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Natriuretic peptides in the control of lipid metabolism and insulin sensitivity

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Abbreviations

Insulin resistance, IR; type 2 diabetes mellitus, T2DM; fatty acid, FA; adipose tissue, AT; natriuretic peptides, NPs; atrial natriuretic peptide, ANP; B-type natriuretic peptide, BNP; C-type natriuretic peptide, CNP; dendroaspis natriuretic peptide, DNP; glucagon-like peptide 1, GLP1; guanylyl cyclase, GC; natriuretic peptide receptor A, MAPK; mitogen-activated protein kinase, NPRA; natriuretic peptide receptor B, NPRB; cyclic GMP, cGMP; natriuretic peptide receptor C, NPRC; neutral endopeptidase, NEP; insulin-degrading enzyme, IDE; dipeptidyl peptidase-4, DPP4; body mass index, BMI; phosphatidylinositol 3-kinase, PI3K; protein kinase G, PKG; perilipin-1, PLIN-1; hormone sensitive lipase, HSL; adipose triglyceride lipase, ATGL; protein kinase A, PKA; cyclic AMP, cAMP; human ANP, hANP; phosphodiesterase 3B, PDE3B; tumor necrosis factor alpha, TNF- α ; brown adipose tissue, BAT; uncoupling protein 1, UCP-1; peroxisome proliferator-activated receptor gamma coactivator 1-alpha, PGC-1 α ; peroxisome proliferator activated receptor, PPAR; non-alcoholic fatty liver, NAFL; lipopolysaccharides, LPS.

1. Abstract

Natriuretic peptides have long been known for their cardiovascular function. However, a growing body of evidence emphasizes the role of natriuretic peptides in human substrate and energy metabolism, thereby connecting the heart with several insulin sensitive organs like adipose tissue, skeletal muscle and liver. Obesity may be associated with an impaired regulation of the natriuretic peptide system, also indicated as a natriuretic handicap. Evidence points towards a contribution of this natriuretic handicap to the development of obesity, type 2 diabetes mellitus and cardiometabolic complications, although the causal relationship is not fully understood. Nevertheless, targeting the natriuretic peptide pathway may improve metabolic health in obesity and type 2 diabetes mellitus. This review will focus on current literature regarding the metabolic roles of natriuretic peptides with emphasis on lipid metabolism and insulin sensitivity. Furthermore, it will be discussed how exercise and lifestyle intervention may modulate the natriuretic peptide-related metabolic effects.

2. Introduction

Obesity is one of the major health problems of the twenty-first century as it is closely associated with the development of chronic metabolic diseases, including cardiovascular disease, insulin resistance (IR) and type 2 diabetes mellitus (T2DM)¹⁻³. Different insulin sensitive organs tightly orchestrate energy and substrate metabolism in the human body. Therefore, alterations in these organs may contribute to the development of disturbances in fatty acid (FA) metabolism, ultimately leading to impaired glucose metabolism, IR and cardiometabolic disease. Next to the liver, skeletal muscle, the gastrointestinal tract and the pancreas, the adipose tissue (AT) is an important central organ in the inter-organ crosstalk in human energy and substrate metabolism. The AT is the primary site for long-term energy storage, mainly as triglycerides. However, a chronic excessive energy intake, like in obesity, results in enlargement (hypertrophy) of existing adipocytes. Since adipocytes have a limited expansion capacity, hypertrophy will lead to a reduced buffering capacity and dysfunctional AT may develop^{4,5}. This AT dysfunction is further characterized by an altered lipid storage capacity and adipokine release, immune cell infiltration and low-grade inflammation, plays an important role in the development and/or progression of IR by promoting ectopic lipid storage and low-grade inflammation⁶⁻¹⁰. Physical activity intervention, whether or not combined with diet, may reduce the progression towards T2DM^{11,12}, possibly due to modulation of AT, liver and/or skeletal muscle FA metabolism¹⁰.

Only recently, research proposed natriuretic peptides (NPs) as important endocrine hormones implicated in the regulation of whole-body energy and substrate metabolism¹³⁻¹⁶. Atrial natriuretic peptide (ANP), B-type natriuretic peptide (BNP), both secreted by the heart, and C-type natriuretic peptide (CNP), mainly expressed by vascular endothelial cells and to a lower extent in cardiomyocytes¹⁷, are the three NP family members that may play a role in human substrate and energy metabolism. Besides their cardiovascular and renal effects

(described extensively by Volpe *et al.* ¹⁸), NPs play a role in different metabolic processes including lipid mobilization in human white AT ^{13,15}, energy dissipation in brown AT, browning of white AT ¹⁹ and fat oxidation in human skeletal muscle ²⁰, possibly influencing whole-body FA metabolism, glucose homeostasis and insulin sensitivity. In addition to their wide range of metabolic effects in human insulin sensitive tissues, plasma NP levels were also reported to be negatively associated with cardiometabolic diseases ²¹⁻²⁶ and have been even suggested to have a predictive value in the development of new onset T2DM ²⁵. However, a better understanding of the interaction between NPs and tissue energy, FA and glucose metabolism is necessary to obtain a better insight in the role of NPs in the development of IR, T2DM and cardiometabolic complications.

In this review, we will discuss the current knowledge regarding the role of NPs in the control of human lipid metabolism and insulin sensitivity. At first, NP secretion, clearance and signaling is discussed. Subsequently, the role of NPs in the etiology of obesity and T2DM is discussed, as well as their effects on AT, skeletal muscle and liver metabolism. Moreover, the benefits of lifestyle and/or exercise interventions with respect to NPs in the control of insulin sensitivity are considered.

3. Secretion and processing of NP

The discovery of the endocrine properties of the heart by deBold in 1981, as shown by a potent natriuretic and diuretic effect of atrial myocardial extracts in rats ²⁷, led to the reexamination of the function of the earlier discovered atrial myocardium granules ²⁸. The dual nature of atrial cardiomyocytes (i.e. secretory-contractile function) became obvious and research led to the identification of ANP ²⁹ and later the other NP-hormone family members BNP, which is found at highest levels in cardiac ventricles, CNP, which is mainly expressed in and produced by endothelial cells ¹⁷. CNP, previously thought to act as a neuropeptide in

the central nervous system^{30,31}, is mainly viewed as a peptide regulating vascular blood pressure³² and bone growth³³, although a minor role in metabolic regulation has been suggested^{34,35}. In mammals, dendroaspis natriuretic peptide (DNP) (of which the synthesis and secretion sites have not been identified) exerts renal actions via its specific receptor³⁶ but because it has not been well studied with respect to metabolic effects in humans, DNP will not be further discussed in the current review.

Currently, ANP and BNP are the main metabolically active NPs described in literature and will therefore be discussed in more detail in the present review. These peptides have a 17-amino acid ring structure in common, formed by an intramolecular disulfide linkage, of which the sequence is highly preserved within the biologically active form of these peptides³⁷. Structural differences between NP family members are due to specific amino- and carboxy-terminal extensions³⁸. At rest, ANP (normal concentration range 5-50 pg/mL) is mainly produced and secreted by the (right) atrial myocardium as a prehormone³⁹. The intracellular granules of the atrial myocardium contain proANP which is cleaved by corin (type II transmembrane serine protease expressed primarily in the heart) during secretion, resulting in a 28-amino acid, bioactive α ANP peptide⁴⁰, with a very short plasma half-life of about 2-4 min⁴¹, and inactive fragments (N-terminal ANP and mid-regional-proANP) which have a longer plasma half-life (about 40-50 min)^{41,42}. BNP is mainly produced and secreted by the ventricular myocardium as preproBNP⁴³. To become biologically active, preproBNP is cleaved to proBNP and subsequently, like for ANP, a cardiac protease, corin or furin, is responsible for the conversion to the 32-amino acid BNP (plasma concentration range 0-65 pg/mL) which is secreted in the circulation having a plasma half-life of about 15-25 min⁴⁴, and the inactive N-terminal fragment proBNP⁴⁵. The latter inactive fragment has a plasma half-life of about 60-120 min and a plasma concentration in the range of 7-220 pmol/L in healthy individuals⁴¹. While the structure of BNP varies distinctly among species, ANP is

strongly homologous between human and rodent ⁴⁵. The post-translational processing, cleavage and degradation sites of NPs were recently reviewed by Volpe *et al.*¹⁸.

4. Determinants of NP secretion

Mechanical stretch of cardiomyocytes is the most important trigger for NP release in the circulation ⁴⁵. Atrial wall stretching causes an increase in ANP gene transcription and increased release of stored granules ⁴⁶. Ventricular wall stress, in case of volume or pressure overload, is mainly responsible for BNP transcription and secretion ³⁸. In addition, hypoxic conditions or myocardial ischemia are potent inducers of ANP secretion due to the presence of hypoxia-responsive elements in the promotor region of the ANP gene ⁴⁷.

Another potent stimulus for NP secretion is cold exposure. Animals and humans exposed to cold display a greater expression of ANP (mRNA) and BNP (mRNA and protein) in the heart, combined with higher plasma levels, in conjunction with an elevated sympathetic nervous system activation in the heart ¹⁹. Cold-induced elevation of NPs levels might result from increased blood pressure in response to skin vasoconstriction and altered central blood volumes, thereby augmenting cardiac filling pressure and thus NPs' secretion ^{48,49}.

Besides mechanical stretch and cold exposure, endocrine regulation of NP secretion is present as well. Sex steroids, thyroid hormones, glucocorticoids, endothelin-1, angiotensin II and inflammatory cytokines (tumor necrosis factor- α , interleukin-1 and -6) all are able to modulate NP secretion ^{38,45,50}. Inflammatory cytokines stimulate BNP transcription and translation *in vitro* in murine cardiomyocyte cultures ⁵¹ and *in vivo* secretion into the plasma in human transplant patients specifically ⁵². In this regard, it was shown that the glucagon-like peptide 1 (GLP1) receptor agonist liraglutide was able to induce a significant increase in ANP secretion in mice due to the presence of GLP1 receptors on right atrial cardiomyocytes ⁵³. However, the existence of a GLP-1-ANP axis could not be confirmed in men or patients with

T2DM⁵⁴⁻⁵⁷. ANP and BNP plasma levels also increase with age, possibly due to an age-related reduction in coronary blood flow reserve and thus increased myocardial ischemia⁵⁸⁻⁶⁰. Modulation by sex steroids may result in sex dependent regulation of NP levels⁶⁰⁻⁶². An effect of sex hormones during adolescence was already observed in pubertal versus post-pubertal adolescents, where NP concentrations are lower in post-pubertal boys compared with pubertal boys⁶³. Estrogens might have a stimulatory effect on the production and secretion of ANP and BNP by the cardiomyocyte, whereas androgens may have an inhibitory effect⁶¹. In part, the increased NP levels in women might have clinical implications for sex-related difference in relative risk of developing metabolic and cardiovascular disease. Furthermore, during adolescence NPs levels seem to increase progressively in girls^{58,59}, probably the result of an interaction between the increased estrogen concentration and ANP transcription and secretion or via the regulation of the NPs receptor expression⁶⁴. Plasma CNP levels alternatively decrease during adolescence until the age of fifty, whereupon they tend to increase. CNP concentrations are higher in men than in women as testosterone and growth hormone are able to induce CNP⁶⁵.

Finally, metabolically compromised conditions like obesity, insulin resistance and T2DM may be characterized by altered systemic NP concentrations, which will be discussed more extensively later in this review.

5. NP receptors and signaling

To exert their main biological effects NPs bind to NP receptors, of which three subtypes have been described (reviewed recently by Kuhn)⁶⁶. ANP and BNP bind with a high affinity to a membrane-bound receptor, containing a transmembrane segment, with specific guanylyl cyclase (GC) activity called NP receptor A (NPRA). CNP is mainly bound to NP receptor B (NPRB)⁶⁷, similar in structure and function to NPRA and mainly expressed by chondrocytes,

207 thereby playing a role in long bone growth ⁶⁸. Ligand binding to a NPRA homodimer results
208 in the internalization of the bound ligand-receptor complex and the activation of cytosolic
209 GC, the catalytic effector of the receptor, subsequently causing hydrolysis of GTP into cyclic
210 GMP (cGMP). This second messenger is able to activate various biological responses via
211 cGMP-dependent protein kinases, cGMP-gated ion channels or other effector proteins ⁶⁹. A
212 large proportion of the ligand-bound receptor undergo lysosomal degradation, in which about
213 75% of the internalized ANP is processed in the lysosomes and 25% is released as intact
214 molecules through a recycling pathway. A small amount of internalized receptors is recycled
215 back to the plasma membrane or released into the cell exterior ⁷⁰. The NP receptor C (NPRC)
216 is the third subtype, having an extracellular domain that is partly homologous to those of
217 NPRA receptors and thus has the ability to bind NPs, with the highest affinity to ANP and
218 lowest to BNP ⁷¹. However, NPRC lacks GC activity and instead its main function is to
219 facilitate scavenging of its ligands, internalization of ligand-receptor complexes and recycling
220 of NPRC, together with lysosomal degradation of its ligands ^{72,73}. Besides via lysosomal
221 clearance, NPs can be degraded intracellularly by endopeptidases including neutral
222 endopeptidase (NEP) ⁷⁴, which is also produced in adipocytes ⁷⁵. In addition, insulin-
223 degrading enzyme (IDE) enzymatically cleaves NP ^{45,76} and dipeptidyl peptidase-4 (DPP4 or
224 CD26) cleaves the N-terminal peptide of NPs thereby lowering biological activity ⁷⁷. Another
225 route to clear circulating NP is via secretion into body fluids like urine (via glomerular
226 filtration) and bile ⁴⁵.

227 The main effector receptor for ANP and BNP, NPRA, is highly expressed throughout the
228 cardiovascular system (vascular smooth muscle and endothelial cells with only a limited
229 expression in the heart), in kidney and adrenal gland, as well as in different metabolic organs
230 like skeletal muscle, pancreas, liver, brain, gut and AT ^{37,78,79}. Expression of the scavenging
231 NPRC, the most widely expressed NPs receptor, is mainly present in the AT, kidneys, lungs,

the cardiovascular system and blood monocytes^{73,80,81}. Interestingly, NPRA and NPRC display diurnal regulations (in antiphase of one other) in the rodent white AT⁸², not in the heart muscle⁸³, which together with the circadian regulated plasma NPs^{84,85}, may be a characteristic for energy homeostasis during the day. Furthermore, the local tissue specific and systemic effects of NP are thought to depend on the ratio between NPRA and NPRC^{86,87}. Collectively, NPs mediate their effects via NP receptors, of which three subtypes have been described. The diverse effects of NPs, systemically as well as the local tissue effects, are determined by NP receptor expression profiles and their ligand-affinity.

6. Systemic NP deficiency in obesity, insulin resistance and type 2 diabetes mellitus

Evidence from several epidemiological studies demonstrated an inverse association between systemic NPs levels (both ANP and BNP) and body weight (mostly expressed by body mass index (BMI))^{21,23,88-92}. The inverse relationship between NP levels and BMI was also found in the presence of left ventricular hypertrophy⁹³. However, these studies lack detailed body composition analyses thereby not being able to differentiate between fat accumulation or fluid retention as a cause of the increased BMI. In contrast, other smaller cohorts showed that there is no or even a positive relationship between circulating NPs levels and BMI^{94,95}. Furthermore, NPs may affect AT distribution^{96,97}. Variations in regional and particularly visceral adiposity were strongly related to circulating N-terminal-pro-BNP. The relationship of NPs with subcutaneous adiposity was less strong⁹⁷. This relation could be partly moderated by the hyperinsulinemic state that is frequently observed in visceral adiposity, as high insulin levels have been shown to suppress NPs secretion and activity^{98,99}. The Dallas Heart Study recently showed that both BNP and N-terminal-proBNP are inversely related to visceral and liver fat, while being positively associated with gluteofemoral body fat, independent of insulin sensitivity¹⁰⁰.

Of interest, it is important to take into account obesity comorbidities including the presence of cardiac burden in considering these results¹⁰¹. The decrease in systemic NPs levels may be accompanied by higher blood aldosterone concentrations, as a consequence of an impaired NPs-mediated renin-angiotensin-aldosterone system inhibition^{102,103}, thereby leading to obesity-related hypertension²² or an increased incidence of all-cause mortality⁹¹. The substantial role of NPs deficiency in the pathogenesis of obesity-related hypertension was recently corroborated in healthy obese men, showing a negative association between serum mid-regional-proANP and mean 24-hour systolic ambulatory blood pressure¹⁰⁴. Moreover, research indicated that NPs deficiency might enhance cardiovascular risk¹⁸. Although not all mechanisms involved in obesity-related hypertension are well understood¹⁰⁵, NPs might partially link obesity and metabolic syndrome to hypertension¹⁰⁶.

As obesity is often associated with IR or T2DM, a link between the NPs system, obesity and T2DM seems plausible. Recent research indicated that NPs deficiency might increase the risk of T2DM onset¹⁰⁷. Indeed, two recent prospective cohort studies showed evidence supporting this hypothesis^{25,26}. Results of the Malmö Diet and Cancer Study showed mid-regional-proANP plasma levels to be inversely associated with new-onset diabetes development (*i.e.*, diabetes incidence) and an impaired glucose metabolism over the 16-year follow-up period of the study, which was also true for N-terminal-proBNP plasma levels, although not statistically significant²⁵. In this regard, mid-regional-proANP is believed to be a better predictor of T2DM incidence compared to N-terminal-proBNP²⁵, the latter being more sensitive to mild forms of left ventricular dysfunction¹⁰⁸ which is relatively frequent (even subclinically) in the obese state¹⁰⁹. Circulating ANP (measured as mid-regional-proANP) within the normal high range (~212-372 pg/mL) was associated with lower risk of IR during a 16-year follow-up period in a middle-aged cohort¹¹⁰. This association was independent of diabetes risk factors (including waist circumference, plasma levels of triglycerides, HDL-cholesterol, systolic

blood pressure, antihypertensive treatment, age and sex) or renal function (cystatin C)²⁵. In the Atherosclerosis Risk in Communities Study (a community-based population study), it was shown that having low N-terminal-proBNP levels (lowest quartile, <31pg/mL) was associated with higher risk of incident diabetes over a 12 year follow-up period in subjects without T2DM at baseline. These results were consistent across race, gender and BMI categories²⁶, and were independent of age^{111,112}. Of interest, statistical adjustment for BMI did not abrogate the association between low NP levels and diabetes onset¹¹³. These results are in line with the Framingham Heart Study and the Malmö Diet and Cancer Study, which showed that lower N-terminal-proBNP levels were associated with higher incidence of IR in lean as well as in obese subjects in a cross-sectional study²³. Additionally, prospective cohort data from the Women's Health Study showed that subjects with N-terminal-proBNP levels near the upper limit of the normal range (>117 pg/mL) have a significantly lower risk of developing diabetes¹¹⁴.

Thus, there is consistent evidence that increased NP concentrations are protective against IR and T2DM¹¹⁴⁻¹¹⁶. In line, lower blood glucose concentrations were transiently observed upon systemic BNP infusion during intravenous glucose tolerance testing in young, healthy lean men with normal glucose tolerance¹¹⁷. Moreover, in a random subset of a general middle-aged population (age >45 years) a genetic variant of the ANP gene (single nucleotide polymorphism rs5068) was associated with higher N-terminal-proANP levels and a beneficial cardiometabolic profile (*i.e.* reduced systemic blood pressure, BMI, waist circumference and a lower risk of metabolic syndrome) compared to the A/A carriers⁸⁹. This ANP gene-polymorphism was accompanied with a lower incidence of T2DM after a 14-year follow-up¹¹⁸. Similarly, a genetic polymorphism in the promotor region of the BNP gene (T-381C polymorphism) is associated with higher plasma BNP levels and lower risk of T2DM in

several population samples including individuals with normoglycemia, impaired glucose tolerance and T2DM¹¹⁹.

Altogether, the presence of a NPs deficiency in metabolic disease is generally accepted, as acknowledged by large (but challenged by some smaller) cohorts, but the cause remains incompletely understood. Nonetheless, it is imperative to understand the etiology of this anomaly to further establish the clinical relevance of using mid-regional-ANP and/or N-terminal-proBNP as biomarkers for diabetes prediction¹⁵.

7. Underlying mechanism for systemic NP deficiency in obesity

Several potential explanations for the observed systemic NPs deficiency in human obesity, and more general human metabolic disease, have been proposed, apart from common variants of the human ANP and BNP genes that affect circulating NP concentrations^{114,116,120}. One explanation could be that the NP deficiency may be due to an increased NP degradation in human AT of obese^{78,71,86} and obese hypertensive individuals²², which is mainly fulfilled by NPRC-mediated lysosomal breakdown as mentioned before^{74,121}. In addition, hyperinsulinemia increased NPRC expression *in vitro* in 3T3-L1 adipocytes⁸⁶, human adipocytes^{86,122} and in human subcutaneous AT of healthy, moderately obese individuals with normal glucose tolerance during hyperinsulinemic-euglycemic and hyperinsulinemic-hyperglycemic clamps⁸¹, mainly through the phosphatidylinositol 3-kinase (PI3K) pathway⁸⁶. Moreover, previous work of Sarzani *et al.*⁹⁶ with a genetic NPRC variant shows that a reduced NPs clearance (or resulting increased systemic levels) might be associated with a reduced content of upper body fat and a lower risk of developing abdominal obesity. Together, these data suggest that the AT may be responsible for the increased NP clearance and lowering systemic NP availability in obese insulin resistant conditions^{81,123}.

However, results from the Dallas Heart Study showed that the association between BMI and circulating NP levels is explained by the amount of lean mass, and not AT mass, indicating that lean tissue could also be important for plasma NP regulation⁸⁸. Indeed, upregulation of NPRC in human skeletal muscle tissue, next to down-regulation of the NPRA expression in the AT and skeletal muscle of obese and/or obese diabetic humans and mice has been found^{124,125}. Thus, besides AT, also skeletal muscle may contribute to the NP deficiency observed in T2DM in the long-term, certainly considering that muscle mass accounts for up to 40% of total body weight. Therefore, even a moderate increase in skeletal muscle NPRC expression could markedly reduce NPs plasma levels¹²⁴.

Additionally, it has been shown that NPRC mRNA expression is down-regulated *in vitro* following starvation in human differentiated adipocytes¹²² and *in vivo* in rat white and brown AT¹²⁶ while the opposite was true under high fat feeding in wild-type mice skeletal muscle, white and brown AT¹²⁷. Like NPRC, NEP expression is increased in the plasma (protein) and AT (mRNA) of obese subjects, although there is no direct evidence for an increased NEP activity in human obesity¹²⁸. Together, these findings propose an altered NPs receptor ratio in obese insulin resistant or T2DM individuals mainly due to an increased expression of adipose NPRC and NEP, possibly leading to elevated NP clearance.

On the other hand, a decreased cardiac ANP and BNP release in metabolic disease has also been proposed. Not only circulating NPs levels but also the side products of NPs release (N-terminal-proANP and N-terminal-proBNP) are reduced in obesity. These proteins are structurally distinct and are biologically inactive compounds, which makes NPRC mediated clearance of these components rather unlikely^{88,129}. Of interest, NPs levels in the aortic root and the coronary sinus were observed to be negatively correlated with BMI¹³⁰. These findings suggest that besides an increased clearance, a reduced cardiac NPs release might potentially contribute to the systemic NPs deficiency in metabolic diseases as well. This hypothesis was

further acknowledged by the notion that cardiac ANP and BNP mRNA expressions were reduced in obese Zucker fatty rats and *db/db* mice^{131,132}. Putative impairments in cardiac NPs secretion in human metabolically compromised conditions needs to be explored further.

8. NPs and their role in inter-organ crosstalk

NPs are long known for their cardiovascular and renal actions¹⁸ resulting in the use of NPs (or their fragments) as cardiovascular biomarkers in the clinic¹³³. Over the last two decades, pioneering studies by the group of Lafontan *et al.* suggested a protective role for the heart in metabolic diseases¹³⁴. The inter-organ crosstalk effectuated by ANP and BNP integrates effects on AT function, skeletal muscle, liver, gut, central nervous system and pancreas, as indicated in Figure 1.

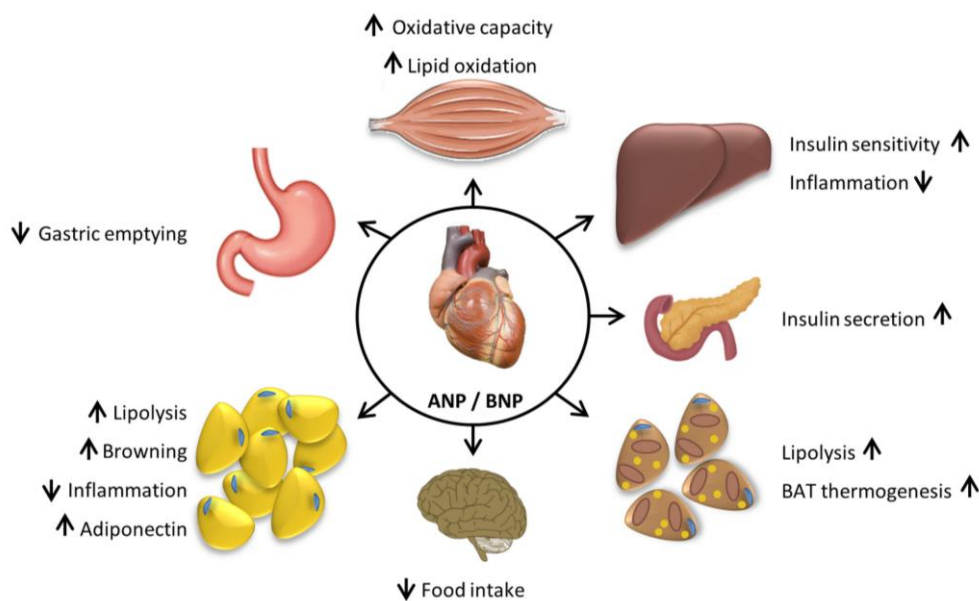


Figure 1 – Overview of the multiple metabolic actions of natriuretic peptides in the control of lipid metabolism and insulin sensitivity.

8.1. NP and adipose tissue function

As the human white AT is one of the main sites of NP receptor expression, investigating the effects of NPs on AT function seems obvious, in particular in the obese state. Next, the effects on AT lipolysis, brown AT metabolism (Table 1) and the role of NP in AT lipid metabolism in obesity and T2DM will be discussed in more detail.

8.1.1. NP and adipose tissue lipolysis

The potency of inducing a lipolytic effect by NPs was first described in isolated human adipocytes, with ANP being the most potent activator of lipolysis as compared to BNP and CNP, the latter only showing a minor maximal lipolytic response (17% as compared to maximal stimulation with isoproterenol)¹³⁴. In addition, these lipolytic properties seem to be primate-specific, which may be due to the differential NPRC clearance receptor expression profiles in other mammalian adipocytes, especially in rodents, making ANP-mediated lipolysis less likely¹³⁵. The signaling pathway relies on cGMP-dependent activation of protein kinase G (PKG), thereby promoting phosphorylation of perilipin-1 (PLIN-1) and hormone sensitive lipase (HSL) to trigger triglyceride hydrolysis^{134,136,137}, in which adipose triglyceride lipase (ATGL) might be involved as well¹²², the latter probably via a different signaling pathway (*i.e.* AMP-activated kinase)¹³⁸ as compared with HSL activation (*i.e.* protein kinase A (PKA) and PKG)¹³⁹. NPs-induced lipolysis is completely independent from the catecholamine-induced (cyclic AMP (cAMP)/PKA mediated) lipolysis, as they rely on different pathways^{140,141}. However, an additive lipolytic effect occurs when human adipocytes are stimulated with ANP and a beta-adrenergic agonist (*e.g.* isoproterenol) simultaneously¹⁴². Infusion studies of human ANP (hANP), either intravenous or *in situ* through microdialysis in the subcutaneous AT, showed promotion of lipid mobilization in healthy subjects, also in the presence of local beta-adrenergic blockade¹⁴⁰. Infusing

intravenous hANP (doses from 6.25-25 ng*kg⁻¹min⁻¹), corresponding to the physiological range observed during moderate exercise, stimulates whole-body lipid mobilization and oxidation (in a dose dependent way), even in the postprandial state^{137,141,143}. Furthermore, exercise-induced increases in systemic ANP concentrations (which may vary depending on the exercise/subjects' characteristics) lead to an increase in lipid mobilization, at least in lean healthy subjects¹⁴⁴. In human obesity, lipolytic catecholamine-resistance is most commonly observed in the subcutaneous AT in the obese insulin resistant state¹⁴⁵⁻¹⁴⁷. Additionally, an impaired ANP-mediated lipolysis has been reported *in vitro* and *in situ* in human subcutaneous AT of patients with obesity and/or type 2 diabetes and overweight men compared to non-obese counterparts^{125,148}. Of interest, ANP-mediated lipid mobilization was reported to be higher in subcutaneous compared to visceral adipocytes of lean individuals¹⁴⁸, a difference that was not present in individuals with obesity^{148,149}. The blunted ANP-mediated lipolysis in the subcutaneous AT of obese insulin resistant individuals may be in part due to an up-regulation of NPRC and a down-regulation of NPRA mRNA and protein in human subcutaneous adipocytes^{125,148}.

An interaction between the NPs' system and the anti-lipolytic hormone insulin was first suggested by Endre *et al.*¹⁵⁰, who showed that hyperinsulinemic euglycemic clamping caused a decrease in serum ANP in normotensive and hypertensive men. This finding was confirmed in obese men⁸¹ but not in young lean individuals¹⁵¹. Insulin inhibits the catecholamine-induced lipolysis via activation of phosphodiesterase 3B (PDE3B), but does not have a direct anti-lipolytic effect on the ANP-mediated lipolytic pathway¹⁵². However, insulin might attenuate ANP-mediated lipolysis by inducing NPRC expression, as described earlier in this review. Of interest, the presence of low-glucose conditions together with insulin stimulation abolished NPRC expression to basal levels, indicating the existence of a "nutritional signaling" in NPRC regulation¹²². The relative ratio of NPRA to NPRC mRNA levels in

subcutaneous AT was decreased depending on glucometabolic status since patients with T2DM had the lowest ratio compared to subjects with normal glucose tolerance or impaired glucose metabolism^{148,153}.. Acute increases in systemic blood glucose decreased circulating N-terminal-proANP in lean, overweight and obese subjects, a mechanism mediated through glucose-induced miR-425 expression¹⁵⁴, a negative regulator of NPRA¹⁵⁵. Insulin thus seems to be a key hormone in the connection between glucose/lipid metabolism and NPs' metabolic activities.

Together, these findings indicate that augmenting ANP-mediated lipolysis, possibly by improving insulin sensitivity, might be a target to improve lipid turnover in the obese insulin resistant and/or T2DM state.

8.1.2. NP and adipokines

Another way to link NPs to AT function is the ability of NPs to alter expression and secretion of adiponectin, an adipokine with insulin sensitizing properties, both *in vitro*¹⁵⁶ and *in vivo*¹⁵⁷ in healthy subjects. Moreover, adiponectin is positively associated with NPs^{100,111,158,159}. Other insulin desensitizing mediators frequently linked to NPs include tumor necrosis factor- α (TNF- α) or interleukin-6. The secretion of these pro-inflammatory factors was reduced by treating human AT pieces with physiological ANP concentrations *in vitro*, possibly through a direct effect on both adipocytes and macrophages¹⁶⁰. In this regard, reducing pro-inflammatory cytokines and increasing adiponectin secretion from AT could indirectly ameliorate the insulin sensitizing effects by NPs (Table 1).

8.1.3. NP and brown adipose tissue metabolism

Next to white AT, the presence and the importance of human brown AT (BAT) for human metabolic diseases receives increasing attention¹⁶¹⁻¹⁶⁴, although the quantitative importance of BAT in human energy and substrate metabolism remains uncertain. BAT is a thermogenic tissue having the ability to dissipate energy in the form of heat, thereby maintaining body temperature. Substrates including glucose and free fatty acids, delivered by white AT lipolysis, are necessary for heat dissipation, a process that is mediated by mitochondrial inner membrane uncoupling protein 1 (UCP-1)¹⁶⁵. In addition, UCP-1 may have a regulatory function in whole-body energy homeostasis¹⁶⁶. However, most of these data are derived from rodent studies and because adult human BAT may have a differential gene expression profile as either rodent BAT or beige fat¹⁶⁷, its physiological function in humans still needs to be determined in more detail. Support for a role of NPs in non-shivering thermogenesis was recently provided by showing that cold exposure acutely increases cardiac BNP secretion and NPRA/NPRC ratio in white AT in mice¹⁹. Mechanistic experiments indeed showed that ANP (and BNP) might activate mitochondrial biogenesis and uncoupling in human and mouse white adipocytes, via p38 MAPK/ATF2 signaling¹⁹. Chronic BNP treatment of *db/+* and *db/db* mice further confirmed these findings, showing increased UCP-1 expression and browning of the white fat pads¹³¹. ANP treatment also enhanced mitochondrial function in human adipocytes¹⁶⁸. Taken together, *in vitro* studies have shown that the NP system is able to induce a thermogenic process in the AT and to induce brown AT activation. Since cold exposure is able to increase both NPs secretion and brown AT activation, the role of NPs in white AT “browning” might be of interest in the human *in vivo* situation, particularly in human metabolic disease. Nevertheless, until today, the role of NPs in human brown AT remains elusive.

8.2. NP and skeletal muscle metabolism

The mobilization of free fatty acids from AT depots by NPs provides substrates for energy production by oxidative tissues^{137,140}. However, enhancement of AT and muscle lipid oxidation has been shown to be susceptible for NPs as well. Birkenfeld *et al.*¹⁴⁸ observed an acute increase in whole-body lipid oxidation (predominantly resulting from increased muscle lipid oxidation) following intravenous ANP infusion. Additionally ANP infusion leads to higher energy expenditure in the postprandial state¹⁴³. The oxidative effect of ANP, as well as BNP, was later confirmed *in vitro* in human muscle cells. Transgenic *in vivo* experiments in mice showed increased skeletal muscle mitochondrial biogenesis, respiration and lipid oxidation upon chronic overexpression of BNP or cGMP-dependent protein kinase, thereby protecting for high fat diet induced obesity and glucose intolerance¹²⁷. A physiological role of NPs in the regulation of skeletal muscle oxidative capacity in human primary myotubes was established by showing that ANP, BNP and cGMP analogs induce peroxisome proliferator-activated receptor gamma coactivator 1-alpha (PGC-1 α) expression, mitochondrial oxidation and lipid (palmitate) oxidation *in vitro*²⁰. In addition, PGC-1 α expression was associated with NPRA expression in skeletal muscle of healthy human subjects²⁰. This proposes that NPs affect mitochondrial respiration and lipid oxidation in skeletal muscle through a cGMP dependent pathway, which was shown to be mediated by the induction of transcription and protein expression of PGC-1 α and several OXPHOS complexes (complex I and complex IV), accompanied by an unchanged peroxisome proliferator activated receptor (PPAR) δ expression and mitochondrial DNA content²⁰.

Moreover, in skeletal muscle of obese and glucose intolerant humans and mice an altered NPRA/NPRC protein ratio was recently reported¹²⁴. In *db/db* and *db/+* mice, this was accompanied with a diminished phosphorylation and activation of p38 MAPK, a downstream effector of the NPs receptor signaling pathway. However, chronic treatment of mice with

obesity-induced glucose intolerance and T2DM with BNP showed a reduced total diacylglycerol content in skeletal muscle, which was accompanied with higher oxidative capacity and PGC-1 α gene expression¹²⁴. This observation was further confirmed in human primary myotubes, showing that increased NP mediated lipid oxidation was accompanied by reduced *de novo* ceramide production¹²⁴ (Table 1).

Yet, recent data indicate a conceivable interaction between the NPs system and an exercise induced myokine called musclin a protein homologous to members of the NPs family¹⁶⁹ which results in the amelioration of the NPs' effectiveness¹⁷⁰. Its physiologically relevant interaction was shown *in vitro* and *in vivo* and indicates the NPRA-mediated increase in skeletal muscle mitochondrial biogenesis to be potentiated by a musclin-NPRC interaction during exercise in mice¹⁷⁰. Musclin is significantly upregulated in skeletal muscle of obese IR mice¹⁶⁹ and its gene expression is known to be increased upon palmitate treatment in C2C12 myotubes¹⁷¹ and high fat diet in rats¹⁷². Furthermore, as musclin was proposed to exert its effects on glucose uptake in skeletal muscle via PPAR- γ ¹⁷³, this suggests a possible role for musclin in substrate metabolism which needs to be explored in humans in the future. These studies indicate the importance of NPs signaling in skeletal muscle lipid oxidative capacity, which is imperative for long-term maintenance of insulin sensitivity in obesity and T2DM.

8.3. NP and liver function

Hepatic IR is an additional hallmark frequently observed in the metabolic syndrome and develops in case of an imbalance between fatty acid supply and utilization of fatty acids by hepatocytes, leading to ectopic lipid accumulation and whole-body IR¹⁷⁴. In obesity the presence of non-alcoholic fatty liver (NAFL) is frequently observed¹⁷⁵, which may further lead to non-alcoholic steatohepatitis, liver cirrhosis or even liver carcinoma¹⁷⁶. Recent studies show inverse relationships between NPs, in particular N-terminal-proBNP, and liver fat

content in individuals without diabetes or self-reported liver disease¹⁷⁷, as well as between NPs and liver function as indicated by aminotransferases enzymes in individuals without cardiovascular disease¹⁷⁸. Additionally, NPs could ameliorate hepatic function as the presence of NPs receptors was shown in the human liver¹⁷⁹. More precisely, these receptors were found on Kupffer-cells, resulting in a hepatoprotective effect of ANP by reducing Kupffer-cell-derived oxidant stress¹⁸⁰ and inhibiting lipopolysaccharides (LPS)-induced release of pro-inflammatory TNF- α via a cGMP-mediated signaling¹⁸¹. ANP or its analogs inhibited hepatic glycolysis and stimulated gluconeogenesis and cGMP production in perfused livers of fed rats¹⁸². Besides, ANP also induced hepatic lipid oxidation in healthy lean individuals, thereby reducing lipid spill-over and ectopic lipid deposition¹⁴³. Consequently, lower liver TAG content was observed in BNP- or cGKI-transgenic mice on a high fat diet¹²⁷. These findings were later confirmed in a cGKI knock out model, indicated by the presence of interleukin-6 mediated liver inflammation, fasting hyperglycemia and reduced insulin signaling¹⁸³. These data together suggest a direct role of NPs in liver lipid catabolism (Table 1) next to indirect effects via AT mass reduction¹²⁷.

9. NP and control of insulin sensitivity

A role of NPs in the regulation of insulin sensitivity is plausible since several studies indicated an inverse association between NP deficiency and IR in human cohorts^{21,24,92,113}. Moreover, the broad range of metabolic effects in insulin sensitive tissues makes these peptides putative targets for lifestyle and exercise interventions in metabolic diseases. However, unraveling the mechanistic link via which NPs signaling can modulate insulin sensitivity remains incompletely understood.

9.1. NP and insulin sensitivity

A role of NPs and their signaling pathway(s) in the control of insulin sensitivity was corroborated by BNP- and cGK-I-transgenic animals, which were protected against the development of diet-induced IR and glucose intolerance¹²⁷, and chronic BNP infusion studies in obese diabetic *db/db* mice^{124,131}, which improved insulin sensitivity and glucose tolerance and was accompanied by a reduced ectopic lipid accumulation^{124,127,131}. On the contrary, genetic knock-down of the NPs signaling cascade impaired fasting glycemia in mice, possibly reflecting an attenuated insulin-mediated regulation of hepatic gluconeogenesis¹⁸³. Little is known about the mechanisms responsible for the improvements in the NP-induced metabolic effects, but these may relate to NP secretion as well as NPs receptor expression and post-receptor signaling. Indeed, in humans, whole-body insulin sensitivity was recently shown to strongly correlate with NPRA in subcutaneous AT¹⁵³ and skeletal muscle¹²⁴. In line, AT^{148,153} and skeletal muscle¹²⁴ NPRC expression was negatively associated with whole-body insulin sensitivity. Additionally, NPs degradation by NEP⁷⁴ may contribute to the development of IR (as was shown in obese Zucker rats)^{184,185}. Indeed NEP expression in plasma and adipocytes was positively associated with obesity and cardiometabolic risk in the presence of IR¹²⁸.

9.2. NP and insulin secretion

In addition to changes in insulin sensitivity, NPs may also affect pancreatic insulin secretion. Increased insulin levels were observed during ANP infusion in healthy subjects^{143,186}, while others showed no alterations during physiological infusion¹⁸⁷. This effect of NPs on insulin concentration could be (partly) mediated by an increased secretion, since NPRA receptors were shown to be present on pancreatic α and β cells¹⁸⁸. Furthermore, β cell insulin content, fasting glycemia as well as islet size and β cell mass were shown to be attenuated in the

NPRA knock out state¹⁸⁸, the latter being confirmed in isolated rat pancreatic islands¹⁸⁹ (Table 1).

10. Impact of exercise/lifestyle intervention on NP-related metabolic effects

The use of exercise as a non-pharmacological strategy to combat NP deficiency is appropriate as several studies have shown that exercise increases ANP levels, at least in healthy subjects (Figure 2)^{144,190-192}. In particular, ANP secretion is enhanced by increasing venous return and cardiac filling pressure (*i.e.* cardiac output)¹⁹³⁻¹⁹⁵, while only slightly increasing¹⁹³ or even not altering circulatory BNP levels¹⁹⁴ in healthy volunteers, possibly indicating opposing regulation in cardiac atria and ventricles. One study reported plasma BNP levels to be positively associated with physical activity levels, although this remains controversial^{196,197}. Recently, 7 days of bed rest induced a decrease in plasma proANP in young healthy males, which was also accompanied with a decreased insulin sensitivity¹⁵¹. Exercise in elderly, healthy subjects caused significantly increased proANP and N-terminal-proBNP levels¹⁹⁸. Of interest, data about exercise effects on NPs in metabolic conditions are scarce. Tanaka *et al.*¹⁹⁹ showed that NP secretion (ANP and BNP) is more sensitive to sympathetic activity in normotensive subjects compared to hypertensive patients, where increased NPs levels may represent cardiac stress. In overweight and obese patients mid-regional-proANP concentrations increased upon incremental exhaustive exercise both before and after diet intervention, with no difference in exercise response between these conditions²⁰⁰. Moreover, NPs were also evaluated in relation to resistance training^{201,202}. Resistance training induces a significant increase in N-terminal-proBNP, which might be partly due to myocardial damage²⁰¹. However, N-terminal-proBNP concentrations did not change in elderly following resistance training²⁰². The latter two studies indicate that the effects of strength training on NPs concentrations are still controversial and thus need more investigation, especially in metabolically compromised conditions.

With respect to CNP, exercise preconditioning (that is, an enhancement of the tolerance of an ischemic heart to subsequent ischemic insult by a single bout of interval exercise) promotes the secretion of CNP in rodents, thereby elevating CNP levels in the myocardium and protecting against high-intensity exercise-induced myocardial injury²⁰³. Indeed, exercise training (more specifically walking or walking plus resistance exercise training) increased plasma CNP levels, which may be one of the mechanisms through which exercise intervention may reverse endothelial-dependent dysfunction in middle-aged individuals with impaired glucose tolerance²⁰⁴. This supports the use of (combined) exercise training to prevent T2DM.

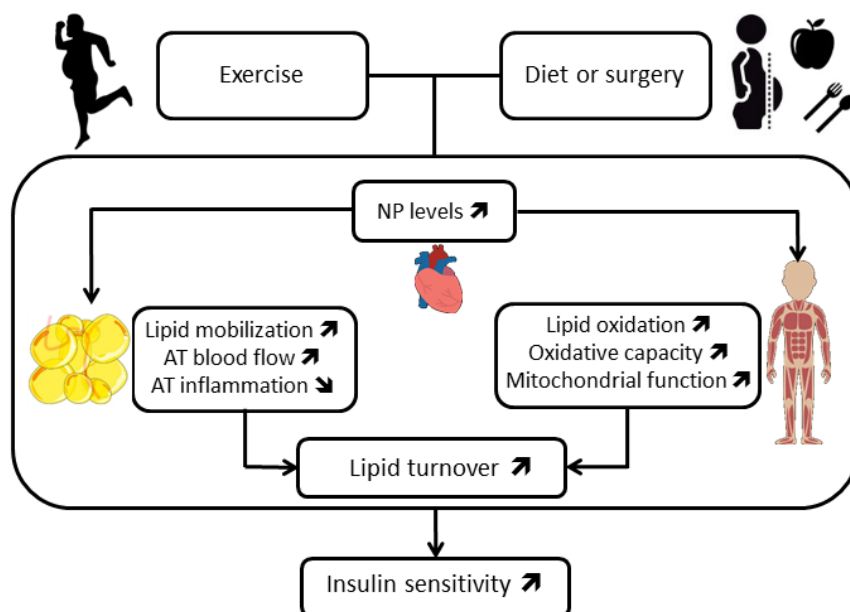


Figure 2 – Lifestyle or surgical intervention effects on natriuretic peptide levels and associated metabolic effects in humans.

10.1. Lifestyle interventions and NP-mediated metabolic effects

Mechanisms responsible for the exercise-/exercise training-induced normalization of the NP deficiency in metabolic disease might include multiple paths, which are currently incompletely understood (Figure 2). Regular physical activity²⁰⁵, rather than caloric restriction²⁰⁰, augments ANP-mediated increases in AT blood flow¹⁹² and AT functional NPRA receptor expression thereby presumably recovering white AT ANP responsiveness^{192, 206}, together resulting in an improved AT lipid mobilization process in the overweight/obese state. As an alternative, water-based exercise has been shown to be not advantageous over moderate intensity land-based exercise with respect to lipid mobilization or fat oxidation in humans despite higher systemic ANP levels during exercise²⁰⁷. Moreover, exercise training enhances mitochondrial function at the level of the skeletal muscle and ultimately insulin sensitivity²⁰⁸, at least partly due to an increased NPRA expression and signaling²⁰⁸, the latter also resulting from caloric restriction-induced weight loss¹²⁴ in obese subjects²⁰. Of interest, pharmacologically improved insulin sensitivity (by the anti-diabetic drug pioglitazone) was accompanied by an increased NPRA/NPRC ratio in subcutaneous AT of obese individuals with T2DM¹⁵³. Liraglutide-induced weight loss in obese individuals with T2DM was correlated with change in NPs levels, although the mechanism responsible remained elusive²⁰⁹.

Diet-induced¹³⁵ and gastric bypass-mediated weight loss¹²⁵ confirmed the reversibility of the reduced maximal ANP responsiveness in the subcutaneous AT of obese women, postulating that the observed impairments in NPs-mediated metabolic effects are secondary to the obese state. With respect to caloric restriction, fasting was shown to restore NPs signaling by reducing NPRC expression in the AT^{126,127}. However, weight loss studies, either involving caloric restriction or gastric bypass surgery, indicated increased systemic NPs levels (*i.e.* NT-proBNP)²¹⁰⁻²¹⁵, which was not confirmed in all studies^{200,216,217}. Comparing these

interventions, it was recently shown that amount of weight loss is associated with the increase in systemic NPs concentrations²¹⁸. Besides changing the NPs' signaling pathway and as many studies also observe changes in the inactive fragments (NT-proANP and NT-proBNP), which are not cleared by NPRC, these findings suggest not only changes in signaling but also adjustments in cardiac production and release following weight loss. In this regard, improvements in other comorbidities which could affect the NPs system following this type of interventions should be taken into account as well.

Together, these data indicate that the NPs signaling pathway may be a suitable target to improve insulin sensitivity in exercise interventions, weight loss interventions or a combination between both (Figure 2). Their modulatory effects with respect to NPs related improvements in insulin sensitivity need further investigation in human metabolic disease. However, the present clinical studies do not show a causal relationship but they do indicate the presence of a strong association between the NPs system and insulin sensitivity management, which needs further focus in upcoming human non-pharmacological intervention studies.

11. Therapeutic opportunities for ANP in metabolic diseases

The natriuretic deficiency present in obesity, the metabolic syndrome and T2DM is described by reduced plasma levels of NPs together with impaired tissue responses in AT and skeletal muscle tissue. Normalizing systemic NPs levels or tissue responses may therefore be imperative in the prevention of metabolic disturbances in the obese state. With respect to systemic NPs levels, pharmacological treatment with the anti-diabetic drug liraglutide was unable to acutely increase cardiac ANP secretion^{54,55,57}. However, upon chronic treatment in obese individuals with T2DM systemic NPs levels increased, thereby being associated with the amount of induced weight loss²⁰⁹. This might indicate that, based on the pleiotropic

effects of NPs in metabolic tissues, several molecular targets of the NP system may be targeted. Strategies aimed to chronically inhibit NPs degradation might be a way to sustain appropriate systemic NPs levels and thus NP signaling in metabolic tissues. Inhibiting NPRC-, NEP- or IDE-mediated NPs breakdown could be suitable options in this respect as recently reviewed ²¹⁹. Secondly, NPs delivery may be envisioned, a therapeutic option in which adequate delivery is crucial to obtain clinical efficacy ²¹⁹. In addition to the use of recombinant ANP (carperitide) and BNP (nesiritide) in acute heart failure treatment ²²⁰⁻²²², the therapeutic potential of these compounds in metabolic diseases may be tested. Furthermore, selective NPRC antagonists or NPs analogs resisting NPRC-mediated clearance might be suitable as well. Finding novel peptides or optimized delivery methods will be a new frontier in the development of therapeutics for metabolic diseases in future research. In addition, to gain knowledge about causality and to identify potential determinants and mechanisms determining tissue-specific effects, more mechanistic studies in whole-body and tissue-specific knockout models of NPs or their signaling pathway are crucial. These insights may be implemented in the optimization of non-pharmacologic treatment strategies of metabolic diseases.

12. Conclusions

The potential role of NPs as an important metabolic target affecting insulin sensitivity in metabolically compromised conditions has been put forward over the last decade. Preclinical and clinical research indicated the presence of a NP deficiency in obesity and T2DM, which is a well-accepted anomaly that could result from inadequate cardiac NPs production and secretion, as well as an increased degree of peripheral degradation. Of interest, several impairments in NPs receptor and post-receptor signaling have been observed in peripheral tissues like the AT or the skeletal muscle tissue of patients with metabolic disease, including overweight, obesity, IR and T2DM. Despite several animal and human data suggest a causal

link between these NPs (signaling) deficiencies and the development of T2DM, the exact molecular mechanism remains incompletely understood. Unraveling the molecular background of these anomalies could therefore further highlight the emerging role of NPs in metabolic diseases. From a clinical point of view, it remains important to investigate therapeutic options to restore this NP deficiency. Next to implementing pharmacological intervention strategies, lifestyle interventions (including physical activity and diet) are of interest in the treatment of metabolic disease. Indeed, previous studies indicated diet-induced weight loss and physical exercise training to sensitize NPs signaling in AT and skeletal muscle tissue, two main metabolic organs with a role in obesity-related IR and T2DM, but also to improve cardiac NPs secretion. However, selecting the appropriate intervention with respect to reducing cardiovascular and metabolic risk factors is of special interest to further improve cardiometabolic health and reduce the development and progression of obesity-related risk factors. Therefore, long-term human intervention studies are needed to clarify the role of NPs in the control of body weight and insulin sensitivity, including investigation of the underlying molecular machinery.

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13. References

1. Shulman G. Ectopic fat in insulin resistance, dyslipidemia and cardiometabolic disease. *N Engl J Med* 2014; **371**:1131-1141.
2. Grundy S. Obesity, metabolic syndrome, and cardiovascular disease. *J Clin Endocrinol Metab* 2004; **89**:2595-2600.
3. Kahn S, Hull R, Utzschneider K. Mechanisms linking obesity to insulin resistance and type 2 diabetes. *Nature* 2006; **444**:840-846.
4. Krotkiewski M, Björntorp P, Sjöström L, Smith U. Impact of obesity on metabolism in men and women. Importance of regional adipose tissue distribution. *J Clin Invest* 1983; **72**:1150-1162.
5. Srdic B, Stokic E, Korac A, Ukropina M, Velickovic K, Breberina M. Morphological characteristics of abdominal adipose tissue in normal-weight and obese women of different metabolic profiles. *Exp Clin Endocrinol Diabetes* 2010; **118**:713-718.
6. Goossens G. The role of adipose tissue dysfunction in the pathogenesis of obesity-related insulin resistance. *Physiol Behav* 2008; **94**:206-218.
7. Unger R, Clark G, Scherer P, Orci L. Lipid homeostasis, lipotoxicity and the metabolic syndrome. *Biochim Biophys Acta* 2010; **1801**:209-214.
8. Virtue S, Vidal-Puig A. Adipose tissue expandability, lipotoxicity and the Metabolic Syndrome--an allostatic perspective. *Biochim Biophys Acta* 2010; **1801**:338-349.
9. Snel M, Jonker J, Schoones J, *et al.* Ectopic fat and insulin resistance: pathophysiology and effect of diet and lifestyle interventions. *Int J Endocrinol* 2012; **2012**:983814.
10. Stinkens R, Goossens G, Jocken J, Blaak E. Targeting fatty acid metabolism to improve glucose metabolism. *Obes Rev* 2015; **16**:715-757.
11. Roumen C, Blaak E, Corpeleijn E. Lifestyle intervention for prevention of diabetes: determinants of success for future implementation. *Nutr Rev* 2009; **67**:132-146.

- 724 12. Tuomilehto J. Nonpharmacologic therapy and exercise in the prevention of type 2
725 diabetes. *Diabetes Care* 2009; **32 Suppl 2**:S189-S193.
- 726 13. Lafontan M, Moro C, Berlan M, Crampes F, Sengenès C, Galitzky J. Control of lipolysis
727 by natriuretic peptides and cyclic GMP. *Trends Endocrinol Metab* 2008; **19**:130-137.
- 728 14. Moro C, Smith S. Natriuretic Peptides: New Players in Energy Homeostasis. *Diabetes*
729 2009; **58**:2726-2728.
- 730 15. Moro C, Lafontan M. Natriuretic peptides and cGMP signaling control of energy
731 homeostasis. *Am J Physiol Heart Circ Physiol* 2013; **304**:H358-H368.
- 732 16. Coué M, Moro C. Natriuretic peptide control of energy balance and glucose homeostasis.
733 *Biochimie* 2016; **124**:84-91.
- 734 17. Del Ry S, Cabiati M, Vozzi F, *et al.* Expression of C-type natriuretic peptide and its
735 receptor NPR-B in cardiomyocytes. *Peptides* 2011; **32**:1713-1718.
- 736 18. Volpe M. Natriuretic peptides and cardio-renal disease. *Int J Cardiol* 2014; **176**:630-639.
- 737 19. Bordicchia M, Liu D, Amri E, *et al.* Cardiac natriuretic peptides act via p38 MAPK to
738 induce the brown fat thermogenic program in mouse and human adipocytes. *J Clin Invest*
739 2012; **122**:1022-1036.
- 740 20. Engeli S, Birkenfeld A, Badin P, *et al.* Natriuretic peptides enhance the oxidative
741 capacity of human skeletal muscle. *J Clin Invest* 2012; **122**:4675-4679.
- 742 21. Wang T, Larson M, Levy D, Benjamin E, Leip E, Wilson P, Vasan R. Impact of obesity
743 on plasma natriuretic peptide levels. *Circulation* 2004; **109**:594-600.
- 744 22. Dessi-Fulgheri P, Sarzani R, Tamburrini P, *et al.* Plasma atrial natriuretic peptide and
745 natriuretic peptide receptor gene expression in adipose tissue of normotensive and
746 hypertensive obese patients. *J Hypertension* 1997; **15**:1695-1699.

- 747 23. Khan A, Cheng S, Magnusson M, *et al.* Cardiac natriuretic peptides, obesity, and insulin
748 resistance: evidence from two community-based studies. *J Clin Endocrinol Metab* 2011;
749 **96**:3242-3249.
- 750 24. Walford G, Ma Y, Christophi C, *et al.* Circulating natriuretic peptide concentrations
751 reflect changes in insulin sensitivity over time in the Diabetes Prevention Program.
752 *Diabetologia* 2014; **57**:935-939.
- 753 25. Magnusson M, Jujic A, Hedblad B, *et al.* Low plasma level of atrial natriuretic peptide
754 predicts development of diabetes: the prospective Malmo Diet and Cancer study. *J Clin*
755 *Endocrinol Metab* 2012; **97**:638-645.
- 756 26. Lazo M, Young J, Brancati F, *et al.* NH2-terminal pro-brain natriuretic peptide and risk
757 of diabetes. *Diabetes* 2013; **62**:3189-3193
- 758 27. De Bold A, Borenstein H, Veress A, Sonnenberg H. A rapid and potent natriuretic
759 response to intravenous injection of atrial myocardial extract in rats. *Life Sci* 1981;
760 **28**:89-94.
- 761 28. Kisch B. Electron microscopy of the atrium of the heart. I Guinea pig. *Exp Med Surg*
762 1956; **14**:99-112
- 763 29. Kangawa K, Fukuda A, Minamino N, Matsuo H. Purification and complete amino acid
764 sequence of beta-rat atrial natriuretic polypeptide (beta-rANP) of 5,000 daltons. *Biochem*
765 *Biophys Res Commun* 1984; **119**:933-940.
- 766 30. Komatsu Y, Nakao K, Suga S, *et al.* C-type natriuretic peptide (CNP) in rats and humans.
767 *Endocrinology* 1991; **129**:1104-1106.
- 768 31. Sudoh T, Minamino N, Kangawa K, Matsuo H. C-type natriuretic peptide (CNP): a new
769 member of natriuretic peptide family identified in porcine brain. *Biochem Biophys Res*
770 *Commun* 1990; **168**:863-870.

- 771 32. Moyes A, Khambata R, Villar I, *et al.* Endothelial C-type natriuretic peptide maintains
772 vascular homeostasis. *J Clin Invest* 2014; **124**:4039-4051.
- 773 33. Kake T, Kitamura H, Adachi Y, *et al.* Chronically elevated plasma C-type natriuretic
774 peptide level stimulates skeletal growth in transgenic mice. *Am J Physiol Endocrinol*
775 *Metab* 2009; **297**:E1339-E1348.
- 776 34. Inuzuka M, Tamura N, Yamada N, *et al.* C-type natriuretic peptide as a new regulator of
777 food intake and energy expenditure. *Endocrinology* 2010; **151**:3633-3642.
- 778 35. Yamada-Goto N, Katsuura G, Ebihara K, *et al.* Intracerebroventricular administration of
779 C-type natriuretic peptide suppresses food intake via activation of the melanocortin
780 system in mice. *Diabetes* 2013; **62**:1500-1504.
- 781 36. Park B, Kim S, Kim S, Noh H, Cho C, Kim S. Characteristics of dendroaspis natriuretic
782 peptide and its receptor in streptozotocin-induced diabetic rats. *Mol Med Rep* 2015;
783 **12**:2969-2976.
- 784 37. Gardner D, Chen S, Glenn D, Grigsby C. Molecular biology of the natriuretic peptide
785 system: implications for physiology and hypertension. *Hypertension* 2007; **49**:419-426.
- 786 38. Nishikimi T, Kuwahara K, Nakao K. Current biochemistry, molecular biology, and
787 clinical relevance of natriuretic peptides. *J Cardiol* 2011; **57**:131-140.
- 788 39. Nakao K, Ogawa Y, Suga S, Imura H. Molecular biology and biochemistry of the
789 natriuretic peptide system. I: Natriuretic peptides. *J Hypertension* 1992; **10**:907-912.
- 790 40. Yan W, Wu f, Morser J, Wu Q. Corin, a transmembrane cardiac serine protease, acts as a
791 pro-atrial natriuretic peptide-converting enzyme. *Proc Natl Acad Sci USA* 2000; **97**:8525-
792 8529.
- 793 41. Clerico A. *Natriuretic peptides – The hormones of the heart*. Clerico A, Emdin M, Eds.
794 Springer Science+ Business Media, 2006.

- 795 42. Morgenthaler N, Struck J, Thomas B, Bergmann A. Immunoluminometric assay for the
796 midregion of pro-atrial natriuretic peptide in human plasma. *Clin Chem* 2004; **50**:234-
797 236.
- 798 43. Nannipieri M, Seghieri G, Catalano C, Prontera T, Baldi S, Ferrannini E. Defective
799 regulation and action of atrial natriuretic peptide in type 2 diabetes. *Horm Metab Res*
800 2002; **34**:265-270.
- 801 44. Nakayama K. Furin: a mammalian subtilisin/Kex2p-like endoprotease involved in
802 processing of a wide variety of precursor proteins. *Biochem J* 1997; **327**:625-635.
- 803 45. Potter L. Natriuretic peptide metabolism, clearance and degradation. *FEBS J* 2011;
804 **278**:1808-1817.
- 805 46. McGrath M, de Bold M, de Bold A. The endocrine function of the heart. *Trends*
806 *Endocrinol Metab* 2005; **16**:469-477.
- 807 47. Chun S, Hyun J, Kwak Y, *et al.* Hypoxic activation of the atrial natriuretic peptide gene
808 promoter through direct and indirect actions of hypoxia-inducible factor-1. *Biochem J*
809 2003; **370**:149-157.
- 810 48. Fregly M, Kikta D, Threatte R, *et al.* Development of hypertension in rats during chronic
811 exposure to cold. *J Appl Physiol* 1989; 66:741-749.
- 812 49. Yuan K, Jin X, Park W, *et al.* Modification of atrial natriuretic peptide system in cold-
813 induced hypertensive rats. *Regul Pept* 2009; 154:112-120.
- 814 50. Ogawa Y, Itoh H, Nakao K. Molecular biology and biochemistry of natriuretic peptide
815 family. *Clin Exp Pharmacol Physiol* 1995; **22**:49-53.
- 816 51. Ogawa T, de Bold A. Brain natriuretic peptide production and secretion in inflammation.
817 *J Transplant* 2012; **2012**:962347.

- 818 52. Meirovich Y, Veinot J, de Bold M, *et al.* Relationship between natriuretic peptides and
819 inflammation: proteomic evidence obtained during acute cellular cardiac allograft
820 rejection in humans. *J Heart Lung Transplant* 2008; **27**:31-37.
- 821 53. Kim M, Platt M, Shibasaki T, *et al.* GLP-1 receptor activation and Epac2 link atrial
822 natriuretic peptide secretion to control of blood pressure. *Nat Med* 2013; **19**:567-575.
- 823 54. Asmar A, Simonsen L, Asmar M, *et al.* Renal Extraction and Acute Effects of
824 Glucagonlike peptide-1 on Central and Renal Hemodynamics in Healthy Men. *Am J*
825 *Physiol Endocrinol Metab* 2015; ajpendo 00429 2014.
- 826 55. Asmar A, Simonsen L, Asmar M, *et al.* Glucagon-like peptide-1 does not have acute
827 effects on central or renal hemodynamics in patients with type 2 diabetes without
828 nephropathy. *Am J Physiol Endocrinol Metab* 2016; 310:E744-E753.
- 829 56. Lovshin J, Bamie A, DeAlmeida A, *et al.* Liraglutide Promotes Natriuresis but Does Not
830 Increase Circulating Levels of Atrial Natriuretic Peptide in Hypertensive Subjects With
831 Type 2 Diabetes. *Diabetes Care* 2015; 38:132-139.
- 832 57. Rudovic N, Pivovarov O, Gögebakan Ö, *et al.* Effect of Exogenous Intravenous
833 Administrations of GLP-1 and/or GIP on Circulating Pro-Atrial Natriuretic Peptide in
834 Subjects With Different Stages of Glucose Tolerance. *Diabetes Care* 2015; 38:e7-e8.
- 835 58. Maffei S, Del Ry S, Prontera C, Clerico A. Increase in circulating levels of cardiac
836 natriuretic peptides after hormone replacement therapy in postmenopausal women. *Clin*
837 *Sci* 2001; **101**:447–453.
- 838 59. Clerico A, Ry Silvia D, Maffei S, Prontera C, Emdin M, Giannessi D. The circulating
839 levels of cardiac natriuretic hormones in healthy adults: effects of age and sex. *Clin*
840 *Chem Lab Med* 2002; **40**:371.

- 841 60. Hamada M, Shigetmatsu Y, Takezaki M, Ikeda S, Ogimoto A. Plasma levels of atrial and
842 brain natriuretic peptides in apparently healthy subjects: Effects of sex, age, and
843 hemoglobin concentration. *Int J Cardiol* 2017; **228**:599-604.
- 844 61. Clerico A, Passino C, Emdin N. When gonads talk to the heart sex hormones and cardiac
845 endocrine function. *J Am Coll Cardiol* 2011; **58**:627-628.
- 846 62. Lam C, Cheng S, Choong K, *et al.* Influence of sex and hormone status on circulating
847 natriuretic peptides. *J Am Coll Cardiol* 2011; **58**:618-626.
- 848 63. Goharian T, Gimsing A, Goetze J, Faber J, Andersen L, Grontved A, Jeppesen J. Mid-
849 regional pro-atrial natriuretic peptide and blood pressure in adolescents: effect of gender
850 and pubertal stage. *Blood Press* 2015; **24**:347-352.
- 851 64. Mahmoodzadeh S, Pham T, Kuehne A, *et al.* 17 β -Estradiol-induced interaction of ER α
852 with NPPA regulates gene expression in cardiomyocytes. *Cardiovasc Res* **2012**; 96:411-
853 421.
- 854 65. Sellitti D, Koles N, Mendonca M. Regulation of C-type natriuretic peptide expression.
855 *Peptides* 2011; 32:1964-1971.
- 856 66. Khun M. Molecular physiology of membrane guanylyl cyclase receptors. *Physiol Rev*
857 2016; **96**:751-804.
- 858 67. Stoupakis G, Klapholz M. Natriuretic peptides: biochemistry, physiology, and
859 therapeutic role in heart failure. *Heart Dis* 2003; **5**:215-223.
- 860 68. Yasoda A, Ogawa Y, Suda M, *et al.* Natriuretic peptide regulation of endochondral
861 ossification: evidence for possible roles of the C type natriuretic peptide/guanylyl
862 cyclase-B pathway. *J Biochem* 1998; **273**:11695–11700.
- 863 69. Misono K, Philo J, Arakawa T, Ogata C, Qiu Y, Ogawa H, Young H. Structure, signaling
864 mechanism and regulation of the natriuretic peptide receptor guanylate cyclase. *FEBS J*
865 2011; **278**:1818-1829.

- 866 70. Pandey K. Endocytosis and Trafficking of Natriuretic Peptide Receptor-A: Potential Role
867 of Short Sequence Motifs. *Membranes (Basel)* 2015; **5**:253-287.
- 868 71. Suga S, Nakao K, Hosoda K, *et al.* Receptor selectivity of natriuretic peptide family,
869 atrial natriuretic peptide, brain natriuretic peptide, and C-type natriuretic peptide.
870 *Endocrinology* 1992; **130**:229–239.
- 871 72. Pandey K. Kinetic analysis of internalization, recycling and redistribution of atrial
872 natriuretic factor-receptor complex in cultured vascular smooth-muscle cells. Ligand-
873 dependent receptor down-regulation. *Biochem J* 1992; **288**:55-61.
- 874 73. Matsukawa N, Grzesik W, Takahashi N, Pandey K, Pang S, Yamauchi M, Smithies O.
875 The natriuretic peptide clearance receptor locally modulates the physiological effects of
876 the natriuretic peptide system. *Proc Natl Acad Sci USA* 1999; **96**:7403–7408.
- 877 74. Kenny A, Bourne A, Ingram J. Hydrolysis of human and pig brain natriuretic peptides,
878 urodilatin, C-type natriuretic peptide and some C-receptor ligands by endopeptidase-
879 24.11. *Biochem J* 1993; **1**:83–88.
- 880 75. Schling P, Löffler G. Cross talk between adipose tissue cells: impact on pathophysiology.
881 *New Physiol Sci* 2002; **17**:99-104
- 882 76. Ralat L, Guo Q, Ren M, Funke T, Dickey D, Potter L, Tang W. Insulin-degrading
883 enzyme modulates the natriuretic peptide-mediated signaling response. *J Biol Chem*
884 2011; **286**:4670-4679.
- 885 77. Brandt I, Lambeir A, Ketelslegers J, Vanderheyden M, Scharpé S, De Meester I.
886 Dipeptidyl-peptidase IV converts intact B-type natriuretic peptide into its des-SerPro
887 form. *Clin Chem* 2006; **52**:82-87.
- 888 78. Sarzani R, Dessi-Fulgheri P, Paci V, Espinosa E, Rappelli A. Expression of natriuretic
889 peptide receptors in human adipose and other tissues. *J Endocrinol Invest* 1996; **19**:581-
890 585.

- 891 79. Bryan P, Smirnov D, Smolenski A, *et al.* A sensitive method for determining the
892 phosphorylation status of natriuretic peptide receptors: cGK-Ialpha does not regulate
893 NPR-A. *Biochemistry* 2006; **45**:1295-1303.
- 894 80. Nagase M, Katafuchi T, Hirose S, Fujita T. Tissue distribution and localization of
895 natriuretic peptide receptor subtypes in stroke prone spontaneously hypertensive rats. *J*
896 *Hypertens* 1997; **15**:1235–1243.
- 897 81. Pivovarov O, Gögebakan Ö, Klöting N, *et al.* Insulin up-regulates natriuretic peptide
898 clearance receptor expression in the subcutaneous fat depot in obese subjects: a missing
899 link between CVD risk and obesity. *J Clin Endocrinol Metab* 2012; **94**:E731-E739.
- 900 82. Smith J, Fahrenkrug J, Jorgensen H, Christoffersen C, Goetze J. Diurnal gene expression
901 of lipolytic natriuretic peptide receptors in white adipose tissue. *Endocr Connect* 2015;
902 **4**:206-214.
- 903 83. Martino T, Tata N, Belsham D, *et al.* Disturbed diurnal rhythm alters gene expression
904 and exacerbates cardiovascular disease with rescue by resynchronization. *Hypertension*
905 2007; **49**:1104-1113.
- 906 84. Goetze J, Jorgensen H, Sennels H, Fahrenkrug J. Diurnal plasma concentrations of
907 natriuretic propeptides in healthy young males. *Clin Chem* 2012; **58**:789-792.
- 908 85. Goetze J, Georg B, Jorgensen H, Fahrenkrug J. Chamber-dependent circadian expression
909 of cardiac natriuretic peptides. *Regul Pept* 2010; **160**:140-145.
- 910 86. Nakatsuji H, Maeda N, Hibuse T, *et al.* Reciprocal regulation of natriuretic peptide
911 receptors by insulin in adipose cells. *Biochem Biophys Res Comm* 2010; **392**:100-105.
- 912 87. Collins S. A heart-adipose tissue connection in the regulation of energy metabolism. *Nat*
913 *Rev Endocrinol* 2014; **10**:157-163.

- 914 88. Das S, Drazner M, Dries D, *et al.* Impact of body mass and body composition on
915 circulating levels of natriuretic peptides: results from the Dallas Heart Study. *Circulation*
916 2005; **112**:2163-2168.
- 917 89. Cannone V, Boerrigter G, Cataliotti A, *et al.* A genetic variant of the atrial natriuretic
918 peptide gene is associated with cardiometabolic protection in the general community. *J*
919 *Am Coll Cardiol* 2011; **58**:629–636.
- 920 90. Sugisawa T, Kishimoto I, Kokubo Y, Nagumo A, Makino H, Miyamoto Y, Yoshimasa
921 Y. Visceral fat is negatively associated with B-type natriuretic peptide levels in patients
922 with advanced type 2 diabetes. *Diabetes Res Clin Pract* 2010; **89**:174-180.
- 923 91. Buglioni A, Cannone V, Cataliotti A, *et al.* Circulating aldosterone and natriuretic
924 peptides in the general community: relationship to cardiorenal and metabolic disease.
925 *Hypertension* 2015; **65**:45-53.
- 926 92. Olsen M, Hansen T, Christensen M, *et al.* N-terminal pro brain natriuretic peptide is
927 inversely related to metabolic cardiovascular risk factors and the metabolic syndrome.
928 *Hypertension* 2005; **46**:660-666.
- 929 93. Taylor J, Christenson R, Rao K, Jorge M, Gottlieb S. B-Type natriuretic peptide and N-
930 terminal pro B-type natriuretic peptide are depressed in obesity despite higher left
931 ventricular end diastolic pressures. *Am Heart J* 2006; **152**:1071-1076.
- 932 94. Grandi A, Laurita E, Selva E, *et al.* Natriuretic peptides as markers of preclinical cardiac
933 disease in obesity. *Eur J Clin Invest* 2004; **34**:342–348.
- 934 95. Abdulle A, Nagelkerke N, Adem A, *et al.* Plasma N terminal pro-brain natriuretic peptide
935 levels and its determinants in a multi-ethnic population. *J Hum Hypertens* 2007; **21**:647–
936 653.
- 937 96. Sarzani R, Strazzullo P, Salvi F, *et al.* Natriuretic peptide clearance receptor alleles and
938 susceptibility to abdominal adiposity. *Obes Res* 2004; **12**:351–356.

- 939 97. Cheng S, Fox C, Larson M, *et al.* Relation of visceral adiposity to circulating natriuretic
940 peptides in ambulatory individuals. *Am J Cardiol* 2011; **108**:979–984.
- 941 98. Trevisan R, Fioretto P, Semplicini A, *et al.* Role of insulin and atrial natriuretic peptide
942 in sodium retention in insulin-treated IDDM patients during isotonic volume expansion.
943 *Diabetes* 1990; **39**:289-298.
- 944 99. Aboucharcra S, Baines A, Zinman B, Skorecki K, Logan A. Insulin blunts the natriuretic
945 action of atrial natriuretic peptide in hypertension. *Hypertension* 1994; **56**:1054-1058.
- 946 100. Neeland I, Winders B, Ayers C, *et al.* Higher natriuretic peptide levels associate with a
947 favorable adipose tissue distribution profile. *J Am Coll Cardiol* 2013; **62**:752–760.
- 948 101. Hermann-Arn timer K, Hanusch-enserer U, Kaestenbauer T, *et al.* N-terminal pro-B-type
949 natriuretic peptide as an indicator of possible cardiovascular disease in severely obese
950 individuals: comparison with patients in different stages of heart failure. *Clin Chem*
951 2005; **51**:138-143.
- 952 102. Burnett J, Granger J, Opgerorth T. Effects of synthetic atrial natriuretic factor on renal
953 function and renin release. *Am J Physiol* 1984; **247**:F863-F866.
- 954 103. Shi S, Nguyen H, Sharma G, Navar L, Pandey K. Genetic disruption of atrial natriuretic
955 peptide receptor-A alters renin and angiotensin II levels. *Am J Physiol Renal Physiol*
956 2001; **281**:F665-F673.
- 957 104. Asferg C, Andersen U, Linneberg A, Hedley P, Christiansen M, Goetze J, Jeppesen J.
958 Serum proatrial natriuretic peptide does not increase with higher systolic blood pressure
959 in obese men. *Heart* 2017; **103**:154-158.
- 960 105. Jordan J, Engeli S. Obesity, hypertension, and cardiovascular health: is there anything
961 poor Cassandra tries to tell us? *J Hypertens* 2012; **30**:1103–1105.
- 962 106. Jordan J, Birkenfeld A. Cardiometabolic crosstalk in obesity-associated arterial
963 hypertension. *Rev Endocr Metab Disord* 2016; **17**:19-28.

- 964 107. Gruden G, Landi A, Bruno G. Natriuretic peptides, heart, and adipose tissue: new
965 findings and future developments for diabetes research. *Diabetes Care* 2014; **37**:2899-
966 2908.
- 967 108. Hammerer-Lercher A, Ludwig W, Falkensammer G, *et al.* Natriuretic peptides as
968 markers of mild forms of left ventricular dysfunction: effects of assays on diagnostic
969 performance of markers. *Clin Chem* 2004; **50**:1174-1183.
- 970 109. Wong C, O'Moore-Sullivan T, Leano R, Byrne N, Beller E, Marwick T. Alterations of
971 left ventricular myocardial characteristics associated with obesity. *Circulation* 2004;
972 **110**:3081-3087.
- 973 110. Jujic A, Nilsson P, Persson M, *et al.* Atrial Natriuretic Peptide in the High Normal Range
974 Is Associated With Lower Prevalence of Insulin Resistance. *J Clin Endocrinol Metab*
975 2016; **414**:1372-1380.
- 976 111. Brutsaert E, Biggs M, Delaney J, *et al.* Longitudinal assessment of N-terminal pro-B-
977 type natriuretic peptide and risk of diabetes in older adults: The cardiovascular health
978 study. *Metabolism* 2016; **65**:1489-1497.
- 979 112. Kim F, Biggs M, Kizer J, *et al.* Brain natriuretic peptide and insulin resistance in older
980 adults. *Diabet Med* 2017; **34**:235-238.
- 981 113. Kroon M, van den Hurk K, Alssema M, Kamp O, Stehouwer C, Henry R. Prospective
982 associations of B-type natriuretic peptide with markers of left ventricular function in
983 individuals with and without type 2 diabetes: an 8-year follow-up of the Hoorn Study.
984 *Diabetes Care* 2012; **35**:2510-2514.
- 985 114. Everett B, Cook N, Chasman D, *et al.* Prospective evaluation of B-type natriuretic
986 peptide concentrations and the risk of type 2 diabetes in women. *Clin Chem* 2013;
987 **59**:557-565.

988 115. Pfister R, Sharp S, Luben R, *et al.* Mendelian randomization study of B-type natriuretic
989 peptide and type 2 diabetes: evidence of causal association from population studies. *PLoS*
990 *Med* 2011; **8**:e1001112.

991 116. Cannone V, Cefalu A, Noto D, *et al.* The atrial natriuretic peptide genetic variant rs5068
992 is associated with a favorable cardiometabolic phenotype in a Mediterranean population.
993 *Diabetes Care* 2013; **36**:2850–2856.

994 117. Heinisch B, Vila G, Resl M, *et al.* B-type natriuretic peptide (BNP) affects the initial
995 response to intravenous glucose: a randomised placebo-controlled cross-over study in
996 healthy men. *Diabetologia* 2012; **55**:1400–1405.

997 118. Jujic A, Nilsson P, Engström G, Hedblad B, Melander O, Magnusson M. Atrial
998 natriuretic peptide and type 2 diabetes development - biomarker and genotype association
999 study. *PLoS One* 2014; **9**:e89201.

1000 119. Meirhaeghe A, Sandhu M, McCarthy M, *et al.* Association between the T-381C
1001 polymorphism of the brain natriuretic peptide gene and risk of type 2 diabetes in human
1002 populations. *Human Molecular Genetics* 2007; **16**:1343–1350.

1003 120. Cannone V, Huntley B, Olson T, *et al.* Atrial natriuretic peptide genetic variant rs5065
1004 and risk for cardiovascular disease in the general community: a 9-year follow-up study.
1005 *Hypertension* 2013; **62**:860-865.

1006 121. Maack T, Suzuki M, Almeida F, Nussenzveig D, Scarborough R, McEnroe G, Lewicki J.
1007 Physiological role of silent receptors of atrial natriuretic factor. *Science* 1987; **238**:675-
1008 678.

1009 122. Bordicchia M, Ceresiani M, Pavani M, *et al.* Insulin/glucose induces natriuretic peptide
1010 clearance receptor in human adipocytes: a metabolic link with the cardiac natriuretic
1011 pathway. *Am J Physiol Regul Integr Comp Physiol* 2016; **311**:R104-R114.

- 1012 123. Halbriek M, Norrelund H, Moller N, Schmitz O, Botker H, Wiggers. Short-term changes
1013 in circulating insulin and free fatty acids affect Nt-pro-BNP levels in heart failure
1014 patients. *Int J Cardiol* 2010; **144**:140-142.
- 1015 124. Coué M, Badin P, Vila I, *et al.* Defective Natriuretic Peptide Receptor Signaling in
1016 Skeletal Muscle Links Obesity to Type 2 Diabetes. *Diabetes* 2015; **64**:4033-4045.
- 1017 125. Rydén M, Backdahl J, Petrus P, *et al.* Impaired atrial natriuretic peptide-mediated
1018 lipolysis in obesity. *Int J Obes* 2016; **40**:714-20
- 1019 126. Sarzani R, Paci V, Zingaretti C, *et al.* Fasting inhibits natriuretic peptides clearance
1020 receptor expression in rat adipose tissue. *J Hypertens* 1995; **13**:1241–1246.
- 1021 127. Miyashita K, Itoh H, Tsujimoto H, *et al.* Natriuretic peptides/cGMP/cGMP-dependent
1022 protein kinase cascades promote muscle mitochondrial biogenesis and prevent obesity.
1023 *Diabetes* 2009; **58**:2880–2892.
- 1024 128. Standeven K, Hess K, Carter A, *et al.* Neprilysin, obesity and the metabolic syndrome.
1025 *Int J Obes* 2011; **35**:1031-1040.
- 1026 129. Minami J, Nishikimi T, Matsuoka H. Plasma brain natriuretic peptide and N terminal
1027 proatrial natriuretic peptide levels in obese patients: a cause or result of hypertension.
1028 *Circulation* 2004; **110**:e76.
- 1029 130. Mizuno Y, Harada E, Katoh D, *et al.* Cardiac production of B-type natriuretic peptide is
1030 inversely related to the plasma level of free fatty acids in obese individuals — possible
1031 involvement of the insulin resistance. *Endocr J* 2013; **60**:87–95.
- 1032 131. Plante E, Menaouar A, Danalache B, Broderick T, Jankowski M, Gutkowska J.
1033 Treatment with brain natriuretic peptide prevents the development of cardiac dysfunction
1034 in obese diabetic db/db mice. *Diabetologia* 2014; **57**:1257-1267.
- 1035 132. Cabiati M, Raucci S, Liistro T, *et al.* Impact of obesity on the expression profile of
1036 natriuretic peptide system in a rat experimental model. *PLoS One* 2013; **8**:e72959.

133. Maisal A. B-type natriuretic peptide levels: diagnostic and prognostic in congestive heart failure: what's next. *Circulation* 2002; **105**:2328-2331.
134. Sengenès C, Berlan M, De Glisezinski I, Lafontan M, Galitzky J. Natriuretic peptides: a new lipolytic pathway in human adipocytes. *FASEB J* 2000; **14**:1345-1351.
135. Sengenès C, Zakaroff-Girard A, Moulin A, *et al.* Natriuretic peptide-dependent lipolysis in fat cells is a primate specificity. *Am J Physiol Regul Integr Comp Physiol* 2002; **283**:R257–R265.
136. Sengenès C, Bouloumie A, Hauner H, Berlan M, Busse R, Lafontan M, Galitzky J. Involvement of a cGMP-dependent pathway in the natriuretic peptide-mediated hormone-sensitive lipase phosphorylation in human adipocytes. *J Biol Chem* 2003; **278**:48617-48626.
137. Birkenfeld A, Boschmann M, Moro C, *et al.* Lipid mobilization with physiological atrial natriuretic peptide concentrations in humans. *J Clin Endocrinol Metab* 2005; **90**:3622-3628.
138. Ahmadian M, Abbott M, Tang T, *et al.* Desnutrin/ATGL is regulated by AMPK and is required for a brown adipose phenotype. *Cell Metab* 2011; **13**:739-748.
139. Zimmerman R, Straus J, Haemmerle G, *et al.* Fat mobilization in adipose tissue is promoted by adipose triglyceride lipase. *Science* 2004; **306**:1383-1386.
140. Galitzky J, Sengenès C, Thalamas C, Marques M, Senard J, Lafontan M, Berlan M. The lipid-mobilizing effect of atrial natriuretic peptide is unrelated to sympathetic nervous system activation or obesity in young men. *J Lipid Res* 2001; **42**:536-544.
141. Birkenfeld A, Boschmann M, Moro C, *et al.* Beta-adrenergic and Atrial Natriuretic Peptide Interactions on Human Cardiovascular and Metabolic Regulation. *J Clin Endocrinol Metab* 2006; **91**:5069-5075.

1061 142. Moro C, Galitzky J, Sengenès C, Crampes F, Lafontan M, Berlan M. Functional and
 1062 pharmacological characterization of the natriuretic peptide-dependent lipolytic pathway
 1063 in human fat cells. *J Pharmacol Exp Therp* 2004; **308**:984-992.

1064 143. Birkenfeld A, Budziarek P, Boschmann M, *et al.* Atrial natriuretic peptide induces
 1065 postprandial lipid oxidation in humans. *Diabetes* 2008; **57**:3199–3204.

1066 144. Moro C, Crampes F, Sengenès C, *et al.* Atrial natriuretic peptide contributes to
 1067 physiological control of lipid mobilization in humans. *FASEB J* 2004; **18**:908-910.

1068 145. Langin D, Dicker A, Tavernier G, *et al.* Adipocyte lipases and defect of lipolysis in
 1069 human obesity. *Diabetes* **54**:3190-3197.

1070 146. Rydén M, Jocken J, van Harmelen V, *et al.* Comparative studies of the role of hormone-
 1071 sensitive lipase and adipose triglyceride lipase in human fat cell lipolysis. *Am J Physiol*
 1072 *Endocrinol Metab* 2007; **292**:E1847-E18455.

1073 147. Jocken J, Blaak E. Catecholamine-induced lipolysis in adipose tissue and skeletal muscle
 1074 in obesity. *Physiol Behav* **2008**; 94:219-230.

1075 148. Verboven K, Hansen D, Moro C *et al.* Attenuated atrial natriuretic peptide-mediated
 1076 lipolysis in subcutaneous adipocytes of obese type 2 diabetic men. *Clin Sci (Lond)* 2016;
 1077 **130**:1105-1114.

1078 149. Dicker A, Aström G, Wahlén K, *et al.* Primary differences in lipolysis between human
 1079 omental and subcutaneous adipose tissue observed using in vitro differentiated
 1080 adipocytes. *Horm Metab Res* 2009; **41**:350-355.

1081 150. Endre T, Mattiasson I, Berglund G, Hulthén U. Insulin and renal sodium retention in
 1082 hypertension-prone men. *Hypertension* 1994; **23**:313-319.

1083 151. Zois N, Terzic D, Faerch K, *et al.* Effect of pancreatic hormones on pro-atrial natriuretic
 1084 peptide in humans. *EBioMedicine* 2017; 17:88-94.

1085 152. Moro C, Polak J, Richterova B, *et al.* Differential regulation of atrial natriuretic peptides
1086 and adrenergic receptor dependent lipolytic pathways in human adipose tissue.
1087 *Metabolism* 2005; **54**:122–131.

1088 153. Kovacova Z, Tharp W, Liu D, Wei W, Xie H, Collins S, Pratley R. Adipose tissue
1089 natriuretic peptide receptor expression is related to insulin sensitivity in obesity and
1090 diabetes. *Obesity* 2016; **24**:820-828.

1091 154. Arora P, Wu C, Hamid T, *et al.* Acute Metabolic Influences on the Natriuretic Peptide
1092 System in Humans. *J Am Coll Cardiol* 2016; **67**:804-812.

1093 155. Arora P, Wu C, Khan A, *et al.* Atrial natriuretic peptide is negatively regulated by
1094 microRNA-425. *J Clin Invest* 2013; **123**:3378-3382.

1095 156. Tsukamoto O, Fujita M, Kato M, *et al.* Natriuretic peptides enhance the production of
1096 adiponectin in human adipocytes and in patients with chronic heart failure. *J Am Coll*
1097 *Cardiol* 2009; **53**:2070-2077.

1098 157. Birkenfeld A, Boschmann M, Engeli S, Moro C, Arafat A, Luft F, Jordan J. Atrial
1099 natriuretic peptide and adiponectin interactions in man. *PLoS One* 2012; **7**:e43238.

1100 158. Wannamethee S, Welsh P, Whincup P, Sawar N, Thomas M, Gudnarsson V, Sattar N.
1101 High adiponectin and increased risk of cardiovascular disease and mortality in
1102 asymptomatic older men: does NT-proBNP help to explain this association. *Eur J*
1103 *Cardiovasc Prev Rehabil* 2011; **18**:65-71.

1104 159. Nakanishi K, Nishida M, Yamamoto R, Koseki M, Moriyama T, Yamauchi-Takahara K.
1105 Association between N-terminal pro-brain natriuretic peptide and adiponectin in healthy
1106 Japanese men. *Clin Chim Acta* 2016; **460**:138-141

1107 160. Moro C, Klimcakova E, Lolmède K, *et al.* Atrial natriuretic peptide inhibits the
1108 production of adipokines and cytokines linked to inflammation and insulin resistance in
1109 human subcutaneous adipose tissue. *Diabetologia* 2007; **50**:1038-1047.

- 1110 161. Van Marken Lichtenbelt W, Vanhommerig J, Smulders N, *et al.* Cold-activated brown
1111 adipose tissue in healthy men. *N Engl J Med* 2009; **360**:1500-1508.
- 1112 162. Virtanen K, Lidell M, Orava J, *et al.* Functional brown adipose tissue in healthy adults. *N*
1113 *Engl J Med* 2009; **360**:1518-1525.
- 1114 163. Cypess A, Lehman S, Williams G, *et al.* Identification and importance of brown adipose
1115 tissue in adult humans. *N Engl J Med* 2009; **360**:1509-1517.
- 1116 164. Schrauwen P, van Marken Lichtenbelt W. Combatting type 2 diabetes by turning up the
1117 heat. *Diabetologia* 2016; **59**:2269-2279.
- 1118 165. Cannon B, Nedergaard J. Brown adipose tissue: function and physiological significance.
1119 *Physiol Rev* 2004; **84**:277-359.
- 1120 166. Feldmann H, Golozoubova V, Cannon B, Nedergaard J. UCP1 ablation induces obesity
1121 and abolishes diet-induced thermogenesis in mice exempt from thermal stress by living at
1122 thermoneutrality. *Cell Metab* 2009; **9**:203-209.
- 1123 167. Park J, Hur W, Lee S. Intricate Transcriptional Networks of Classical Brown and Beige
1124 Fat Cells. *Front Endocrinol* 2015; **6**:124.
- 1125 168. Souza S, Chau M, Yang Q, *et al.* Atrial natriuretic peptide regulates lipid mobilization
1126 and oxygen consumption in human adipocytes by activating AMPK. *Biochim Biophys Res*
1127 *Comm* 2011; **410**:398-403.
- 1128 169. Nishizawa H, Matsuda M, Yamada Y, *et al.* Musclin, a novel skeletal muscle-derived
1129 secretory factor. *J Biol Chem* 2004; **279**:19391-19395.
- 1130 170. Subbotina E, Sierra A, Zhu Z, *et al.* Musclin is an activity-stimulated myokine that
1131 enhances physical endurance. *Proc Natl Acad Sci USA* 2015; **112**:16042-16047.
- 1132 171. Gu N, Guo Q, Mao K, *et al.* Palmitate increases musclin gene expression through
1133 activation of PERK signaling pathway in C2C12 myotubes. *Biochem Biophys Res*
1134 *Commun* 2015; **467**:521-526.

1135 172. Yu J, Zheng J, Liu X, Feng Z, Zhang X, Cao L, Zhou Z. Exercise improved lipid
1136 metabolism and insulin sensitivity in rats fed a high-fat diet by regulating glucose
1137 transporter 4 (GLUT4) and musclin expression. *Braz J Med Biol Res* 2016; **49**:e5129.

1138 173. Liu Y, Huo X, Pang X, Zong Z, Meng X, Liu G. Musclin inhibits insulin activation of
1139 Akt/protein kinase B in rat skeletal muscle. *J Int Med Res* 2008; **36**:496-504.

1140 174. Birkenfeld A, Shulman G. Nonalcoholic fatty liver disease, hepatic insulin resistance,
1141 and type 2 diabetes. *Hepatology* 2014; **59**:713-723.

1142 175. Gaggini M, Morelli M, Buzzigoli E, DeFronzo R, Bugianese E, Gastaldelli A. Non-
1143 alcoholic fatty liver disease (NAFLD) and its connection with insulin resistance,
1144 dyslipidemia, atherosclerosis and coronary heart disease. *Nutrients* 2013; **5**:1544-1560.

1145 176. Day C. Pathogenesis of steatohepatitis. *Best Pract Res Clin Gastroenterology* 2002;
1146 **16**:663-678.

1147 177. Sanchez O, Lazo-Elizondo M, Zeb I, *et al.* Computerized tomography measured liver fat
1148 is associated with low levels of N-terminal pro-brain natriuretic protein (NT-proBNP) -
1149 Multi-Ethnic Study of Atherosclerosis. *Metabolism* 2016; **65**:728-735.

1150 178. Lazo M, Rubin J, Clark J, *et al.* The Association of Liver Enzymes with Biomarkers of
1151 Subclinical Myocardial Damage and Structural Heart Disease. *J Hepatol* 2015; **62**:841-
1152 847.

1153 179. Vollmar A, Paumgartner G, Gerbes A. Differential gene expression of the three
1154 natriuretic peptides and natriuretic peptide receptor subtypes in human liver. *Gut* 1997;
1155 **40**:145-150.

1156 180. Bilzer M, Jaeschke H, Vollmar A, Paumgartner G, Gerbes A. Prevention of Kupffer cell-
1157 induced oxidant injury in rat liver by atrial natriuretic peptide. *Am J Physiol* 1999;
1158 276:G1137-G1144.

- 1159 181. Kiemer A, Baron A, Gerbes A, Bilzer M, Vollmar A. The atrial natriuretic peptide as a
1160 regulator of Kupffer cell functions. *Shock* 2002; **17**:365-371.
- 1161 182. Rashed H, Nair B, Patel T. Regulation of hepatic glycolysis and gluconeogenesis by
1162 atrial natriuretic peptide. *Arch Biochem Biophys* 1992; **298**:640-645.
- 1163 183. Lutz S, Hennige A, Feil S, Peter A, Gerling A, Machann J. Genetic ablation of cGMP-
1164 dependent protein kinase type I causes liver inflammation and fasting hyperglycemia.
1165 *Diabetes* 2011; **60**:1566-1576.
- 1166 184. Arbin V, Claperon N, Fournié-Zaluski M, Roques B, Peyroux J. Acute effect of the dual
1167 angiotensin-converting enzyme and neutral endopeptidase 24-11 inhibitor mixanpril on
1168 insulin sensitivity in obese Zucker rat. *Br J Pharmacol* 2001; **133**:495-502.
- 1169 185. Arbin V, Claperon N, Fournié-Zaluski M, Roques B, Peyroux J. Effects of dual
1170 angiotensin-converting enzyme and neutral endopeptidase 24-11 chronic inhibition by
1171 mixanpril on insulin sensitivity in lean and obese Zucker rats. *J Cardiovasc Pharmacol*
1172 2003; **41**:254-264.
- 1173 186. Uehlinger D, Weidmann P, Gnädinger M, *et al.* Increase in circulating insulin induced by
1174 atrial natriuretic peptide in normal humans. *J Cardiovasc Pharmacol* 1986; **8**:1122–1129.
- 1175 187. Ferrari P, Shaw S, Riesen W, Weidmann P. Plasma insulin during physiological and
1176 pathophysiological changes in atrial natriuretic factor. *Eur J Clin Pharmacol* 1992;
1177 **42**:453-455.
- 1178 188. Ropero A, Soriano S, Tudurí E, *et al.* The atrial natriuretic peptide and guanylyl cyclase-
1179 a system modulates pancreatic betacell function. *Endocrinology* 2010; **151**:3665–3674.
- 1180 189. You H, Laychock S. Atrial natriuretic peptide promotes pancreatic islet beta-cell growth
1181 and Akt/Foxo1a/cyclin D2 signaling. *Endocrinology* 2009; **150**:5455-5465.

- 1182 190. Moro C, Polak J, Hejnova J, *et al.* Atrial natriuretic peptide stimulates lipid mobilization
1183 during repeated bouts of endurance exercise. *Am J Physiol Endocrinol Metab* 2006;
1184 **290**:E864-E869.
- 1185 191. Moro C, Pillard F, de Glisezinski I, *et al.* Exercise-induced lipid mobilization in
1186 subcutaneous adipose tissue is mainly related to natriuretic peptides in overweight men.
1187 *Am J Physiol Endocrinol Metab* 2008; **295**:E505-E513.
- 1188 192. Moro C, Pillard F, De Glisezinski I, *et al.* Training Enhances ANP Lipid-Mobilizing
1189 Action in Adipose Tissue of Overweight Men. *Medicine & Science in Sports & Exercise*
1190 2005; **37**:1126-1132.
- 1191 193. Barletta G, Stefani L, Del Bene R, *et al.* Effects of exercise on natriuretic peptides and
1192 cardiac function in man. *Int J Cardiol* 1998; **65**:217-225.
- 1193 194. Kjaer A, Appel J, Hildebrandt P, Petersen C. Basal and exercise-induced neuroendocrine
1194 activation in patients with heart failure and in normal subjects. *Eur J Heart Fail* 2004;
1195 **6**:29-39.
- 1196 195. Mandroukas A, Metaxas T, Heller J, *et al.* The effect of different exercise-testing
1197 protocols on atrial natriuretic peptide. *Clin Physiol Funct Imaging* 2011; **31**:5-10.
- 1198 196. Steele I, McDowell G, Moore A, Campbell N, Shaw C, Buchanan K, Nicholls D.
1199 Responses of atrial natriuretic peptide and brain natriuretic peptide to exercise in patients
1200 with chronic heart failure and normal control subjects. *Eur J Clin Invest* 1997; **27**:270-
1201 276.
- 1202 197. Kato M, Kinugawa T, Ogino K, *et al.* Augmented response in plasma brain natriuretic
1203 peptide to dynamic exercise in patients with left ventricular dysfunction and congestive
1204 heart failure. *J Intern Med* 2000; **248**:309-315.

- 1205 198. Engelmann M, Nieman L, Kanstrup I, Skagen K, Godtfredsen J. Natriuretic peptide
1206 response to dynamic exercise in patients with atrial fibrillation. *Int J Cardiol* 2005;
1207 **105**:31-39.
- 1208 199. Tanaka M, Ishizaka Y, Ishiyama Y, *et al.* Exercise-induced secretion of brain natriuretic
1209 peptide in essential hypertension and normal subjects. *Hypertens Res* 1995; **18**:159-166.
- 1210 200. Haufe S, Kaminski J, Utz W, *et al.* Differential response of the natriuretic peptide system
1211 to weight loss and exercise in overweight or obese patients. *J Hypertens* 2015; **33**:1458-
1212 1464.
- 1213 201. Bordbar S, Bigi M, Aslani A, Rahimi E, Ahmadi N. Effect of endurance and strength
1214 exercise on release of brain natriuretic peptide. *J Cardiovasc Dis Res* 2012; **3**:22-25.
- 1215 202. Beltran Valls M, Dimauro I, Brunelli A, *et al.* Explosive type of moderate-resistance
1216 training induces functional, cardiovascular, and molecular adaptations in the elderly. *Age*
1217 2014; **36**:759-772.
- 1218 203. Lu J, Pan S. Elevated C-type natriuretic peptide elicits exercise preconditioning-induced
1219 cardioprotection against myocardial injury probably via the up-regulation of NPR-B. *J*
1220 *Physiol Sci* 2016 [Epub ahead of print]
- 1221 204. Liu Y, Li J, Zhang Z, Tang Y, Chen Z, Wang Z. Effects of exercise intervention on
1222 vascular endothelium functions of patients with impaired glucose tolerance during
1223 prediabetes mellitus. *Exp Ther Med* 2013; **5**:1559-1565.
- 1224 205. Jenkins N, Padilla J, Rector R, Laughlin M. Influence of regular physical activity and
1225 caloric restriction on β -adrenergic and natriuretic peptide receptor expression in
1226 retroperitoneal adipose tissue of OLETF rats. *Exp Physiol* 2013; **98**:1576-1584.
- 1227 206. Moro C, Pasarica M, Elkind-Hirsch K, Redman L. Aerobic exercise training improves
1228 atrial natriuretic peptide and catecholamine-mediated lipolysis in obese women with
1229 polycystic ovary syndrome. *J Clin Endocrinol Metab* 2009; **94**:2579-2586.

- 1230 207. Fenzl M, Schnizer W, Aebli N, *et al.* Release of ANP and fat oxidation in overweight
1231 persons during aerobic exercise in water. *Int J Sports Med* 2013; **34**:795-799.
- 1232 208. Menshikova E, Ritov V, Toledo F, Ferrell R, Goodpaster B, Kelley D. Effects of weight
1233 loss and physical activity on skeletal muscle mitochondrial function in obesity. *Am J*
1234 *Physiol Endocrinol Metab* 2005; **288**:E818-E825.
- 1235 209. Li C, Yu Q, Yu P, Yu T, Zhang Q, Lu S, Yu D. Changes in liraglutide-induced body
1236 composition are related to modifications in plasma cardiac natriuretic peptides levels in
1237 obese type 2 diabetic patients. *Cardiovasc Diabetol* 2014; **13**:36.
- 1238 210. St Peter J, Hartley G, Murakami M, Apple F. B-type natriuretic peptide (BNP) and N-
1239 terminal pro-BNP in obese patients without heart failure: relationship to body mass index
1240 and gastric bypass surgery. *Clin Chem* 2006; **52**:680-685.
- 1241 211. Changchien E, Ahmed S, Betti F, Higa J, Kiely K, Hernandez-Boussard T, Morton J. B-
1242 type natriuretic peptide increases after gastric bypass surgery and correlates with weight
1243 loss. *Surg Endosc* 2011; **25**:2338-2343.
- 1244 212. Chainani-Wu N, Weidner G, Purnell D, *et al.* Relation of B-type natriuretic peptide
1245 levels to body mass index after comprehensive lifestyle changes. *Am J Cardiol* 2010;
1246 **105**:1570-1576.
- 1247 213. Chen-Tournoux A, Khan A, Baggish A, *et al.* Effect of weight loss after weight loss
1248 surgery on plasma N-terminal pro-B-type natriuretic peptide levels. *Am J Cardiol* 2010;
1249 **106**:1450–1455.
- 1250 214. Abrahamsson N, Engström B, Sundbom M, Karlsson F. Gastric bypass surgery elevates
1251 NT-ProBNP levels. *Obes Surg* 2013; **23**:1421–1426.
- 1252 215. Kistorp C, Bliddal H, Goetze J, Christensen R, Faber J. Cardiac natriuretic peptides in
1253 plasma increase after dietary induced weight loss in obesity. *BMC Obes* 2014; **1**:24

216. Hanusch-Enserer U, Hermann K, Cauza E, *et al.* Effect of gastric banding on aminoterminal pro-brain natriuretic peptide in the morbidly obese. *Obes Res* 2003; **11**:695-698.
217. Minami J, Nishikimi T, Ishimitsu T, *et al.* Effect of a hypocaloric diet on adrenomedullin and natriuretic peptides in obese patients with essential hypertension. *J Cardiovasc Pharmacol* 2000; **36**:S83-S86.
218. Gabrielsen A, Omland T, Brokner M, *et al.* The effect of surgical and non-surgical weight loss on N-terminal pro-B-type natriuretic peptide and its relation to obstructive sleep apnea and pulmonary function. *BMC Res Notes* 2016; **9**:440.
219. Ichiki T, Burnett J. Atrial natriuretic peptide – old but new therapeutic in cardiovascular disease. *Circ J* 2017; **81**:913-919.
220. Asakura M, Jiyoong K, Minamino T, *et al.* Rationale and design of a large-scale trial using atrial natriuretic peptide (ANP) as an adjunct to percutaneous coronary intervention for ST-segment elevation acute myocardial infarction: Japan-Working groups of acute myocardial infarction for the reduction of Necrotic Damage by ANP (J-WIND-ANP). *Circ J* 2004; **68**:95-100.
221. O'Connor C, Starling R, Hernandez A, *et al.* Effect of nesiritide in patients with acute decompensated heart failure. *N Engl J Med* 2011; **365**:32-43.
222. Suwa M, Seino Y, Nomachi Y, *et al.* Multicenter prospective investigation on efficacy and safety of carperitide for acute heart failure in the 'real world' of therapy. *Circ J* 2005; **69**:283-290.