (1.00-1.01)	**0.004**	1.00 (1.00-1.01)	**0.005**	1.00 (1.00-1.01)	**0.005**
E. GLP-1 receptor agonist therapy						
IL-8	1.08 (1.01-1.15)	**0.025**	1.08 (0.99-1.17)	0.069	1.08 (1.00-1.18)	0.058

IL-15	0.57 (0.23-1.41)	0.226	0.29 (0.09-0.95)	**0.042**	0.27 (0.08-0.92)	**0.036**
IL-16	1.00 (0.98-1.00)	**0.042**	1.00 (0.98-1.00)	0.077	1.00 (0.98-1.00)	0.068
TNF-α	6.50 (2.07-20.42)	**0.001**	4.60 (1.26-16.76)	**0.021**	4.70 (1.25-17.69)	**0.022**
F. SGLT2 inhibitor therapy						
MDC	1.00 (1.00-1.00)	**0.014**	1.00 (1.00-1.00)	**0.027**	1.00 (1.00-1.00)	**0.033**

Table 3: Multiple logistic regression analysis of plasma concentrations between A) type 2 diabetes+BMI<30 (n=40) and Type 2 diabetes+BMI>30 (n=58), B) type 2 diabetes with HbA1c<55(n=47) and type 2 diabetes with HbA1c>55 (n=51), C) male type 2 diabetes (n=62) and female type 2 diabetes (n=36), D) type 2 diabetes (n=80) and type 2 diabetes treated with DPP-4 inhibitors (n=18), E) type 2 diabetes (n=75) and type 2 diabetes treated with GLP-1 receptor agonists (n=23), and F) type 2 diabetes (n=75) and type 2 diabetes treated with SGLT2 inhibitor therapy (n=23) with overall R-squared value and effect size (95% CI) of BMI, HbA1c, sex, DPP-4 inhibitor therapy, GLP-1 receptor agonist therapy, or SGLT2 inhibitor therapy displayed. Results presented as odds ratio (OR) and 95% confidence interval (CI). Total plasma cholesterol, BMI, HbA1c, and sex were included in the adjusted model 1 as appropriate, while statin use, BMI, HbA1c, and sex were included in the adjusted model 2 as appropriate. For simplicity, only analytes with p-values below 0.05 in either model are shown. Bold font indicated statistical significance after Bonferroni adjustment (p<0.003).

3.4 Diabetic comorbidities

When subdividing the type 2 diabetes cohort into groups according to number of diabetic comorbidities, five biomarkers (IL-6, IL-10, IL12/IL-23p40, IL-15, and CRP) were significantly elevated in participants with three or more comorbidities compared to those with fewer or none (Figure 2 – only analytes with p-values below 0.05 shown).

4 DISCUSSION

In this study, we investigated the level of systemic low-grade inflammation in a cohort of individuals diagnosed with type 2 diabetes. Elevated levels of several inflammatory biomarkers were found in comparison to healthy controls, evident in both short- and long-term disease duration. Moreover, in the type 2 diabetes cohort, obesity, hyperglycemia and female sex were found to be associated with elevated levels of various inflammatory biomarkers. Lastly, we were able to establish a connection between the number of common diabetic comorbidities and elevated levels of inflammatory biomarkers.

4.1 Inflammatory biomarkers in type 2 diabetes compared to healthy

After adjustment for age and BMI, we showed that IL-7 was significantly decreased, while eotaxin and TNF-α was significantly increased in type 2 diabetes compared to healthy. The majority of research regarding IL-7 has been conducted in type 1 diabetes, where elevated levels are shown compared to healthy (17). IL-7 is highly involved in T cell function and proliferation, and a role of this cytokine in mediating expansion of insulin-producing β-cell-autoreactive T cells have been proposed thus implicating IL-7 in the pathogenesis of type 1 diabetes (18). The decreased levels in type 2 diabetes compared to healthy controls found in this study were somewhat surprising but may reflect the lack of T-cell activation the pathology of type 2 diabetes. Eotaxin has been linked to the development of atherosclerosis by facilitating monocyte infiltration in smooth muscle cells under the influence of proinflammatory mediators (19), and elevated levels of this chemokine have previously been reported in type 1 diabetes individuals with complications compared to individuals with no diabetic complications as well as healthy controls (20). Increased levels of CRP have previously been reported in adults with type 2 diabetes (13,21), but in our cohorts, the difference could be attributed to a skewed distribution of age and BMI in the two cohorts.

IL-10 is generally regarded as an anti-inflammatory cytokine with the ability to dampen the immune response, and previous data have shown downregulation of IL-10 in both type 2 diabetes and obesity *per se* (22). This contrasts our findings, which showed no differences in the overall diabetes cohort but an increase in individuals with long disease duration. This observation could reflect manifestations of compensatory mechanisms toward a long-term elevated inflammatory environment attempting to elicit an anti-inflammatory response. However, pro-inflammatory factors (e.g. TNF-α) were elevated regardless of disease duration suggesting that any attempt of balancing the immune response remain challenging in the presence of type 2 diabetes.

4.2 Inflammatory biomarkers in subgroups of type 2 diabetes

Obesity and blood glucose regulation

In our type 2 diabetes cohort, obesity (BMI>30) was significantly associated with the levels of IL-12/IL-23p40 and CRP, while eotaxin and TNF-α levels were associated with glycemic regulation (HbA1c). Previously it has been shown that TNF-α release is upregulated in connection with obesity and has been linked to the progression of insulin resistance (23,24). The fact that TNF-α was not associated with by obesity in our cohort is thus surprising. However, elevated levels of TNF-α in adipose tissue, but not in plasma have previously been reported (25), which could also be the case in our cohort. In animal models, TNF-α antagonist treatment improves insulin resistance in obesity (26). A clinical study, however, failed to show the same effect in humans (27). Regarding eotaxin, this chemokine has been linked to the development of cardiovascular disease, which is likewise a complication to long-term hyperglycemia, and our findings of increased levels in dysregulated individuals could therefore be a possible sign of atherosclerosis (19).

Sex

We showed that the level of the chemokine MDC was associated with sex with higher levels seen in females compared to males. Different obesity-related inflammatory pathways between men and women with metabolic syndrome have previously been shown. Increased levels of pro-inflammatory mediators seem to facilitate low-grade systemic inflammation in males, while an insufficient anti-inflammatory milieu appears to be dominant in females (28). These findings suggest that any inflammation-modulating therapy in obesity should be differentiated according to sex and underlying mechanisms. In our type 2 diabetes cohort, however, this pattern was not recreated, indicating that the crucial factor may be aspects related to the metabolic syndrome rather than hyperglycemia.

Therapeutical management

Lower levels of three chemokines (IL-8, IP-10 and MDC) were all associated with DPP-4 inhibitor therapy. DPP-4 inhibitor therapy is known to improve glycemic control via prevention of breakdown of the incretin hormone GLP-1. In addition, several cytokines and chemokines are also substrates of the DPP-4 enzyme, and DPP-4 inhibitor therapy thus possesses immunomodulating properties possibly facilitating low-grade systemic inflammation in diabetes (9). Potentially this could explain why promising *in vitro* anti-inflammatory actions of DPP-4 inhibitors have failed to show convincingly results in humans (29). Surprisingly, we found lower levels of three DPP-4 substrates (IL-8, IP-10, and MDC) in connection with DPP-4 inhibitor therapy. Though seemingly in contrast with the expected result, similar observations have previously been reported (30), underlining the need for further research in the immunomodulating effects of DPP-4 inhibitor therapy.

GLP-1 receptor agonist therapy, which share the same pharmacodynamic endpoint as DPP-4 inhibitor therapy, is known to possess anti-inflammatory properties independent of improved glycemic control (31). However, our results showed an approximately 25% increase in proinflammatory TNF-α levels in connection with GLP-1 receptor agonist therapy. This finding is unexpected and in contrast with a previous pilot study showing that liraglutide significantly decreased TNF-α levels in a type 2 diabetes cohort (32). Preclinical studies have likewise shown inhibitory effects of liraglutide on TNF-α expression (33). Other preclinical studies, however, have reported decreased proinflammatory effects of TNF-α through inhibition of the NK-κB pathway after GLP-1 receptor agonist therapy (34). If this is the case, this would neutralize the proinflammatory pathways caused by increased TNF-α levels seen in this study.

In our cohort, SGLT2 inhibitor therapy was associated with a decrease in MDC, known to facilitate and amplify type II immune response (35). The anti-diabetic effects of SGLT2 inhibitors rely on the inhibition of renal reabsorption of glucose, but anti-inflammatory effects have also been reported including attenuation of IL-6 production (36) and modulation of macrophage polarization (37). The prospect of utilizing the anti-inflammatory potential of SGLT2 inhibitors in various pathologies is currently receiving much attention (38).

Additional subgroups

Apart from obesity, hyperglycemia, and sex, other factors such as current smoking status and specific medical therapy may likewise influence the level of inflammation in type 2 diabetes (39,40). In our cohort only 5% were smokers, which is surprisingly low, giving the fact that smoking is a substantial risk factor for development of type 2 diabetes (39). The low number of current smokers may reflect selection or reporting bias or perhaps successful free smoking cessation programs, as 40% of our participants reported to be previous smokers. This is, however, highly speculative. Nonetheless, the degree of a persistent pro-inflammatory effect of nicotine following smoking cessation is debated (41), and could potentially be influencing the results in the current study. Moreover, the high proportion of previous smokers could indicate that our cohort consisted of individuals with a high degree of determination and self-efficacy. Such selection bias is potentially also reflected in the median HbA1c of 55 mmol/mol, which is lower in comparison to other cohorts (13,42).

In our cohort, 66% received lipid-lowering statin therapy, which is known to possess anti-inflammatory properties (8), which again could impact the level of investigated inflammatory biomarkers. Consequently, the reported elevated levels of several biomarkers compared to the healthy control cohort could be artificially low due to the anti-inflammatory effect of statins. Potentially this could explain why no pro-inflammatory biomarkers were increased in individuals with longer disease duration as these individuals were more likely to be on statin therapy.

4.3 Diabetic comorbidities

It has previously been established that low-grade systemic inflammation plays a role in progression of diabetic complications (10–12). We found that IL-6, IL-10, IL-12/IL-23p40, IL-15, and CRP were elevated in individuals with multiple diabetic comorbidities compared to those with fewer or none. In the literature, IL-6 elevation has in particular been associated with diabetic complications (43–46). Likewise, increased levels of CRP has previously been linked to development and severity of diabetic complications (44,47). In addition, the observed elevated levels of IL-10 were primarily found in subjects with longer disease duration, which could reflect that diabetes comorbidities typically become more prevalent with increasing exposure to glycemic fluctuations and disease duration (48). Furthermore, IL-12 has previously been shown to be involved in the pathogenesis of several diabetic micro- and macrovascular comorbidities (49). Interestingly, a study in obese and insulin resistant IL-12 knockout mice showed that IL-12 disruption increased angiogenesis and restored peripheral blood flow perfusion through attenuation of oxidative stress and increased levels of angiogenic factors (50). In humans, a monoclonal antibody (Ustekinumab) targeting IL-12/IL-23p40 is currently used as a safe and effective treatment of psoriasis (51). Our data raise the intriguing possibility of applying this drug as a novel treatment option for diabetic micro- and macrovascular complications but needs to be investigated in future randomized controlled trials. Finally, circulating levels of IL-15 have been shown to be influenced by fat mass and physical activity (52). Furthermore, IL-15 improve lipid deposition and insulin sensitivity by activation of the GLUT-4 transporter in skeletal muscles. Hence, IL-15 has been proposed as a novel therapeutic option for treating obesity and type 2 diabetes (53). The increased levels of IL-15 in individuals with three or more comorbidities found in this study seem to contradict the beneficial effects normally attributed to this cytokine, but as this is a cross-sectional study no conclusions of causality can be made.

4.4 Strengths and limitations

A major limitation of this study is the cross-sectional study design, which hinders any assumptions of the predictive potential of low-grade inflammation and clinical characteristics of type 2 diabetes. On this dataset, we tested for association between low grade inflammation in type 2 diabetes, and we selected á priori the anti-inflammatory markers, as they are part of the underlying pathogenesis. According to the study design, each of the serum markers were tested individually, and based on our unadjusted and adjusted models we suggest an association to the specific marker IL-10. As the manufacturer of the multiplex assay had defined division of serum markers into cytokines (n=4), chemokines (n=6), pro-inflammatory cytokines (n=5), vascular injury (n=1), we believe that Bonferroni's correction is too conservative. The major strength of this study is the high degree of heterogeneity of our cohort, obtained by systematically screening all people in our out-patient diabetes clinic, thereby facilitating generalization to the larger population of type 2 diabetes. However, selection bias in which individuals with low symptom burdens are more likely to participate cannot be ruled out. Contrary, a majority of patients with complications, who regard participation

in a clinical trial as a possibility to receive extra attention from health care professionals, is likewise conceivable. It should also be noted that because this study is based on secondary analyses, the inclusion and exclusion criteria were not designed to exclude participants with comorbidities or medication use, which could impact the levels of the investigated inflammatory factors. Lastly, registration of retinopathy was restricted to participant recollection and reporting. Objective measures or consultation in patient records would have improved the validity of this outcome.

4.5 Conclusion

We showed that individuals with type 2 diabetes exhibit higher degrees of various inflammatory factors in plasma, and that obesity and glycemic dysregulation are associated with the level of specific inflammatory factors. Furthermore, a considerable increase in several inflammatory factors was seen in people with multiple diabetic comorbidities. Regarding medication, DPP-4 inhibitor therapy was associated with decreased levels of several chemokines, while increased TNF-α levels were observed in association with GLP-1 receptor agonist therapy. Taken together, our results show that individuals with type 2 diabetes have systemic low-grade inflammation. Although the cross-sectional nature of our study hinders the ability to look at the causality between systemic low-grade inflammation and diabetic complications, it is intriguing to speculate whether dampening of the inflammatory state could protect against development of comorbidities in type 2 diabetes.

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AUTHOR CONTRIBUTIONS

Study design and original idea by CB and BB. AMW collected the data. TO, AMW, FP, BB, JS, and CB analysed and interpreted the data. TO wrote the first draft, but all authors contributed to the final manuscript. CB are the guarantor of the work, has full access to the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis. The data that support the findings of this study are available from the corresponding author upon reasonable request.

COMPETING INTERESTS

None

FUNDING

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DATA SHARING STATEMENT

Deidentified participant data are available upon reasonable request to the corresponding author.

ETHICS APPROVAL

The protocol was approved by The North Denmark Region Committee on Health Research Ethics, Denmark (N-20170045)

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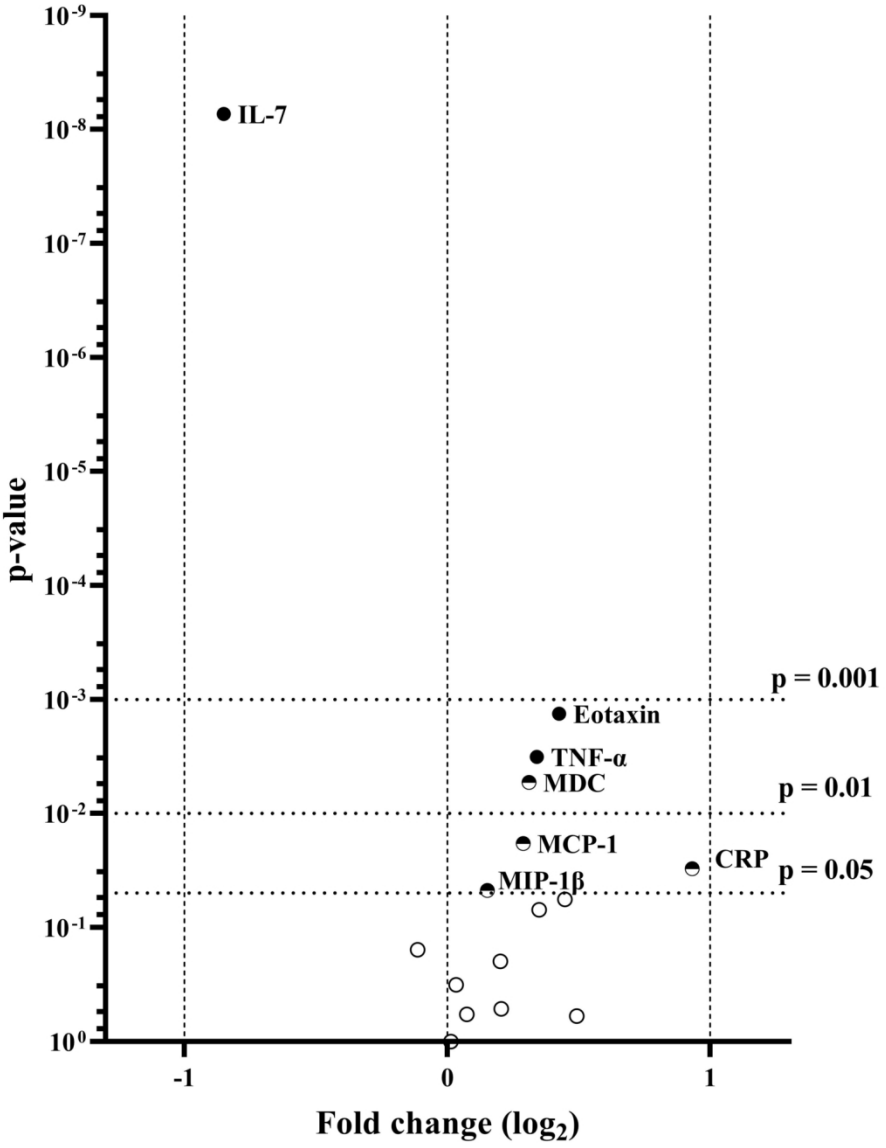
FIGURE LEGENDS

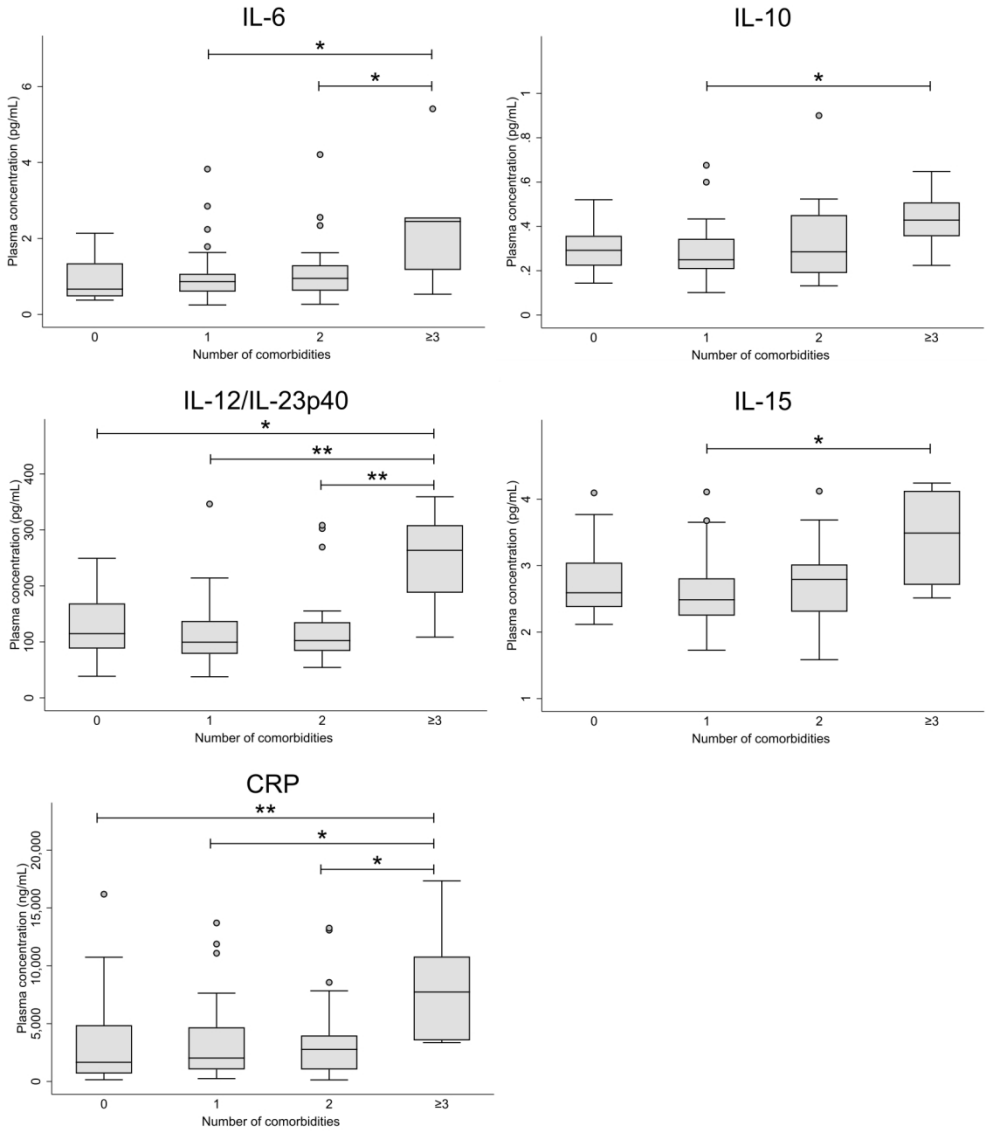
Figure 1: Volcano plot displaying pairwise comparisons of inflammatory factors in type 2 diabetes and healthy controls. Vertical dashed lines indicate threshold for two-fold differences among groups. Horizontal dashed lines indicate p-value thresholds of 0.05, 0.01, and 0.001, respectively. ● significantly different after adjustment for age and BMI, ◓ significantly different in the unadjusted model, ○ above significance threshold in both models. Only significant analytes are labeled.

Figure 2: Box plots displaying plasma concentrations of biomarkers in individuals with type 2 diabetes and 0 (n=20), 1 (n=43), 2 (n=28), or 3 or more (n=7) diabetic comorbidities (retinopathy, nephropathy, neuropathy, cardiac autonomic neuropathy). Only analytes with p-values below 0.05 are shown. *p<0.05, **p<0.01



Volcano plot displaying pairwise comparisons of inflammatory factors in type 2 diabetes and healthy controls. Vertical dashed lines indicate threshold for two-fold differences among groups. Horizontal dashed lines indicate p-value thresholds of 0.05, 0.01, and 0.001, respectively. ● significantly different after adjustment for age and BMI, ◓ significantly different in the unadjusted model, ○ above significance threshold in both models. Only significant analytes are labeled.

136x175mm (300 x 300 DPI)



Box plots displaying plasma concentrations of biomarkers in individuals with type 2 diabetes and 0 (n=20), 1 (n=43), 2 (n=28), or 3 or more (n=7) diabetic comorbidities (retinopathy, nephropathy, neuropathy, cardiac autonomic neuropathy). Only analytes with p-values below 0.05 are shown. *p<0.05, **p<0.01

301x342mm (150 x 150 DPI)

SUPPLEMENTARY TABLES

	% of samples with estimated values† (T2D/healthy)	**% of excluded samples‡** (T2D/healthy)	**Number of readings above 3 SD from group mean** (T2D/healthy)
IL-1α§	95/95	3/5	-
IL-1β§	93/95	3/0	-
IL-2§	19/29	30/29	-
IL-4§	14/14	51/43	-
IL-5§	32/19	23/14	-
IL-6	**0/0**	**0/0**	**2/0**
IL-7	**0/0**	**1/0**	**1/0**
IL-8	**0/0**	**0/0**	**2/0**
IL-10	**0/0**	**0/0**	**1/0**
IL-12/IL-23p40	**0/0**	**0/0**	**1/0**
IL-13§	82/100	10/0	-
IL-15	**0/0**	**1/0**	**2/0**
IL-16	**0/0**	**1/0**	**1/0**
IL-17A§	0/0	17/19	-
IFN-γ	**0/0**	**0/0**	**2/0**
TNF-α	**0/0**	**0/0**	**2/0**
TNF-β§	21/5	33/19	-
Eotaxin	**0/0**	**1/0**	**0/0**
Eotaxin-3§	0/0	15/10	-
IP-10	**0/0**	**1/0**	**3/0**
MCP-1	**0/0**	**1/0**	**0/0**
MCP-4§	0/0	1/10	-
MDC	**0/0**	**1/0**	**1/0**
MIP-1α§	0/0	10/5	-
MIP-1β	**0/0**	**1/5**	**2/0**
TARC	**0/0**	**1/0**	**2/0**
CRP	**0/0**	**0/0**	**3/1**

Supplementary table 1: Overview of MSD multiplex analysis and data handling. † calculated as the lower detection limit divided by the square root of two, ‡ excluded due to a coefficient of variance above 30%

between duplicates, § excluded from further analysis due to insufficient data quality. Boldface font indicates analytes included in the analysis.

	Healthy (n=21)	**Type 2 diabetes** (n=98)	**p-value**
IL-6	0.6 (0.4-0.9)	0.9 (0.6-1.3)	0.056
IL-7	15.5 ± 5.0	8.2 (5.9-10.2)	**<0.001**
IL-8	12.1 ± 3.8	12.4 (8.8-16.7)	0.514
IL-10	0.2 (0.2-0.3)	0.3 (0.2-0.4)	0.198
IL-12/IL-23p40	100.9 ± 45.5	107.5 (82.9-145.8)	0.070
IL-15	2.7 ± 0.4	2.6 (2.3-3.0)	0.999
IL-16	225.0 ± 53.9	208.0 ± 48.4	0.156
IFN-γ	5.1 ± 2.4	5.2 (3.1-7.7)	0.594
TNF-α	1.2 ± 0.2	1.5 (1.3-1.8)	**0.003**
Eotaxin	267.6 ± 74.3	339.9 (259.8-434.1)	**0.001**
IP-10	539.4 (397.7-767.9)	575.9 (443.6-725.4)	0.576
MCP-1	243.3 (215.9-287.8)	323.1 ± 105.0	**0.018**
MDC	912.3 ± 255.5	1059.7 (887.9-1279.2)	**0.005**
MIP-1β	131.5 (102.0-167.8)	161.9 ± 48.3	**0.047**
TARC	218.6 (120.7-531.7)	275.4 (168.6-412.4)	0.316
CRP (ng/mL)	871.3 (528.6-3353.3)	2769.3 (1037.6-5236.5)	**0.030**

Supplementary table 2: Plasma concentrations of inflammatory factors. Results (in pg/mL, unless otherwise stated) displayed as either mean ± SD or median (1^{st}-3^{rd} quartiles) based on distribution of the data. Boldface font indicates statistical significance ($p<0.05$).

STROBE Statement—Checklist of items that should be included in reports of ***cross-sectional studies***

	Item No	Recommendation	Page No
Title and abstract	1	(*a*) Indicate the study's design with a commonly used term in the title or the abstract	1, 2
		(*b*) Provide in the abstract an informative and balanced summary of what was done and what was found	2
Introduction			
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported	3
Objectives	3	State specific objectives, including any prespecified hypotheses	4
Methods			
Study design	4	Present key elements of study design early in the paper	4
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection	4
Participants	6	(*a*) Give the eligibility criteria, and the sources and methods of selection of participants	4
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable	4-5
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group	4-5
Bias	9	Describe any efforts to address potential sources of bias	4-5
Study size	10	Explain how the study size was arrived at	Secondary analysis
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why	5
Statistical methods	12	(*a*) Describe all statistical methods, including those used to control for confounding	5-6
		(*b*) Describe any methods used to examine subgroups and interactions	5
		(*c*) Explain how missing data were addressed	5
		(*d*) If applicable, describe analytical methods taking account of sampling strategy	n/a
		(*e*) Describe any sensitivity analyses	n/a
Results			
Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed	Secondary analysis
		(b) Give reasons for non-participation at each stage	n/a
		(c) Consider use of a flow diagram	n/a
Descriptive data	14*	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders	Table 1
		(b) Indicate number of participants with missing data for each variable of interest	Supp. material

Outcome data	15*	Report numbers of outcome events or summary measures	
Main results	16	(*a*) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included	Table 2, Table 3
		(*b*) Report category boundaries when continuous variables were categorized	n/a
		(*c*) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period	n/a
Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses	n/a
Discussion			
Key results	18	Summarise key results with reference to study objectives	12
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias	15-16
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence	12-15
Generalisability	21	Discuss the generalisability (external validity) of the study results	14-15
Other information			
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based	15

*Give information separately for exposed and unexposed groups.

Note: An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available on the Web sites of PLoS Medicine at http://www.plosmedicine.org/, Annals of Internal Medicine at http://www.annals.org/, and Epidemiology at http://www.epidem.com/). Information on the STROBE Initiative is available at www.strobe-statement.org.

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TITLE PAGE

Full Title: Low-grade inflammation in type 2 diabetes: A cross-sectional study from a Danish diabetes outpatient clinic

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STRUCTURED ABSTRACT

Objectives: To investigate low-grade inflammation in type 2 diabetes and explore associations to clinical aspects as well as micro- and macrovascular complications.

Design: Cross-sectional analysis

Setting: The out-patient diabetes clinic at the department of endocrinology at Aalborg University Hospital, Denmark

Participants: 100 participants with type 2 diabetes confirmed by a HbA1C ≥ 6.5% for a minimum of one year and 21 healthy controls

Outcome measures: Plasma levels of 27 inflammation-related biomarkers measured by immunoassay. Associations with micro-and macrovascular complications, body weight, glycemic control, medication, and sex were investigated in the diabetes cohort.

Results: Plasma levels of TNF-α and eotaxin, were elevated in type 2 diabetes ($p<0.05$), while IL-7 was decreased ($p<0.001$). IL-12/IL-23p40, IL-15, MDC, and CRP levels were increased with body weight ($p<0.05$), while eotaxin and TNF-α were increased with elevated HbA1c levels ($p<0.04$). DPP-4 inhibitor therapy was associated with lower levels of IP-10, MDC, and TARC ($p<0.02$), while females had higher levels of MDC ($p=0.027$). Individuals with ≥3 diabetic complications had elevated levels of IL-6, IL-10, IL-12/IL-23p40, IL-15, and CRP compared to those with ≤3 ($p<0.05$).

Conclusion: The level of low-grade inflammation in type 2 diabetes is associated with obesity, glycemic regulation, therapeutical management, sex, and complications. Our results underline the importance of addressing inflammatory issues in type 2 diabetes, as these may predispose for crippling comorbidities.

Strengths and limitations of this study:

- Analysis of a broad palette of inflammatory biomarkers in plasma in 100 participants with type 2 diabetes and 21 healthy controls
- High degree of heterogeneity of our cohort, which allows for generalization to the population of type 2 diabetes
- Well-characterized cohort in regard to micro- and macrovascular comorbidities
- The cross-sectional design is a limitation of the study and hinders any assumptions of causality
- This study is based on secondary analysis and thus inclusion and exclusion criteria were not designed specifically with the investigation of inflammatory biomarkers in mind

1 INTRODUCTION

Tight glycemic regulation is vital for balancing the existing energy demand in tissues by combining resources originating from the nutritional supply and release from internal storages. Low blood glucose is potentially life-threatening, while long-term elevated levels have several metabolic consequences, including sorbitol production, mitochondrial dysfunction, and formation of advanced glycation end products (1). Chronic hyperglycemia can be caused either by insulin deficiency, as seen in type 1 diabetes, or by a combination of generalized insulin resistance in peripheral tissues and insufficient insulin production resulting in type 2 diabetes. The latter is the most prevalent diabetes type accounting for up to 90% of the cases (2).

The pathogenesis of type 2 diabetes is highly complex and multifactorial, and many aspects of the disease require further elucidation. However, it is clear that obesity along with a sedentary lifestyle is a substantial risk factor for development of insulin resistance and type 2 diabetes through stress-induced inflammation in adipose tissue leading to insensitivity of the insulin receptor (3). In recent years, the previous view on adipose tissue as a mere storage of fat has been disproved, and it is now accepted that especially visceral adipose tissue possesses important endocrine and inflammatory properties. As an example, adipocytes activated by expansion-associated hypoxia secrete cytokines and so-called adipokines, many of which are pro-inflammatory in nature (4). As the prevalence of both obesity and type 2 diabetes continue to rise worldwide (2), a better understanding of the inflammatory link between these lifestyle-associated conditions is crucial.

In addition to obesity-induced inflammation, excess glucose availability in diabetes causes alterations in normal homeostasis, facilitating the progression of proinflammatory cytokine release to the microenvironment. Low-grade systemic inflammation is thus regarded as an accompanying condition in type 2 diabetes (5). Increased levels of proinflammatory biomarkers such as interleukin (IL) 6 and C-reactive protein (CRP) have been shown to be associated with an increased risk of type 2 diabetes development in several prospective studies (6,7). This suggests that the pathogenetic mechanisms in type 2 diabetes is influenced by systemic low-grade inflammation. It is, however, unclear whether this proinflammatory state remains during the course of the disease or if it increases or diminishes over time. In addition, standard medical treatment in type 2 diabetes such as statins and dipeptidyl peptidase-4 (DPP-4) inhibitors have immunomodulating properties and may thus influence the inflammatory response (8,9).

The low-grade systemic inflammation in type 2 diabetes is clinically essential, because it is associated with the development and progression of long-term complications such as nephropathy, neuropathy and retinopathy (10–12). Moreover, low-grade inflammation is associated with cardiovascular disease in diabetes (13), which is the primary cause of morbidity and mortality in individuals with type 2 diabetes (14).

The aim of this study was to investigate the level of low-grade systemic inflammation in a cohort of individuals with type 2 diabetes with varying disease duration. We hypothesized that individuals with type 2 diabetes exhibited higher levels of pro-inflammatory biomarkers than healthy controls, and accordingly, the primary endpoint was differences in circulating inflammatory biomarkers in healthy and people with type 2 diabetes. Furthermore, we hypothesized that levels of pro-inflammatory biomarkers in type 2 diabetes were associated with disease duration, obesity, glycemic control, therapeutical management, and presence of diabetes-related micro- and macrovascular complications. The secondary endpoints were thus to investigate associations between inflammatory biomarkers and clinical characteristics of type 2 diabetes.

2 METHODS

2.1 Study population

All individuals with type 2 diabetes scheduled for regular health visits at the out-patient diabetes clinic at the department of endocrinology at Aalborg University Hospital, Denmark were informed about the study and screened for eligibility after signing of the informed consent form, and 100 participants were included for cross-sectional analysis. Inclusion criteria included Northern European descent, age above 18 years, a verified diagnosis of type 2 diabetes with HbA1C ≥ 6.5% for a minimum of one year, and stable diabetes treatment. People with other endocrinological or neurological diseases were excluded. Prior to study initiation, the protocol was approved by The North Denmark Region Committee on Health Research Ethics, Denmark (N-20170045). The primary outcome of the study was cardiac vagal tone and the results have been published elsewhere (15). The control cohort consisted of sex-matched healthy volunteers (n=21) recruited for a randomized controlled trial (N-20090008) likewise conducted by our research group.

2.2 Blood samples

Morning blood samples were drawn from the cubital vein after a fasting period of minimum six hours. For analysis of inflammatory biomarkers, blood was collected in EDTA tubes and centrifuged for 10 minutes at 1000 g. Isolated plasma was aliquoted in appropriate volumes and stored in a biobank at -80°C until the complete data set was collected. All samples were thawed just prior to analysis. Samples from both cohorts were analyzed consecutively to minimize interplate variability. For analysis of hemoglobin A1c (HbA1c), blood was collected in lithium heparin tubes and analyzed by routine biochemical procedures.

2.3 Inflammatory biomarkers

Biomarker concentrations in plasma samples were analyzed using the V-PLEX Neuroinflammation Panel 1 Human Kit (Meso Scale Diagnostics® [MSD], Gaithersburg, MD, USA) on a MESO QuickPlex SQ 120 instrument (MSD) according to the manufacturer´s specifications. Sample values below the detection limit of the assay were assigned a value of the detection limit divided by √2 (16). If more than 30% of the measured samples for any given biomarker were below the detection limit, the biomarker was excluded from the analysis. Likewise, samples with a coefficient of variation (CV) >30% between duplicate measurements

were excluded from the analysis (Supplementary Table 1). Biomarkers on the panel included: IL-1α, IL-1β, IL-2, IL-4, IL-5, IL-6, IL-7, IL-8, IL-10, IL-12/IL-23p40, IL-13, IL-15, IL-16, IL-17A, interferon (IFN)-γ, tumor necrosis factor (TNF)-α, TNF-β, eotaxin, eotaxin-3, IFN-γ-induced protein (IP)-10, monocyte chemoattractant protein (MCP)-1, MCP-4, macrophage-derived chemokine (MDC), macrophage inflammatory protein (MIP)-1α, MIP-1β, thymus and activation regulated chemokine (TARC), and CRP.

2.4 Assessment of diabetic comorbidities

All participants in the type 2 diabetes cohort underwent investigations concerning common diabetic comorbidities: 1) *Peripheral neuropathy*: Signs of peripheral neuropathy was investigated by vibration perception threshold (VPT) at the dorsum of the first phalanx using a biothesiometer (Bio-Medical Instruments). The measurement was done three consecutive times bilaterally, and the final vibration perception threshold was calculated as the mean value of both feet. Results above 18 volts were considered abnormal and thus as signs of diabetic peripheral neuropathy. 2) *Nephropathy*: Morning urine samples were collected by participants at home and handed over to study personnel for standard biochemical analysis. Diabetic nephropathy was defined as a urine albumin/creatinine ratio above 30 mg/g, which is a standard cut-off for early diabetic nephropathy and microalbuminuria. 3) *Retinopathy*: Participants were asked if they had ever been diagnosed with proliferative or non-proliferative retinopathy 4) *Cardiac autonomic neuropathy*: Electrocardiographic recordings by the VAGUS™ device (Medicus Engineering Aps, Aarhus, Denmark) described in detail elsewhere (15) were applied for evaluation of cardiac autonomic neuropathy. Recordings were made during rest, postural change, deep breathing, and the Valsalva maneuver. Age-specific cut-off values were applied (17), and abnormal results in one or more exercises were considered as signs of cardiac autonomic neuropathy.

2.5 Data handling and statistics

Distribution of raw and log-transformed data was evaluated by Shapiro-Wilk test of normality. Pairwise comparisons among groups were achieved by independent samples t-test or Mann-Whitney U based on data distribution. Differences in inflammatory biomarkers between healthy and type 2 diabetes were investigated firstly by pairwise comparisons and secondly by a logistic regression model including age and BMI as confounders, as these factors were different between groups and known to influence systemic low-grade inflammation. For the volcano plot, the fold difference was calculated as the $\log_2$-ratio between two group means. Differences in inflammatory biomarkers between people with short- and long-term disease duration were likewise investigated by a logistic regression model including age and BMI as confounders. Multiple logistic regression analyses were performed to investigate the association between clinical parameters and inflammatory biomarkers. The independent variables included obesity (BMI<30 versus BMI>30), blood glucose level (HbA1c<55 versus HbA1c>55), DPP-4 inhibitor therapy, GLP-1 receptor agonist therapy, and sex. Additionally, two models were applied in which associations were adjusted for the remaining clinical

variables, and total plasma cholesterol or statin therapy, all of which may have an impact on the systemic inflammatory status. Differences in inflammatory biomarkers between people with 0, 1, 2 og ≥3 comorbidities were investigated by a Bonferroni-corrected ANOVA and subsequently the Dunn's Test. An α-level of 0.05 was applied for all analyses. The STATA software (StataCorp LLC, version 15.1) was applied for all statistical analyses.

2.6 Patient and public involvement

Patients or members of the public were not included in the design, conduction, reporting, or dissemination plans of this project.

3 RESULTS

3.1 Study population

Two subjects in the type 2 diabetes group were excluded due to hemolysis of collected blood samples. Individuals in the diabetes group were older, had higher BMI, and higher HbA1c compared to the healthy controls ($p<0.001$). On the contrary, healthy controls had higher total cholesterol ($p<0.001$), high-density lipoprotein (HDL) ($p=0.006$), and low-density lipoprotein (LDL) ($p<0.001$) compared to individuals in the type 2 diabetes cohort of which 66% were on lipid-lowering statin therapy. A full demographic overview can be found in Table 1.

	Healthy (n=21)	**Type 2 diabetes** (n=98)	**p-value**
Basic demography			
Age (years)	52 (48-55)	65 (56-71)	**<0.001**
Sex (% of males)	71	63	0.478
BMI (kg/m$^{2)}$	25.6 (23.7-28.0)	31.4 (27.5-34.5)	**<0.001**
Current smokers (%)	19	5	**0.028**
Disease duration (y)	-	10 (5-17)	-
Vital signs			
Systolic BP (mmHg)	128 (119-137)	137 (128-147)	**0.021**
Diastolic BP (mmHg)	76 ± 11	77 ± 9	0.720
Pulse (beats/min)	66 ± 7	69.8 ± 10	0.110
Biochemistry			
HbA1c			
(mmol/mol)	33 (33-37)	55 (48-61.5)	**<0.001**
(%)	5.2 (5.2-5.5)	7.2 (6.5-7.8)	**<0.001**
Cholesterol (mmol/l)	5.4 ± 0.9	3.9 ± 0.9	**<0.001**

eGFR (mL/min/1.73 m^2)			
>90 (%)	62	46	0.197
40-90 (%)	38	52	0.264
<40 (%)	0	<1	0.507
HDL (mmol/l)	1.5 (1.3-1.8)	1.2 (1.0-1.5)	**0.006**
LDL (mmol/l)	3.3 ± 0.9	1.9 ± 0.7	**<0.001**
Triglycerides (mmol/l)	1.1 (0.7-1.4)	1.4 (1.0-2.0)	**0.023**
Diabetic comorbidities			
Neuropathy (%)	-	60	-
Nephropathy (%)	-	19	-
Retinopathy (%)	-	8	-
CAN (%)	-	40	-
Medication			
Antihypertensives (%)	-	67	-
DPP-4 inhibitor (%)	-	18	-
Metformin (%)	-	78	-
SGLT-2 inhibitor (%)	-	23	-
GLP-1 receptor agonist (%)	-	23	-
Statins (%)	-	66	-

Table 1: Demographic and clinical characteristics among groups. Results displayed as either mean ± SD or median (1st-3rd quartiles) based on distribution of the data. Boldface font indicates statistical significance ($p<0.05$). Antihypertensive medication includes ACE inhibitors, angiotensin II receptor antagonists, calcium channel blockers, beta blockers, diuretics, and I1-imidazoline receptor antagonists. BMI: Body mass index; eGFR: Estimated glomerular filtration rate; HDL: High-density lipoprotein; LDL: Low-density lipoprotein; CAN: Cardiac autonomic neuropathy; DPP-4: Dipeptidyl peptidase-4; SGLT: Sodium-glucose transport protein; GLP: Glucagon-like peptide.

3.2 Inflammatory biomarkers in type 2 diabetes compared to healthy

Plasma levels of 27 inflammatory biomarkers were measured in individuals with type 2 diabetes and healthy controls. Eleven biomarkers were excluded from the statistical analyses due to being undetectable or of insufficient measurement quality due to low levels (Supplementary Table 1). The remaining 16 biomarkers (IL-6, IL-7, IL-8, IL-10, IL-12/IL-23p40, IL-15, IL-16, IFN-γ, TNF-α, eotaxin, IP-10, MCP-1, MDC, MIP-1β, TARC, CRP) were measured in ≥95% of the samples. The concentrations of TNF-α ($p = 0.003$) and CRP

(p=0.030) were significantly higher in the type 2 diabetes cohort compared to the control cohort (Figure 1). Similarly, 4 chemokines (eotaxin (p=0.001), MCP-1 (p=0.018), MDC (p=0.005), and MIP-1β (p=0.047)) showed elevated levels in the diabetes cohort. In contrast, the level of cytokine IL-7 was significantly lower in participants with type 2 diabetes compared to healthy controls (p<0.001). After adjustment for age and BMI, only IL-7,eotaxin, and TNF-α remained significantly different. Plasma concentrations of all measured biomarkers are presented in supplementary Table 2. When subdividing the type 2 diabetes cohort according to disease duration, only IL-10 was significantly different (p=0.008) between groups, even after adjustment for age and BMI, with a modestly increased levels found in subjects with disease duration above ten years. (Table 2). Similarly, we investigated whether presence of CAN (early or manifest) influenced the levels of inflammatory factors, however, none of these reached significant levels (data not shown).

		UNADJUSTED MODEL		ADJUSTED MODEL	
		OR (95% CI)	**p-value**	**OR (95% CI)**	**p-value**
Cytokines	IL-7	1.03 (0.93-1.15)	0.565	1.04 (0.93-1.18)	0.466
	IL-12 /IL-23p40	1.00 (1.00-1.00)	0.446	1.00 (0.99-1.01)	0.717
	IL-15	1.51 (0.74-3.10)	0.256	1.32 (0.62-2.79)	0.471
	IL-16	1.00 (1.00-1.00)	0.832	1.00 (1.00-1.00)	0.813
Chemokines	Eotaxin	1.00 (1.00-1.00)	0.887	1.00 (1.00-1.00)	0.687
	IP-10	1.00 (1.00-1.00)	0.512	1.00 (1.00-1.00)	0.244
	MCP-1	1.00 (1.00-1.00)	0.864	1.00 (1.00-1.00)	0.523
	MDC	1.00 (1.00-1.00)	0.810	1.00 (1.00-1.00)	0.319
	MIP-1β	1.00 (0.99-1.01	0.992	1.00 (0.99-1.01)	0.916
	TARC	1.00 (1.00-1.00)	0.719	1.00 (1.00-1.00)	0.260
Pro-inflammatory cytokines	IL-6	1.34 (0.79-2.27)	0.271	1.21 (0.70-2.09)	0.504
	IL-8	1.00 (0.94-1.06)	0.983	1.00 (0.94-1.06)	0.904
	IL-10	111.85 (2.86-4377.78)	**0.012**	103.97 (2.30-4699.58)	**0.017**
	IFN-γ	1.02 (0.97-1.08)	0.438	1.02 (0.96-1.09)	0.447
	TNF-α	1.69 (0.70-4.12)	0.246	1.78 (0.69-4.62)	0.234
Vascular injury	CRP	1.00 (1.00-1.00)	0.697	1.00 (1.00-1.00)	0.713

Table 2: Odds ratio (OR) for associations between plasma concentrations of inflammatory factors (cytokines (n=4), chemokines (n=6), pro-inflammatory cytokines (n=5), vascular injury (n=1)) in type 2 diabetes with short-term disease duration (<10 years, n=44) and long-term disease duration (>10 years, n=50) unadjusted and adjusted for age and BMI. Boldface font indicates statistical significance ($p<0.05$).

3.3 Inflammatory biomarkers in subgroups of type 2 diabetes

Obesity was significantly associated with concentration of five inflammatory biomarkers (IL-12/IL-23p40, IL-15, IFN-γ, MDC, and CRP) (Table 3 – only analytes with p-value below 0.05 shown). When adjusting for HbA1c, sex, and total plasma cholesterol or statin use, IL-12/IL-23p40, IL-15, and CRP remained statistically significant associated with obesity. HbA1c was significantly associated with eotaxin and IL-12/IL-23p40 levels after adjusting for confounders, and levels of MDC were associated with sex with lower levels found in male subjects compared to females. Lower levels of IL-8, IP-10, and MDC were associated with DPP-4 inhibitor therapy, while higher levels of TNF-α were associated with GLP-1 receptor agonist therapy. Lastly, SGLT2 inhibitor therapy was associated with lower levels of MDC.

	UNADJUSTED MODEL		ADJUSTED MODEL 1		ADJUSTED MODEL 2	
	OR (95% CI)	**p-value**	**OR (95% CI)**	**p-value**	**OR (95% CI)**	**p-value**
A. Obesity						
IL-12/IL-23p40	1.01 (1.00-1.02)	**0.003**	1.01 (1.00-1.02)	**0.007**	1.01 (1.00-1.02)	**0.007**
IL-15	2.32 (1.05-5.11)	**0.038**	2.30 (1.02-5.15)	**0.043**	2.30 (1.02-5.16)	**0.043**
IFN-γ	1.12 (1.00-1.25)	**0.041**	1.10 (0.99-1.23)	0.087	1.10 (0.99-1.22)	0.091
MDC	1.00 (1.00-1.00)	**0.029**	1.00 (1.00-1.00)	0.051	1.00 (1.00-1.00)	**0.049**
CRP	1.00 (1.00-1.00)	**0.001**	1.00 (1.00-1.00)	**0.001**	1.00 (1.00-1.00)	**0.001**
B. Blood glucose						
IL-8	1.08 (1.00-1.15)	**0.037**	1.07 (0.99-1.14)	0.076	1.07 (1.00-1.15)	0.055
TNF-α	3.25 (1.21-8.73)	**0.019**	2.64 (0.95-7.34)	0.062	3.09 (1.11-8.58)	**0.031**
Eotaxin	1.00 (1.00-1.01)	**0.031**	1.00 (1.00-1.01)	**0.027**	1.00 (1.00-1.01)	**0.025**
C. Sex						
MDC	1.00 (1.00-1.00)	**0.009**	1.00 (1.00-1.00)	**0.021**	1.00 (1.00-1.00)	**0.027**
D. DPP-4 inhibitor therapy						
IL-8	0.88 (0.79-0.99)	**0.040**	0.89 (0.79-1.00)	0.052	0.89 (0.79-1.00)	0.051
IP-10	1.00 (1.00-1.00)	**0.013**	0.99 (0.99-1.00)	**0.008**	0.99 (0.99-1.00)	**0.008**
MDC	1.00 (1.00-1.00)	**0.027**	1.00 (1.00-1.00)	**0.011**	1.00 (1.00-1.00)	**0.011**
TARC	1.00 (1.00-1.01)	**0.004**	1.00 (1.00-1.01)	**0.005**	1.00 (1.00-1.01)	**0.005**
E. GLP-1 receptor agonist therapy						
IL-8	1.08 (1.01-1.15)	**0.025**	1.08 (0.99-1.17)	0.069	1.08 (1.00-1.18)	0.058

IL-15	0.57 (0.23-1.41)	0.226	0.29 (0.09-0.95)	**0.042**	0.27 (0.08-0.92)	**0.036**
IL-16	1.00 (0.98-1.00)	**0.042**	1.00 (0.98-1.00)	0.077	1.00 (0.98-1.00)	0.068
TNF-α	6.50 (2.07-20.42)	**0.001**	4.60 (1.26-16.76)	**0.021**	4.70 (1.25-17.69)	**0.022**
F. SGLT2 inhibitor therapy						
MDC	1.00 (1.00-1.00)	**0.014**	1.00 (1.00-1.00)	**0.027**	1.00 (1.00-1.00)	**0.033**

Table 3: Multiple logistic regression analysis of plasma concentrations between A) type 2 diabetes+BMI<30 (n=40) and Type 2 diabetes+BMI>30 (n=58), B) type 2 diabetes with HbA1c<55(n=47) and type 2 diabetes with HbA1c>55 (n=51), C) male type 2 diabetes (n=62) and female type 2 diabetes (n=36), D) type 2 diabetes (n=80) and type 2 diabetes treated with DPP-4 inhibitors (n=18), E) type 2 diabetes (n=75) and type 2 diabetes treated with GLP-1 receptor agonists (n=23), and F) type 2 diabetes (n=75) and type 2 diabetes treated with SGLT2 inhibitor therapy (n=23) with overall R-squared value and effect size (95% CI) of BMI, HbA1c, sex, DPP-4 inhibitor therapy, GLP-1 receptor agonist therapy, or SGLT2 inhibitor therapy displayed. Results presented as odds ratio (OR) and 95% confidence interval (CI). Total plasma cholesterol, BMI, HbA1c, and sex were included in the adjusted model 1 as appropriate, while statin use, BMI, HbA1c, and sex were included in the adjusted model 2 as appropriate. For simplicity, only analytes with p-values below 0.05 in either model are shown. Bold font indicated statistical significance after Bonferroni adjustment (p<0.003).

3.4 Diabetic comorbidities

When subdividing the type 2 diabetes cohort into groups according to number of diabetic comorbidities, five biomarkers (IL-6, IL-10, IL12/IL-23p40, IL-15, and CRP) were significantly elevated in participants with three or more comorbidities compared to those with fewer or none (Figure 2 – only analytes with p-values below 0.05 shown).

4 DISCUSSION

In this study, we investigated the level of systemic low-grade inflammation in a cohort of individuals diagnosed with type 2 diabetes. Elevated levels of several inflammatory biomarkers were found in comparison to healthy controls, evident in both short- and long-term disease duration. Moreover, in the type 2 diabetes cohort, obesity, hyperglycemia and female sex were found to be associated with elevated levels of various inflammatory biomarkers. Lastly, we were able to establish a connection between the number of common diabetic comorbidities and elevated levels of inflammatory biomarkers.

4.1 Inflammatory biomarkers in type 2 diabetes compared to healthy

After adjustment for age and BMI, we showed that IL-7 was significantly decreased, while eotaxin and TNF-α was significantly increased in type 2 diabetes compared to healthy. The majority of research regarding IL-7 has been conducted in type 1 diabetes, where elevated levels are shown compared to healthy (18). IL-7 is highly involved in T cell function and proliferation, and a role of this cytokine in mediating expansion of insulin-producing β-cell-autoreactive T cells have been proposed thus implicating IL-7 in the pathogenesis of type 1 diabetes (19). The decreased levels in type 2 diabetes compared to healthy controls found in this study were somewhat surprising but may reflect the lack of T-cell activation the pathology of type 2 diabetes. Eotaxin has been linked to the development of atherosclerosis by facilitating monocyte infiltration in smooth muscle cells under the influence of proinflammatory mediators (20), and elevated levels of this chemokine have previously been reported in type 1 diabetes individuals with complications compared to individuals with no diabetic complications as well as healthy controls (21). Increased levels of CRP have previously been reported in adults with type 2 diabetes (13,22), but in our cohorts, the difference could be attributed to a skewed distribution of age and BMI in the two cohorts.

IL-10 is generally regarded as an anti-inflammatory cytokine with the ability to dampen the immune response, and previous data have shown downregulation of IL-10 in both type 2 diabetes and obesity *per se* (23). This contrasts our findings, which showed no differences in the overall diabetes cohort but an increase in individuals with long disease duration. This observation could reflect manifestations of compensatory mechanisms toward a long-term elevated inflammatory environment attempting to elicit an anti-inflammatory response. However, pro-inflammatory factors (e.g. TNF-α) were elevated regardless of disease duration suggesting that any attempt of balancing the immune response remain challenging in the presence of type 2 diabetes.

4.2 Inflammatory biomarkers in subgroups of type 2 diabetes

Obesity and blood glucose regulation

In our type 2 diabetes cohort, obesity (BMI>30) was significantly associated with the levels of IL-12/IL-23p40 and CRP, while eotaxin and TNF-α levels were associated with glycemic regulation (HbA1c). Previously it has been shown that TNF-α release is upregulated in connection with obesity and has been linked to the progression of insulin resistance (24,25). The fact that TNF-α was not associated with by obesity in our cohort is thus surprising. However, elevated levels of TNF-α in adipose tissue, but not in plasma have previously been reported (26), which could also be the case in our cohort. In animal models, TNF-α antagonist treatment improves insulin resistance in obesity (27). A clinical study, however, failed to show the same effect in humans (28). Regarding eotaxin, this chemokine has been linked to the development of cardiovascular disease, which is likewise a complication to long-term hyperglycemia, and our findings of increased levels in dysregulated individuals could therefore be a possible sign of atherosclerosis (20).

Sex

We showed that the level of the chemokine MDC was associated with sex with higher levels seen in females compared to males. Different obesity-related inflammatory pathways between men and women with metabolic syndrome have previously been shown. Increased levels of pro-inflammatory mediators seem to facilitate low-grade systemic inflammation in males, while an insufficient anti-inflammatory milieu appears to be dominant in females (29). These findings suggest that any inflammation-modulating therapy in obesity should be differentiated according to sex and underlying mechanisms. In our type 2 diabetes cohort, however, this pattern was not recreated, indicating that the crucial factor may be aspects related to the metabolic syndrome rather than hyperglycemia.

Therapeutical management

Lower levels of three chemokines (IL-8, IP-10 and MDC) were all associated with DPP-4 inhibitor therapy. DPP-4 inhibitor therapy is known to improve glycemic control via prevention of breakdown of the incretin hormone GLP-1. In addition, several cytokines and chemokines are also substrates of the DPP-4 enzyme, and DPP-4 inhibitor therapy thus possesses immunomodulating properties possibly facilitating low-grade systemic inflammation in diabetes (9). Potentially this could explain why promising *in vitro* anti-inflammatory actions of DPP-4 inhibitors have failed to show convincingly results in humans (30). Surprisingly, we found lower levels of three DPP-4 substrates (IL-8, IP-10, and MDC) in connection with DPP-4 inhibitor therapy. Though seemingly in contrast with the expected result, similar observations have previously been reported e.g. lower levels of eotaxin in type 2 diabetes during DPP-4 inhibitor therapy (31). In our study, however, eotaxin levels were unaffected by DPP-4 inhibitor therapy, underlining the need for further research in the immunomodulating effects of these compounds.

GLP-1 receptor agonist therapy, which share the same pharmacodynamic endpoint as DPP-4 inhibitor therapy, is known to possess anti-inflammatory properties independent of improved glycemic control (32). However, our results showed an approximately 25% increase in proinflammatory TNF-α levels in connection with GLP-1 receptor agonist therapy. This finding is unexpected and in contrast with a previous pilot study showing that liraglutide significantly decreased TNF-α levels in a type 2 diabetes cohort (33). Preclinical studies have likewise shown inhibitory effects of liraglutide on TNF-α expression (34). Other preclinical studies, however, have reported decreased proinflammatory effects of TNF-α through inhibition of the NK-κB pathway after GLP-1 receptor agonist therapy (35). If this is the case, this would neutralize the proinflammatory pathways caused by increased TNF-α levels seen in this study.

In our cohort, SGLT2 inhibitor therapy was associated with a decrease in MDC, known to facilitate and amplify type II immune response (36). The anti-diabetic effects of SGLT2 inhibitors rely on the inhibition of renal reabsorption of glucose, but anti-inflammatory effects have also been reported including attenuation of IL-6 production (37) and modulation of macrophage polarization (38). The prospect of utilizing the anti-inflammatory potential of SGLT2 inhibitors in various pathologies is currently receiving much attention (39).

Additional subgroups

Apart from obesity, hyperglycemia, and sex, other factors such as current smoking status and specific medical therapy may likewise influence the level of inflammation in type 2 diabetes (40,41). In our cohort only 5% were smokers, which is surprisingly low, giving the fact that smoking is a substantial risk factor for development of type 2 diabetes (40). The low number of current smokers may reflect selection or reporting bias or perhaps successful free smoking cessation programs, as 40% of our participants reported to be previous smokers. This is, however, highly speculative. Nonetheless, the degree of a persistent pro-inflammatory effect of nicotine following smoking cessation is debated (42), and could potentially be influencing the results in the current study. Moreover, the high proportion of previous smokers could indicate that our cohort consisted of individuals with a high degree of determination and self-efficacy. Such selection bias is potentially also reflected in the median HbA1c of 55 mmol/mol, which is lower in comparison to other cohorts (13,43).

In our cohort, 66% received lipid-lowering statin therapy, which is known to possess anti-inflammatory properties (8), which again could impact the level of investigated inflammatory biomarkers. Consequently, the reported elevated levels of several biomarkers compared to the healthy control cohort could be artificially low due to the anti-inflammatory effect of statins. Potentially this could explain why no pro-inflammatory biomarkers were increased in individuals with longer disease duration as these individuals were more likely to be on statin therapy.

4.3 Diabetic comorbidities

It has previously been established that low-grade systemic inflammation plays a role in progression of diabetic complications (10–12). We found that IL-6, IL-10, IL-12/IL-23p40, IL-15, and CRP were elevated in individuals with multiple diabetic comorbidities compared to those with fewer or none. In the literature, IL-6 elevation has in particular been associated with diabetic complications (44–47). Likewise, increased levels of CRP has previously been linked to development and severity of diabetic complications (45,48). In addition, the observed elevated levels of IL-10 were primarily found in subjects with longer disease duration, which could reflect that diabetes comorbidities typically become more prevalent with increasing exposure to glycemic fluctuations and disease duration (49). Furthermore, IL-12 has previously been shown to be involved in the pathogenesis of several diabetic micro- and macrovascular comorbidities (50). Interestingly, a study in obese and insulin resistant IL-12 knockout mice showed that IL-12 disruption increased angiogenesis and restored peripheral blood flow perfusion through attenuation of oxidative stress and increased levels of angiogenic factors (51). In humans, a monoclonal antibody (Ustekinumab) targeting IL-12/IL-23p40 is currently used as a safe and effective treatment of psoriasis (52). Our data raise the intriguing possibility of applying this drug as a novel treatment option for diabetic micro- and macrovascular complications but needs to be investigated in future randomized controlled trials. Finally, circulating levels of IL-15 have been shown to be influenced by fat mass and physical activity (53). Furthermore, IL-15 improve lipid deposition and insulin sensitivity by activation of the GLUT-4 transporter in skeletal muscles. Hence, IL-15 has been proposed as a novel therapeutic option for treating obesity and type 2 diabetes (54). The increased levels of IL-15 in individuals with three or more comorbidities found in this study seem to contradict the beneficial effects normally attributed to this cytokine, but as this is a cross-sectional study no conclusions of causality can be made.

4.4 Strengths and limitations

A major limitation of this study is the cross-sectional study design, which hinders any assumptions of the predictive potential of low-grade inflammation and clinical characteristics of type 2 diabetes. On this dataset, we tested for association between low grade inflammation in type 2 diabetes, and we selected á priori the anti-inflammatory markers, as they are part of the underlying pathogenesis. According to the study design, each of the serum markers were tested individually, and based on our unadjusted and adjusted models we suggest an association to the specific marker IL-10. As the manufacturer of the multiplex assay had defined division of serum markers into cytokines (n=4), chemokines (n=6), pro-inflammatory cytokines (n=5), vascular injury (n=1), we believe that Bonferroni's correction is too conservative. The major strength of this study is the high degree of heterogeneity of our cohort, obtained by systematically screening all people in our out-patient diabetes clinic, thereby facilitating generalization to the larger population of type 2 diabetes. However, selection bias in which individuals with low symptom burdens are more likely to participate cannot be ruled out. Contrary, a majority of patients with complications, who regard participation

in a clinical trial as a possibility to receive extra attention from health care professionals, is likewise conceivable. It should also be noted that because this study is based on secondary analyses, the inclusion and exclusion criteria were not designed to exclude participants with comorbidities or medication use, which could impact the levels of the investigated inflammatory factors. Lastly, registration of retinopathy was restricted to participant recollection and reporting. Objective measures or consultation in patient records would have improved the validity of this outcome.

4.5 Conclusion

We showed that individuals with type 2 diabetes exhibit higher degrees of various inflammatory factors in plasma, and that obesity and glycemic dysregulation are associated with the level of specific inflammatory factors. Furthermore, a considerable increase in several inflammatory factors was seen in people with multiple diabetic comorbidities. Regarding medication, DPP-4 inhibitor therapy was associated with decreased levels of several chemokines, while increased TNF-α levels were observed in association with GLP-1 receptor agonist therapy. Taken together, our results show that individuals with type 2 diabetes have systemic low-grade inflammation. Although the cross-sectional nature of our study hinders the ability to look at the causality between systemic low-grade inflammation and diabetic complications, it is intriguing to speculate whether dampening of the inflammatory state could protect against development of comorbidities in type 2 diabetes.

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AUTHOR CONTRIBUTIONS

Study design and original idea by CB and BB. AMW collected the data. TO, AMW, FP, BB, JS, and CB analysed and interpreted the data. TO wrote the first draft, but all authors contributed to the final manuscript. CB are the guarantor of the work, has full access to the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis. The data that support the findings of this study are available from the corresponding author upon reasonable request.

COMPETING INTERESTS

None

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DATA SHARING STATEMENT

Deidentified participant data are available upon reasonable request to the corresponding author.

ETHICS APPROVAL

The protocol was approved by The North Denmark Region Committee on Health Research Ethics, Denmark (N-20170045)

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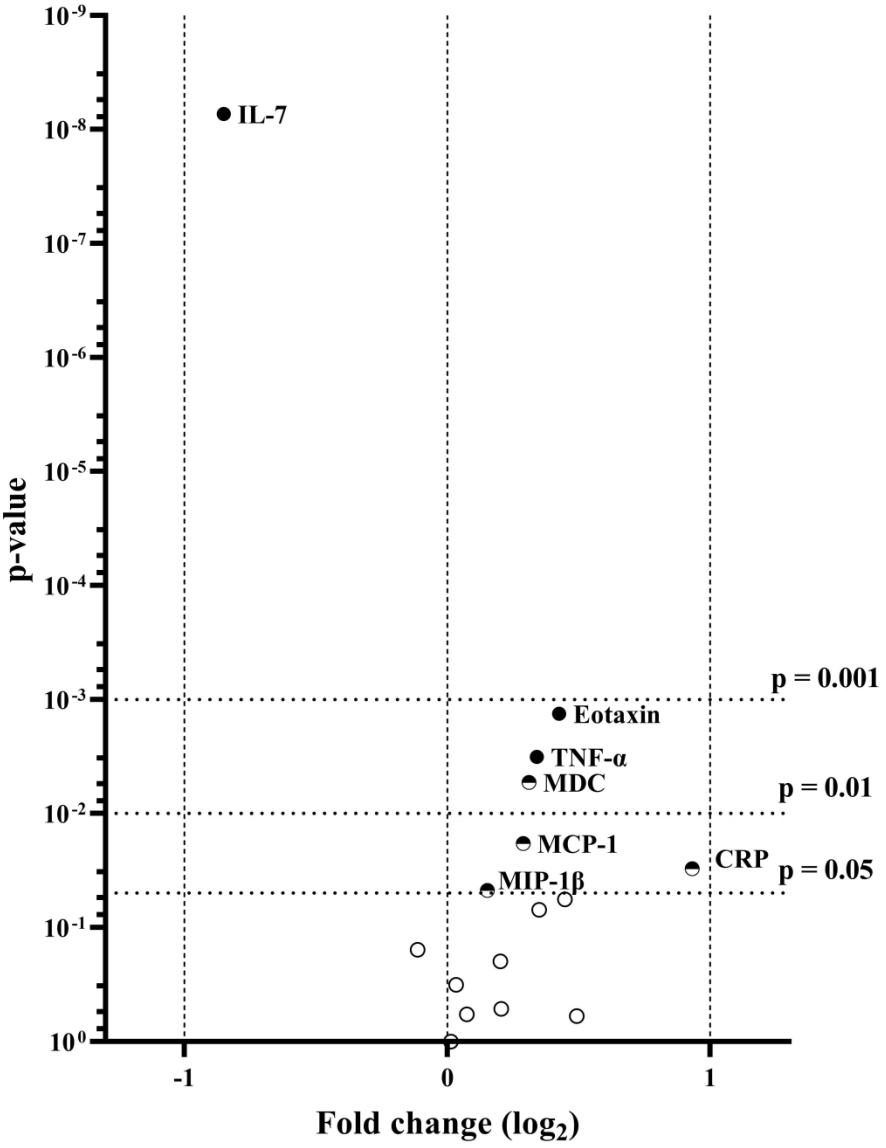
FIGURE LEGENDS

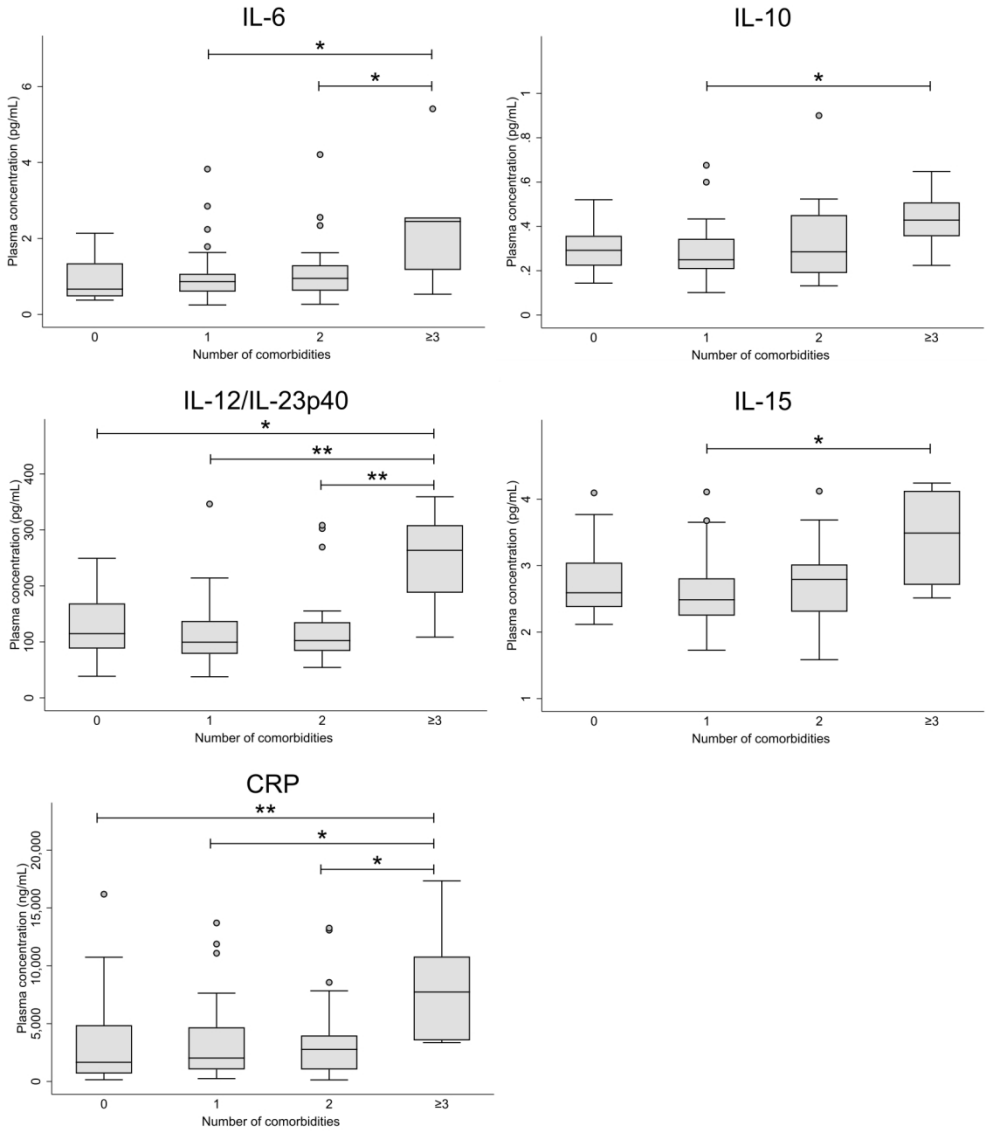
Figure 1: Volcano plot displaying pairwise comparisons of inflammatory factors in type 2 diabetes and healthy controls. Vertical dashed lines indicate threshold for two-fold differences among groups. Horizontal dashed lines indicate p-value thresholds of 0.05, 0.01, and 0.001, respectively. ● significantly different after adjustment for age and BMI, ◓ significantly different in the unadjusted model, ○ above significance threshold in both models. Only significant analytes are labeled.

Figure 2: Box plots displaying plasma concentrations of biomarkers in individuals with type 2 diabetes and 0 (n=20), 1 (n=43), 2 (n=28), or 3 or more (n=7) diabetic comorbidities (retinopathy, nephropathy, neuropathy, cardiac autonomic neuropathy). Only analytes with p-values below 0.05 are shown. *p<0.05, **p<0.01



Volcano plot displaying pairwise comparisons of inflammatory factors in type 2 diabetes and healthy controls. Vertical dashed lines indicate threshold for two-fold differences among groups. Horizontal dashed lines indicate p-value thresholds of 0.05, 0.01, and 0.001, respectively. ● significantly different after adjustment for age and BMI, ◓ significantly different in the unadjusted model, ○ above significance threshold in both models. Only significant analytes are labeled.

136x175mm (600 x 600 DPI)



Box plots displaying plasma concentrations of biomarkers in individuals with type 2 diabetes and 0 (n=20), 1 (n=43), 2 (n=28), or 3 or more (n=7) diabetic comorbidities (retinopathy, nephropathy, neuropathy, cardiac autonomic neuropathy). Only analytes with p-values below 0.05 are shown. *p<0.05, **p<0.01

301x342mm (150 x 150 DPI)

SUPPLEMENTARY TABLES

	% of samples with estimated values† (T2D/healthy)	**% of excluded samples‡** (T2D/healthy)	**Number of readings above 3 SD from group mean** (T2D/healthy)
IL-1α§	95/95	3/5	-
IL-1β§	93/95	3/0	-
IL-2§	19/29	30/29	-
IL-4§	14/14	51/43	-
IL-5§	32/19	23/14	-
IL-6	**0/0**	**0/0**	**2/0**
IL-7	**0/0**	**1/0**	**1/0**
IL-8	**0/0**	**0/0**	**2/0**
IL-10	**0/0**	**0/0**	**1/0**
IL-12/IL-23p40	**0/0**	**0/0**	**1/0**
IL-13§	82/100	10/0	-
IL-15	**0/0**	**1/0**	**2/0**
IL-16	**0/0**	**1/0**	**1/0**
IL-17A§	0/0	17/19	-
IFN-γ	**0/0**	**0/0**	**2/0**
TNF-α	**0/0**	**0/0**	**2/0**
TNF-β§	21/5	33/19	-
Eotaxin	**0/0**	**1/0**	**0/0**
Eotaxin-3§	0/0	15/10	-
IP-10	**0/0**	**1/0**	**3/0**
MCP-1	**0/0**	**1/0**	**0/0**
MCP-4§	0/0	1/10	-
MDC	**0/0**	**1/0**	**1/0**
MIP-1α§	0/0	10/5	-
MIP-1β	**0/0**	**1/5**	**2/0**
TARC	**0/0**	**1/0**	**2/0**
CRP	**0/0**	**0/0**	**3/1**

Supplementary table 1: Overview of MSD multiplex analysis and data handling. † calculated as the lower detection limit divided by the square root of two, ‡ excluded due to a coefficient of variance above 30%

between duplicates, § excluded from further analysis due to insufficient data quality. Boldface font indicates analytes included in the analysis.

	Healthy (n=21)	**Type 2 diabetes** (n=98)	**p-value**
IL-6	0.6 (0.4-0.9)	0.9 (0.6-1.3)	0.056
IL-7	15.5 ± 5.0	8.2 (5.9-10.2)	**<0.001**
IL-8	12.1 ± 3.8	12.4 (8.8-16.7)	0.514
IL-10	0.2 (0.2-0.3)	0.3 (0.2-0.4)	0.198
IL-12/IL-23p40	100.9 ± 45.5	107.5 (82.9-145.8)	0.070
IL-15	2.7 ± 0.4	2.6 (2.3-3.0)	0.999
IL-16	225.0 ± 53.9	208.0 ± 48.4	0.156
IFN-γ	5.1 ± 2.4	5.2 (3.1-7.7)	0.594
TNF-α	1.2 ± 0.2	1.5 (1.3-1.8)	**0.003**
Eotaxin	267.6 ± 74.3	339.9 (259.8-434.1)	**0.001**
IP-10	539.4 (397.7-767.9)	575.9 (443.6-725.4)	0.576
MCP-1	243.3 (215.9-287.8)	323.1 ± 105.0	**0.018**
MDC	912.3 ± 255.5	1059.7 (887.9-1279.2)	**0.005**
MIP-1β	131.5 (102.0-167.8)	161.9 ± 48.3	**0.047**
TARC	218.6 (120.7-531.7)	275.4 (168.6-412.4)	0.316
CRP (ng/mL)	871.3 (528.6-3353.3)	2769.3 (1037.6-5236.5)	**0.030**

Supplementary table 2: Plasma concentrations of inflammatory factors. Results (in pg/mL, unless otherwise stated) displayed as either mean ± SD or median (1^{st}-3^{rd} quartiles) based on distribution of the data. Boldface font indicates statistical significance ($p<0.05$).

STROBE Statement—Checklist of items that should be included in reports of ***cross-sectional studies***

	Item No	Recommendation	Page No
Title and abstract	1	(*a*) Indicate the study's design with a commonly used term in the title or the abstract	1, 2
		(*b*) Provide in the abstract an informative and balanced summary of what was done and what was found	2
Introduction			
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported	3
Objectives	3	State specific objectives, including any prespecified hypotheses	4
Methods			
Study design	4	Present key elements of study design early in the paper	4
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection	4
Participants	6	(*a*) Give the eligibility criteria, and the sources and methods of selection of participants	4
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable	4-5
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group	4-5
Bias	9	Describe any efforts to address potential sources of bias	4-5
Study size	10	Explain how the study size was arrived at	Secondary analysis
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why	5
Statistical methods	12	(*a*) Describe all statistical methods, including those used to control for confounding	5-6
		(*b*) Describe any methods used to examine subgroups and interactions	5
		(*c*) Explain how missing data were addressed	5
		(*d*) If applicable, describe analytical methods taking account of sampling strategy	n/a
		(*e*) Describe any sensitivity analyses	n/a
Results			
Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed	Secondary analysis
		(b) Give reasons for non-participation at each stage	n/a
		(c) Consider use of a flow diagram	n/a
Descriptive data	14*	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders	Table 1
		(b) Indicate number of participants with missing data for each variable of interest	Supp. material

Outcome data	15*	Report numbers of outcome events or summary measures	
Main results	16	(*a*) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included	Table 2, Table 3
		(*b*) Report category boundaries when continuous variables were categorized	n/a
		(*c*) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period	n/a
Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses	n/a
Discussion			
Key results	18	Summarise key results with reference to study objectives	12
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias	15-16
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence	12-15
Generalisability	21	Discuss the generalisability (external validity) of the study results	14-15
Other information			
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based	15

*Give information separately for exposed and unexposed groups.

Note: An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available on the Web sites of PLoS Medicine at http://www.plosmedicine.org/, Annals of Internal Medicine at http://www.annals.org/, and Epidemiology at http://www.epidem.com/). Information on the STROBE Initiative is available at www.strobe-statement.org.