INTRODUCTION

The steps by which Type 2 diabetes mellitus (T2DM) causes atherosclerotic vascular disease are not clear. Emphasis is shifting from elucidation of risk factors, such as insulin resistance, to an understanding of the process occurring at the vasculature (Playford and Watts, 1999). An increase in the concentration of serum sialic acid has been shown to be a possible cardiovascular risk factor in patients with non insulin dependent diabetes (Crook et al, 1993). The earliest event associated with atherosclerosis is the accumulation of low density lipoprotein cholesterol (LDL) and fibrinogen/fibrin in the affected arterial wall (Smith and Staples, 1980). It is therefore important to understand the mechanisms, which govern the endothelial binding, uptake, and transport of these macromolecules across the vessel wall as a prerequisite to the prevention of atherogenesis. The role of the luminal endothelial plasma membrane may be particularly relevant because it is the first interface between the vessel wall and circulating blood components. The luminal surface of the endothelium is rich in sialoglycated proteins and thus provides an anionic barrier for the receptor mediated uptake of LDL. It has been shown that the removal of sialic acid, as well as glycosaminoglycans, increases the internalization of LDL by 20 fold (Gorog and Pearson, 1984). Thus, desialylation at the endothelium could be an early event in the atherosclerotic process of cardiovascular disease and in NIDDM.

Recent evidence suggests that inflammatory processes play a part in the cause of atherosclerotic cardiovascular disease (Ross, 1999) and that the increase in acute phase proteins rich in sialoglycated proteins in serum reflects the atherosclerotic process in the endothelium (Pickup et al, 1997). Thus, an increase in the acute phase proteins may partly explain the elevation of serum sialic acid in Type 2 DM. Since sialic acid is a marker for the early atherosclerotic process and is present in most acute phase proteins, there is a need for a specific assay, which is cost effective, and can be employed in large scale epidemiological studies. In our laboratory, we have modified the periodate resorcinol method (Jourdian et al, 1971) for the measurement of total sialic acid, and compared the values to those obtained with the enzymatic assay (Simpson et al, 1993).
MATERIALS AND METHODS

Subjects

Twenty control subjects were studied along with 20 first-degree relatives with asymptomatic impaired glucose tolerance (IGT), who were age matched. The control subjects with a body mass index of < 30 kg/m² were chosen randomly from the Klang Valley, Kuala Lumpur, through the distribution of questionnaires. Any subject with a family history of diabetes, hypertension, or coronary artery disease were excluded from the study. First degree relatives with an impaired glucose tolerance test (IGT) were chosen from diabetic families through the diabetic clinic, University of Malaya Medical Center, Kuala Lumpur. The study was approved by the Ethics Committee of the Medical Center. None of the subjects had received hypolipidemic drug therapy, nor had any renal, hepatic or thyroid disease affecting glucose or lipid metabolism.

Sialic acid determination

Fasting blood was collected in bottles containing disodium ethylene diamine tetraacetate dehydrate (EDTA), and the plasma was separated immediately by centrifugation at 3,000 rpm for 15 minutes at 4°C and the sialic acid was measured using the enzymatic method or the periodate-resorcinol method. Sialic acid was determined by the enzymatic method as described by Simpson et al (1993). The glycoprotein was hydrolysed by neuraminidase, and the sialic acid was cleaved by the second enzyme N-acetyl neuraminic acid adolase, which produced pyruvate. The pyruvate was oxidized by the pyruvate oxidase in the presence of FAD and the hydrogen peroxide released was measured colorimetrically by peroxidase in the presence of 4-amino antipyrine and N-ethyl-N-2-hydroxyethyl-3-toluidine, when a red product was formed. The optical density was measured at 630 nm using a MRX ELISA reader. The above assay was adapted so that the reaction could be carried out on microtiter plates. Standard curves for both the enzymatic and resorcinol-periodate method ranging from 0 to 1.0 μmole were plotted using N-acetyl neuraminic acid obtained from the manufacturer (Sigma). Pyruvate, in the range of 0.3-0.7 mg/100 ml, did not interfere with the chemical assay.

Statistical analysis

Data were expressed as mean ± standard deviation. The coefficient of variation was calculated using SPSS and Microsoft EXCEL packages.

RESULTS

From Table 1, the mean sialic acid concentration for the control subjects using enzymatic assay method was 1.747±0.047 mmole/l and for the chemical method it was 1.753±0.067 mmole/l. For the enzymatic assay, the intra- and inter-assay coefficients of variation were 1.96% and 2.69%, respectively. The corresponding values for the chemical assay were 2.73% and 3.82 %, respectively. The mean sialic acid concentration for the subjects with IGT using enzymatic assay method was 2.583±0.070 mmole/l and for the chemical method it was 2.591±1.02 mmole/l. For the enzymatic assay, the intra- and inter-assay coefficients of variation were 1.58% and 2.72%, respectively. The corresponding values for the chemical assay were 2.43% and 3.95 %, respectively.
From Table 2, the 95% confidence intervals for the mean sialic acid concentrations for control subjects using the enzymatic and chemical methods were 1.726, 1.768 and 1.724, 1.782, respectively. For subjects with IGT, the 95% confidence interval for the mean sialic acid concentration using the enzymatic and chemical methods were 2.552, 2.614 and 2.144, 3.038, respectively.

**REFERENCES**


