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14-fold increased prevalence of rare glucokinase gene variant carriers in unselected Danish patients with newly diagnosed type 2 diabetes

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Aims: Rare variants in the glucokinase gene (GCK) cause Maturity-Onset Diabetes of the Young (MODY2/GCK-MODY). We investigated the prevalence of GCK variants, phenotypic characteristics, micro- and macrovascular disease at baseline and follow-up, and treatment among individuals with and without pathogenic GCK variants.

Methods: This is a cross-sectional study in a population-based cohort of 5,433 individuals without diabetes (Inter99 cohort) and in 2,855 patients with a new clinical diagnosis of type 2 diabetes (DD2 cohort) with sequencing of GCK. Phenotypic characteristics, presence of micro- and macrovascular disease and treatment information were available for patients in the DD2 cohort at baseline and after an average follow-up of 7.4 years.

Results: Twenty-two carriers of potentially deleterious GCK variants were found among patients with type 2 diabetes compared to three among 5,433 nondiabetic individuals (OR = 14.1 (95 % CI 4.2; 47.0), p = 8.9 × 10⁻⁶). Patients with type 2 diabetes carrying GCK variants had significantly lower waist circumference, hip circumference and BMI, compared to non-carriers. Three GCK variant carriers with diabetes had microvascular complications during follow-up.

Conclusions: Approximately 0.8% of Danish patients with newly diagnosed type 2 diabetes carry non-synonymous variants in GCK and resemble patients with GCK-MODY. Glucose-lowering treatment cessation should be considered in this subset of diabetes patients.

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ABSTRACT

Aims: Rare variants in the glucokinase gene (GCK) cause Maturity-Onset Diabetes of the Young (MODY2/GCK-MODY). We investigated the prevalence of GCK variants, phenotypic characteristics, micro- and macrovascular disease at baseline and follow-up, and treatment among individuals with and without pathogenic GCK variants.

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Conclusions: Approximately 0.8% of Danish patients with newly diagnosed type 2 diabetes carry non-synonymous variants in GCK and resemble patients with GCK-MODY. Glucose-lowering treatment cessation should be considered in this subset of diabetes patients.

1. Introduction

Maturity-Onset Diabetes of the Young (MODY) is a clinical definition of diabetes in patients presenting with autosomal dominant heritance, age-of-diagnosis before 25 years of age, and residual C-peptide production. A large fraction of patients clinically diagnosed with MODY...
have a known genetic etiology, with variants in the gene encoding glucokinase (GCK-MODY) being among the most common causes [1–3].

By phosphorylating glucose to glucose-6-phosphate, glucokinase functions as the pancreatic beta-cell glucose sensor, regulating glucose-stimulated insulin secretion [4]. In addition, glucokinase plays a critical role in the hepatic conversion of glucose into glycogen, which is a major contributor to the removal of glucose from the portal vein in the postprandial state [5]. Moreover, reduced glucokinase activity is also thought to play a key role in the central response to hypoglycaemia [6].

Patients with GCK-MODY maintain the capacity to produce insulin. However, the level of glucose necessary to stimulate insulin secretion is increased reflecting a higher set point for glucose to enhance pancreatic insulin secretion. GCK-MODY patients also have an elevated hepatic glucose output, and the hormonal counter-regulation is set at higher glucose concentrations [7]. Thus, GCK-MODY patients have a slightly increased fasting plasma glucose concentration between 5.5 and 8 mmol/l [8]. Following an oral glucose tolerance test (OGTT), GCK-MODY patients only have a minor increase in plasma glucose (often < 3 mmol/l), and ~50 % have 2-hour plasma glucose values exceeding the diagnostic threshold for diabetes at 11.1 mmol/l [7]. Therefore, GCK-MODY patients are often asymptomatic and diagnosed incidentally, e.g. in connection with pregnancy or if familial diabetes is suspected. GCK-MODY is present from birth and glucose levels only slightly deteriorate with age [9]. The penetrance of pathogenic GCK variants is complete and there is a homogenous phenotype among affected family members [10]. Glucose-lowering therapy seems ineffective in patients with GCK-MODY and consequently, treatment outside of pregnancy is not recommended [11].

A European case-control study sequenced GCK in 2,872 non-diabetic control individuals and in 4,016 patients with type 2 diabetes, among whom a third of the patients were diagnosed before age 40 years. Twenty missense variants were identified, representing a prevalence of 0.5 % among patients with type 2 diabetes versus a prevalence of 0.035 % in controls [12]. A second case-control study including 2,178 patients with type 2 diabetes and 4,170 non-diabetic individuals, found that 0.6 % of patients with diabetes were carriers of GCK variants classified as pathogenic or likely pathogenic yielding a sevenfold higher prevalence among patients with diabetes [OR: 7.08 (95 % CI: 2.23–27.3)]. The carriers with diabetes were significantly leaner than non-carriers with diabetes. An equal proportion of carriers and non-carriers were treated with glucose-lowering agents [13].

One previous cross-sectional study examined the prevalence of micro- and macrovascular complications in 99 GCK-MODY patients with a mean age greater than 50 years, 91 non-diabetic individuals and 83 young-onset diabetes patients. The proportion of non-severe retinopathy was similar or slightly higher among GCK-MODY patients compared to healthy controls. However, no severe eye disease was found among GCK-MODY patients. Neuropathy and microalbuminuria were rare in patients with GCK-MODY (2 % and 1 % of the participants respectively) with risks similar to those found in non-diabetic individuals [9].

The aim of this study was to examine the prevalence and the clinical presentation of GCK variants in a nondiabetic population-based cohort and in a cohort of newly diagnosed patients with type 2 diabetes. A novelty of the current study is the investigation of a large cohort of newly diagnosed type 2 diabetes patients with phenotypic characteristics at the time of diagnosis and up to 10 years of complete follow-up for use of medications and development of micro- and macrovascular disease. Additionally, a correct identification of pathogenic variants is essential to accurately assess the clinical consequence of carrying deleterious variants. Thus, pathogenicity classification was related to a cell based functional assay (MAVE) and an in silico functionality score (GEMME).

2. Methods and materials

2.1. Subjects

Targeted sequencing was performed in the population-based Inter99 cohort. Glucose tolerance was classified based on a 2-hour OGTT using the 1999 World Health Organisation criteria [14]. Based on this classification, we included 4,413 glucose tolerant individuals and 1,020 prediabetic individuals from the Inter99 cohort, who are collectively referred to as nondiabetic individuals (n = 5,433). In addition, we sequenced 2,855 patients with newly diagnosed type 2 diabetes with available DNA samples from the nationwide Danish DD2 cohort. Phenotypic information was available for 2,824 of these individuals [15]. The DD2 cohort has enrolled patients since 2010 and is ongoing. Patients from the DD2 cohort included in the present study were those recruited until 2015. Patients with newly diagnosed diabetes were either enrolled by their general practitioner or from a hospital clinic, on average between 1 and 1.5 years after their first record of glucose-lowering therapy [16]. All patients were GAD65 antibody-negative and had a fasting serum C-peptide above 150 mmol/l (if available).

Clinical characteristics of participants can be found in Table 1.

Informed consent was obtained from all participants. The study design was in accordance with the ethical scientific principles of the Helsinki Declaration II.

2.2. Anthropometrics and biochemistry

All participants in the Inter99 cohort had body weight and height measured wearing light indoor clothes and without shoes. Waist circumference at the umbilical level was measured on subjects in an upright position to the nearest 0.5 cm using a non-extendable linen tape measure according to the WHO recommendation.

In the Inter99 study cohort, a standard 75 g OGTT was performed after a 12-hour overnight fast. Fasting serum insulin levels (excluding des-31,32 and intact proinsulin) were measured using the AutoDELFIA insulin kit (Perkin-Elmer, Wallac, Turku, Finland) and fasting plasma glucose was analysed using a glucose oxidase method (Granulab; Merck, Darmstadt, Germany) [17]. Serum triglycerides and total and high-density lipoprotein (HDL) serum cholesterol were analysed using enzymatic colorimetric methods (GPO-PAP and CHOD-PAP, Roche Molecular Biochemicals, Germany). Hba1c was measured using ion-exchange high performance liquid chromatography (normal reference range: 4.1 %–6.4 %).

For patients from the DD2-cohort, anthropometric measures such as height and weight and biomarkers including Hba1c, lipids and auto-antibodies were extracted from the Danish Diabetes Database for Adults [16]. Laboratory values, such as fasting plasma glucose, fasting plasma

### Table 1

<table>
<thead>
<tr>
<th>Trait</th>
<th>Non-diabetic patients (Inter99 cohort, n = 5,433)</th>
<th>Newly diagnosed diabetes patients (DD2 cohort, n = 2,824)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex (men/women)</td>
<td>2625/2808</td>
<td>1662/1162</td>
</tr>
<tr>
<td>Age at enrolment (years)</td>
<td>45.0 (40.0; 50.1)</td>
<td>61.9 (53.3; 68.2)</td>
</tr>
<tr>
<td>Age at diagnosis (years)</td>
<td>NA</td>
<td>60.3 (51.7; 66.9)</td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
<td>25.3 (23.0; 28.2)</td>
<td>30.6 (27.1; 34.6)</td>
</tr>
<tr>
<td>Waist/hip ratio</td>
<td>1.0 (0.9; 1.0)</td>
<td>0.85 (0.78; 0.91)</td>
</tr>
<tr>
<td>Fasting plasma glucose (mmol/l)</td>
<td>5.4 (5.1; 5.7)</td>
<td>7.1 (6.4; 8.1)</td>
</tr>
<tr>
<td>Fasting serum C-peptide (pmol/l)</td>
<td>518 (407; 678)</td>
<td>1138 (862; 1497)</td>
</tr>
<tr>
<td>Triglycerides (mmol/l)</td>
<td>1.0 (0.8; 1.5)</td>
<td>1.6 (1.1; 2.4)</td>
</tr>
<tr>
<td>Total cholesterol (mmol/l)</td>
<td>5.4 (4.8; 6.1)</td>
<td>4.4 (3.7; 5.1)</td>
</tr>
</tbody>
</table>

Data are presented as medians and interquartile ranges. BMI: Body mass index.
C-peptide and C-reactive protein (CRP) were measured directly using biobank samples. C-peptide levels were measured using the ADVIA Centaur C-Peptide assay (Siemens Healthcare Diagnostics Ltd, Frimley, Camberley, UK) and fasting plasma glucose levels were analysed using an enzymatic hexokinase method (gluco-quant Glucose/HK, Roche Diagnostics). The particle-enhanced immunoturbidimetric method using Tina-quant C-reactive Protein Gen.3 (Roche Diagnostics GmbH, Mannheim, Germany) was used to measure CRP, allowing measurement of CRP within the limits of 0.3–350 mg/l [16].

Information on micro- and macrovascular disease was based on a complete hospital inpatient and outpatient contact history starting 10 years before the diabetes diagnosis date and ending on 1st of August 2018. Average follow-up time was 7.4 years after diagnosis. Denmark has a free tax supported health care system [18].

Data were extracted from the Danish National Patient Registry (DNPR), which contains all discharge records from all Danish hospitals since 1977 and from hospital outpatient clinic and emergency visits since 1995 [19]. Microvascular diseases were identified in the DNPR based on the presence of retinopathy, atherosclerotic eye disease, blindness, severe vision impairment, use of retinal photocoagulation therapy, neuropathy, nephropathy, albuminuria and chronic dialysis or renal failure. Macrovascular diseases were extracted based on the presence of ischemic heart disease, atherosclerotic cerebrovascular disease, atherosclerotic peripheral vascular disease, or any operation for macroangiopathy [20–21].

Treatment information was retrieved from the Danish National Health Service Prescription Database [20] using the treatment codes in Supplementary Table 1. Treatment patterns were investigated among patients with newly diagnosed diabetes one year prior to study inclusion and until present day and for the current study, data was included from 1st of January 2004 until 1st of August 2018.

2.3. Targeted resequencing platform

Targeted sequencing was performed using a chip-based customized nucleotide probe designed to capture the coding regions of GCK. Methods for DNA extraction, target region capture, and NGS have been extensively described previously [22]. The final captured DNA libraries were sequenced using the Illumina HiSeq2000 Analyzers as PE 90 bp reads following the manufacturer’s standard cluster generation and sequencing protocols. All of the variable sites were covered with a minimum depth of 30X with a mean depth of 182X. The variants located by height in meters squared (kg/m²).

2.4. Pathogenicity of variants

Variants were classified in accordance with the American College of Medical Genetics and Genomics (ACMG) terminology: Benign, likely benign, variants of uncertain significance (VUS), likely pathogenic or pathogenic [23]. If variants were present in the ClinVar database [24] variants were classified according to this, with all variants being classified no later than 2015. If ACMG classification was available in addition to other classifications, the ACMG classification was selected. If variants were not present in ClinVar, variants were classified manually according to ACMG guidelines [23]. In the remainder of the manuscript, variants classified as either likely pathogenic or pathogenic will be denoted as pathogenic, variants classified as either likely benign or benign will be denoted as benign and variants classified as variants of uncertain significance will be denoted as VUS.

2.5. Functionality score

The activity of eight of the identified variants was investigated using the results from a multiplexed assay of variant effects (MAVE), also known as deep mutational scanning, in which nearly all possible variants of human GCK were assayed for their function using a yeast-based complementation assay [25]. The method is described in [25] and the full dataset is available on MaveDB.org under accession number urn: mavedb:00000096-a.

An in silico functionality score was calculated for each of the identified missense variants using information from evolutionary sequence conservation. First, HHBlits [26] was used to generate a multiple sequence alignment of 1179 GCK homologs with an E-value threshold of 10⁻²⁰. This was reduced to 1079 homologs by filtering out sequences with more than 50 % gaps. From this, an evolutionary conservation score was calculated using the Global Epistatic Model for predicting Mutational Effects (GEMME) software [27].

2.6. Statistical analyses

Body Mass Index (BMI) was defined as weight in kilograms divided by height in meters squared (kg/m²). HbA1c stability was calculated as the maximal change in HbA1c from baseline and throughout the study period. The statistical difference in carrier-frequency between patients with diabetes and participants without, was calculated both as the prevalence difference with 95 % confidence intervals (CI) and using Fisher’s exact test. Differences in quantitative traits between carriers of GCK variants and non-carriers among newly diagnosed type 2 diabetes patients and nondiabetic individuals were analysed using the difference in the means with 95 % (CI) and the Student’s t-test comparing the means of phenotypic characteristics. The following traits were log-transformed prior to statistical analysis: BMI, CRP, fasting C-peptide, fasting plasma glucose, HbA1c, HDL-cholesterol, low-density lipoprotein (LDL) cholesterol, total cholesterol, triglycerides and maximal change in HbA1c. The mean difference was calculated by subtracting the means from the compared groups. The CI for the mean difference between log transformed traits, is the CI for the ratio between the two variables. A CI for log transformed traits around one signifies that variables are similar, whereas for non-transformed traits a CI around zero signifies that the two variables are similar. In addition a p-value < 0.05 was considered statistically significant.

Statistical analyses were performed using RStudio software (version 3.6.1 and 4.0.2; R Foundation for Statistical Computing, Boston, MA, USA).

The prevalence of micro- and macrovascular diseases was assessed in the 10 year time period prior to type 2 diabetes diagnosis date. Prevalence for disease was expressed in terms of proportions, and 95 % CIs were calculated using the Wilson Score method. The 95 % CI for the crude prevalence ratio was calculated by log-transformation of the prevalence ratio and use of the delta method.

Incidence of micro- and macrovascular complications was assessed from the beginning of the follow-up period which was the date of type 2 diagnosis until 1st of August 2018. Patients with a prevalent diagnosis of a microvascular disease were excluded from the analysis of microvascular complications. The incidence rate was expressed as number of events per 100 patient-years together with the Poisson exact CIs. The CI for the incidence rate ratio was calculated by log-transformation of the incidence rate ratio and using the delta method.

Differences in prescriptions patterns between patients with type 2 diabetes with and without pathogenic GCK variants from 1st of January 2004 until 1st of August 2018, was examined using the Wilson score method to estimate the 95 % CI and the z-test for calculating the p-value for equal proportions.
3. Results

Sequencing of GCK in 8,288 individuals with different levels of glucose tolerance, identified a total of 24 variants in 29 carriers. The amino acid variant p.Gly72Arg was present with two different underlying nucleotide substitutions (c.214G > C and c.214G > A), thus a total of 21 missense variants, one stop variant and one frameshift variant were found in 29 carriers (Supplementary Table 2).

All identified variants were rare (MAF < 0.1 %) and six of the variants have not previously been described in international reference databases [28] nor in MODY-families [29]. However, the p.Asp4Asn has been described previously as a polymorphism [29] and the p.Cys221Tyr has been seen in a MODY family also carrying a homozygous HNF1A variant [30].

3.1. Prevalence of variants

In the Inter99 cohort of nondiabetic carriers, five non-synonymous variants were identified (four carriers were glucose tolerant and one had impaired fasting glycaemia) resulting in a prevalence of non-synonymous variants in GCK among nondiabetic individuals of 0.092 % (Supplementary Table 2). Within the DD2 cohort of patients with newly diagnosed diabetes, 24 carriers of non-synonymous GCK variants were found resulting in a prevalence of 0.84 % (Supplementary Table 2). One patient carried two GCK variants (p.Asp124Asn and p.Glu279Gln).

3.2. Pathogenicity classification of variants

The variants identified were assessed with regard to their pathogenicity based on the ACMG classification. This classification was compared with results from a functional assay of GCK using yeast complementation (MAVE score) for 18 of the variants found in the present study and the GEMME score was calculated for all of the 21 missense variants from the present study.

The MAVE score cut-off for loss of function variants is < 0.6. One ACMG classified pathogenic variant had a MAVE score above 0.6. This was the p.Gly318Arg variant with a score of 1.3. The GEMME score showed complete segregation between pathogenic and non-pathogenic variants with all pathogenic variants having a score below minus two (Supplementary Fig. 1).

3.3. Variants associated with diabetes

In the Inter99 cohort, two nondiabetic individuals were carriers of benign variants and three were carriers of VUS. In DD2, two patients carried benign variants, five carried VUS and 17 carried pathogenic variants (Supplementary Table 2).

In a cross-sectional case-control analysis comparing the prevalence of identified non-synonymous GCK variants between nondiabetic persons and patients with newly diagnosed type 2 diabetes, a 14-fold higher prevalence of pathogenic or VUS GCK variants was seen in patients with newly diagnosed type 2 diabetes (OR (95 % CI) = 14.1 (4.2–47.0), p = 8.9*10^-6) (Supplementary Fig. 1 and Supplementary Table 2). Variants classified as pathogenic were found exclusively in patients with newly diagnosed type 2 diabetes.

3.4. Phenotypic characteristics of patients with newly diagnosed type 2 diabetes carrying GCK variants

The phenotype of patients with newly diagnosed type 2 diabetes carrying pathogenic GCK variants was compared to patients with type 2 diabetes and nondiabetic individuals without GCK variants (Fig. 1 and Supplementary Table 3). Carriers and non-carriers with diabetes had a similar age at enrolment (58.1 years in carriers versus 61.9 years in non-carriers, p = 0.2), but there were fewer men among carriers (24 %) versus non-carriers (60 %), p = 0.003. Measures of body composition were significantly different between carriers and non-carriers with diabetes. Waist circumference was lower among carriers compared to non-carriers with diabetes (carriers: 88 cm (IQR: 80–104 cm); non-carriers: 106 cm (IQR: 97–116 cm); p = 1.8*10^-5) with a mean difference of 15.7 cm (95 % CI:8.5–22.8 cm). Also hip circumference (carriers: 100 cm (IQR: 97–106 cm); non-carriers: 108 cm (IQR: 101–116 cm); p = 0.006) and BMI (carriers: 24.3 kg/m² (IQR: 22.8–30.8 kg/m²); non-carriers: 30.6 kg/m² (IQR: 27.1–34.6 kg/m²), p = 0.02) was lower among carriers compared to non-carriers with diabetes with a mean difference of 8.9 cm (95 % CI: 2.6–15.2 cm) and 1.2 (95 % CI: 1.0–1.3), respectively. Waist and hip circumference as well as BMI among carriers with diabetes were comparable to those of nondiabetic individuals (Fig. 1 A-C and Supplementary Table 3).

Table 2

<table>
<thead>
<tr>
<th>GCK variant</th>
<th>With variant N = 2807</th>
<th>Without variant N = 2807</th>
<th>Crude prevalence ratio, with vs without GCK variant (95 % CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic with any microvascular disease</td>
<td>0</td>
<td>0</td>
<td>1.15 (0.5; 1.1)</td>
</tr>
<tr>
<td>Diabetic with any eye disease</td>
<td>0</td>
<td>0</td>
<td>0.7 (0.5; 1.1)</td>
</tr>
<tr>
<td>Diabetic with any neurologic disease</td>
<td>0</td>
<td>0</td>
<td>0.7 (0.5; 1.1)</td>
</tr>
<tr>
<td>Diabetic with any macrovascular disease</td>
<td>0</td>
<td>0</td>
<td>1.0 (0.5; 1.1)</td>
</tr>
<tr>
<td>Diabetic with any ischemic heart disease</td>
<td>0</td>
<td>0</td>
<td>1.0 (0.5; 1.1)</td>
</tr>
<tr>
<td>Diabetic with any atherosclerotic cerebrovascular disease</td>
<td>0</td>
<td>0</td>
<td>1.0 (0.5; 1.1)</td>
</tr>
<tr>
<td>Diabetic with any atherosclerotic peripheral vascular disease</td>
<td>0</td>
<td>0</td>
<td>1.0 (0.5; 1.1)</td>
</tr>
</tbody>
</table>

Measures of glucose metabolism, expressed as fasting plasma glucose and HbA1c, did not differ between carriers of pathogenic variants and non-carriers with diabetes (Fig. 1 D-E and Supplementary Table 3). HbA1c stability was also examined by comparing maximal HbA1c of patients and patients with newly diagnosed type 2 diabetes, a 14-fold higher prevalence of pathogenic or VUS GCK variants was seen in patients with newly diagnosed type 2 diabetes (OR (95 % CI) = 14.1 (4.2–47.0), p = 8.9*10^-6) (Supplementary Fig. 1 and Supplementary Table 2). Variants classified as pathogenic were found exclusively in patients with newly diagnosed type 2 diabetes.
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was found among carriers compared to a change of 0.61 % (IQR: 0.29–1.33 %) in non-carriers with diabetes resulting in a mean difference of 2.6 (95 % CI: P = t-test for difference in mean. Abbreviations: WC = Waist circumference; HC = Hip circumference; FBG = Fasting blood glucose; Δ HbA1c = Maximal HbA1c change; Chol = Cholesterol; Trig = Triglyceride.

Lipid composition was also compared between carriers and non-carriers. Total cholesterol and LDL-cholesterol among carriers [total cholesterol: 4.1 mmol/l (IQR: 3.9–4.3); LDL-cholesterol: 2.2 mmol/l (IQR: 1.9–3.2 mmol/l)] and non-carriers with diabetes [total cholesterol: 4.4 mmol/l (IQR: 3.7–5.1 mmol/l); LDL-cholesterol: 2.2 mmol/l (IQR: 1.8–2.9 mmol/l)] were comparable but were significantly lower than levels observed in nondiabetic individuals [total cholesterol: 5.4 mmol/l (IQR: 4.8–6.1 mmol/l); LDL-cholesterol: 3.4 mmol/l (IQR: 2.8–4.1)] (Fig. 1 G-H and Supplementary Table 3). Levels of triglycerides in carriers [0.9 mmol/l (IQR: 0.8–1.5 mmol/l)] were lower than the levels in
non-carriers with diabetes [1.6 mmol/l (IQR: 1.1–2.4 mmol/l)] and were similar to the levels observed in nondiabetic individuals [1.0 mmol/l (IQR: 0.8–1.5 mmol/l)] (Fig. 1I and Supplementary Table 3).

The number of patients, who reported parental diabetes, was significantly higher among carriers (65 %) than among non-carriers (34 %), $p = 0.007$ (Supplementary Table 3).

### 3.5. Micro- and macrovascular disease

The prevalence of micro- and macrovascular disease reported up to 10 years prior to diagnosis of diabetes was examined in patients with newly diagnosed type 2 diabetes (Table 2). Among carriers of pathogenic GCK variants, 82 % had not experienced any disease compared to 81 % of non-carriers. None of the carriers had experienced any microvascular diseases compared to 3 % among non-carriers. Macrovascular disease in the form of ischemic heart disease and atherosclerotic cerebrovascular disease at baseline was observed in three carriers (Table 2), but was not significantly different from macrovascular disease at baseline in non-carriers (prevalence ratio 1.00 (95 % CI 0.36–2.79) (Table 2).

### 3.6. Treatment

Among patients carrying a pathogenic variant in GCK, all except two patients were treated with metformin. Three patients received insulin in addition to metformin and two patients received another antidiabetic drug (but not insulin), in addition to metformin. Two patients did not receive any glucose-lowering treatment. Prescription patterns were also investigated among diabetes patients without pathogenic variants in GCK and no significant differences were observed (Table 4).
MAVE and (computational) GEMME scores used here each rely on a
activating, although the score is associated with a standard error of 0.4.

tions, and to be independent of each other.
clinical annotations of unseen variants as well as for previous annota
annotations of variants. Thus, both are reliable in their ability to predict
were significantly lower among patients with pathogenic
-ogenic were found exclusively in patients with type 2 diabetes with a

- pathogenic variants in MODY patients, i.e. a non-obese driven diabetes with Hba1c levels
- 5.6 % and 7.6 % (38–60 mmol/mol) and fasting glucose levels between 5.5 mmol/l and 8.0 mmol/l [9,33]. Glucose-lowering treatmen
- not efficient for the majority of GCK-MODY patients [33]. Nevertheless, most patients in the present study with GCK variants were treated for their hyperglycaemia including three individuals who received insulin in addition to metformin. Overall, the treatment regimen was similar in patients with type 2 diabetes with and without GCK variants, consistent with previous findings reported by Bonnefond et al. [13]. The modest fluctuations in Hba1c among carriers of GCK variants with diabetes despite treatment, is consistent with the notion that these patients are less responsive to glucose-lowering treatment.

4. Discussion

Non-synonymous pathogenic variants or VUS in GCK were 14-fold more prevalent among patients with newly diagnosed type 2 diabetes compared to nondiabetic individuals, and variants classified as patho-
gen were found exclusively in patients with type 2 diabetes with a

prescription pattern in patients with newly diagnosed type 2 diabetes with and

Table 4
Prescription pattern in patients with newly diagnosed type 2 diabetes with and

<table>
<thead>
<tr>
<th>Patients with any prescription of:</th>
<th>GCK carriers</th>
<th>Non-carriers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 17</td>
<td>N = 2807</td>
</tr>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td></td>
<td>95 % CI</td>
<td>95 % CI</td>
</tr>
<tr>
<td>Any glucose-lowering drug (antidiabetics)</td>
<td>15 (65.7; 2610 (92.0; 0.4)</td>
<td></td>
</tr>
<tr>
<td>Metformin</td>
<td>15 (65.7; 2567 (90.4; 0.6)</td>
<td></td>
</tr>
<tr>
<td>Metformin monotherapy only</td>
<td>10 (36.0; 1250 (42.7; 0.2)</td>
<td></td>
</tr>
<tr>
<td>Monotherapy other than metformin</td>
<td>2 (3.3; 867 (29.2; 0.09)</td>
<td></td>
</tr>
<tr>
<td>combination therapy (all excluding insulin)</td>
<td>3 (6.2; 493 (16.2; 1.0)</td>
<td></td>
</tr>
</tbody>
</table>

4.1. Non-metformin therapy

4.1.1. Insulin-based therapy

<table>
<thead>
<tr>
<th>Treatment</th>
<th>N (%)</th>
<th>95 % CI</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metformin</td>
<td>55.5 (38)</td>
<td>43.6; 67.6</td>
<td></td>
</tr>
<tr>
<td>Metformin and insulin</td>
<td>26.5 (26)</td>
<td>18.6; 36.5</td>
<td></td>
</tr>
<tr>
<td>Metformin, insulin and other glucose-lowering drugs</td>
<td>18.0 (18)</td>
<td>10.0; 28.0</td>
<td></td>
</tr>
<tr>
<td>Any glucose-lowering drug (antidiabetics)</td>
<td>3 (6.2; 493 (16.2; 1.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metformin</td>
<td>15 (65.7; 2610 (92.0; 0.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metformin monotherapy only</td>
<td>10 (36.0; 1250 (42.7; 0.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monotherapy other than metformin</td>
<td>2 (3.3; 867 (29.2; 0.09)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>combination therapy (all excluding insulin)</td>
<td>3 (6.2; 493 (16.2; 1.0)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.2. Metformin therapy

4.2.1. Metformin monotherapy

4.2.2. Metformin and insulin

4.2.3. Metformin, insulin and other glucose-lowering drugs

4.2.4. Any glucose-lowering drug (antidiabetics)

4.3. Metformin, insulin and other glucose-lowering drugs

4.4. Any glucose-lowering drug (antidiabetics)
practice, our knowledge of the effect of individual variants will evolve. Thus, the certainty with which we can identify patients with causal GCK variations will improve. However, at this point, treatment termination in patients carrying these uncertain variants must be closely monitored, and the clinician must be ready to continue treatment, if glucose values increase beyond those known in GCK-MODY.

Diagnosing diabetes patients with variants in GCK is economically and clinically relevant. In Denmark, the healthcare cost of diabetes is ~1,800 USD per person-year for patients with minor complications [35]. The total Danish type 2 diabetes population encompasses approximately 270,000 patients [36]. Extrapolating the prevalence of pathogenic GCK variations from the present study population suggests that close to 1,600 (0.6 %×270,000) Danish patients have diabetes due to GCK variants. Correct diagnosis of these patients with subsequent discontinuation of treatment and lowered intensity of clinical follow-up has the potential for a reduction of ~ 4.0 million USD/year in the cost of diabetes care in Denmark (1,800 USD per 1,600 patients). The price of genetic diagnosticians is currently 300 USD per sample in Denmark. When whole genome sequencing in the future will become generally available in clinical care, information on the glucokinase gene can be extracted without additional cost.

As a group, patients with newly diagnosed type 2 diabetes carrying GCK variants slightly differ phenotypically from patients without GCK variants. However, at the individual level, there are no clear phenotypic traits that could guide referral for genetic testing. We therefore suggest that genetic evaluation should be considered in non-obese patients with type 2 diabetes having an HbA1c below 7.6 % (60 mmol/mol) and fasting plasma glucose below 8 mmol/l.

4.1. Conclusion

Close to 1 % of patients with newly diagnosed type 2 diabetes are carriers of functional non-synonymous variants in GCK. Carriers resemble patients with GCK-MODY. Considering the benefit for the patient, their family members, and society, sequencing should be considered in all patients with non-obese type 2 diabetes and stable marginally increased glycaemia.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Author contributions

AL, JSN, HTS, IV, HBN, AV, JR, OP and TH were responsible for conception. APG, CTH, LE, and TH were responsible for design of the study. AL, JSN, HTS, IV, HBN, AV and JR were responsible for sample collection. APG, CTH, LE, ACBT, MH, NG, LBC, RWT and TH took part in the analyses. APG, OP, NG and TH were involved in funding acquisition. APG and TH drafted the article. APG, CTH, LE, ACBT, MH, NG, LBC, RWT, JSN, HTS, AV, OP and TH critically revised the manuscript and contributed to the discussion. The final version of the paper was read and approved by all authors.

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Appendix A. Supplementary data

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References


