Leptin, malnutrition, and immune response in rural Gambian children

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Background: The adipocyte derived hormone, leptin, has cytokine like function and may mediate the effects of starvation on immunity. Mice with congenital leptin deficiency (ob/ob) have small hypocellular thymuses and impaired cellular immunity. In humans leptin influences the differentiation of naive and memory cells in vitro, and genetic leptin deficiency has been associated with an ill defined susceptibility to infection.

Aims: To describe the in vivo relation of leptin and immune function in children.

Methods: Fasting plasma leptin concentrations, immune function (T and B cell mediated vaccine responses and delayed type hypersensitivity), and mucosal function (dual sugar permeability test and salivary sIgA concentrations) were measured in a cohort of 472 moderately undernourished rural Gambian children.

Results: Leptin concentrations correlated with body fat assessed by mid upper arm circumference or BMI for age Z scores, and were very low compared to well nourished European norms (males 1.8 v 11.1 ng/ml; females 2.4 v 13.8 ng/ml). No detectable relations were found between leptin concentrations and any of the measures of immune or mucosal function.

Conclusions: The data confirm that leptin acts as a peripheral signal of energy restriction, but do not support an association between fasting plasma leptin levels and immune function in children of this age.

METHODS

Study design

A total of 472 children (aged 7–9 years; mean 8.00 (SD 0.68) years) were recruited from rural villages in the West Kiang region of The Gambia, West Africa. The subjects were the oldest children from a cohort studied from birth in the West Kiang Maternal Dietary Supplementation Trial. Children were drawn from both the intervention and control arms of the trial. We have shown that the prenatal intervention had no detectable effect on the immune function in this cohort. The nutritional status of these children followed the characteristic pattern for the region. Low birth weight (~2850 g) is followed by centile catch up in the first three months of life when fully breast fed. There follows a precipitate deterioration in nutritional status to about ~2 Z scores for weight-for-age by 12 months.

Abbreviations: ACT, α, antichymotrypsin; BMI, body mass index; CMI, cell mediated immunity; DTH, delayed type hypersensitivity; IL, interleukin; MUAC, mid upper arm circumference; sIgA, secretory immunoglobulin A; TNFα, tumour necrosis factor alpha
months. A very gradual recovery occurs in later childhood (see table 1 for nutritional status when studied).

At baseline subjects were brought to the field laboratory in the early morning after an overnight fast. Weight, height, and mid upper arm circumference (MUAC) were measured. The dual sugar (lactulose–mannitol) test was performed as a measure of small intestinal integrity (permeability).

This has been shown to correlate with a chronic gastrointestinal inflammation and an excessive mucosal Th1 response (DI Campbell, personal communication). A sample of saliva was collected for measurement of salivary concentrations of secretory IgA (sIgA), and a venous blood sample was collected for assessment of antibody response to the first rabies vaccination. On day 30 a second rabies vaccination was given. At the same visit, a second finger prick blood sample was obtained for assessment of antibody response to the Pneumovax vaccine. On day 60 a final finger prick blood sample was collected for the second measurement of rabies antibodies.

Laboratory analysis

Plasma leptin concentrations were determined using a well characterised commercially available human leptin radioimmunoassay kit (Linco Research Inc., St Charles, Missouri). The limit of sensitivity was 0.5 ng/ml, the intra-assay CV was 5.1%, and the interassay CV was 2.8%. Urinary lactulose and mannitol were measured by an automated enzymatic assay using the Cobas-Bio centrifugal analyser, as described previously. The interassay CVs were 5.83% for the lactulose and 6.63% for the mannitol. Salivary concentrations of sIgA were measured by ELISA using an adapted method of the procedure developed for determination of breast milk antimicrobial factors. The interassay CV was 5.7%. Plasma ACT was measured by nephelometric assay using the Cobas-Bio centrifugal analyser (Roche Diagnostica Instruments, Basle, Switzerland). All assays were performed at MRC Human Nutrition Research, Cambridge.

Antibody levels against the pneumococcal polysaccharide vaccine were measured at the Department of Immunobiology, Institute of Child Health, London. Antibody responses were tested against four polysaccharides (types 1, 5, 14, and 23). Antibodies against four polysaccharides were tested against four polysaccharides (types 1, 5, 14, and 23). Antibodies against four polysaccharides (types 1, 5, 14, and 23). Antibodies against four polysaccharides (types 1, 5, 14, and 23).

On day 16 a finger prick blood sample was collected for assessment of antibody response to the first rabies vaccination. On day 30 a second rabies vaccination was given. At the same visit, a second finger prick blood sample was obtained for assessment of antibody response to the Pneumovax vaccine. On day 60 a final finger prick blood sample was collected for the second measurement of rabies antibodies.

Ethical approval

Ethical approval for the study was obtained from the joint Gambian Government/MRC The Gambia ethical committee. Informed consent was obtained from all parents/guardians of the participating children.

Table 1

| Table 1 Mean (SD) anthropometry and plasma leptin concentrations by gender |
|-----------------|-----------------|-----------------|
| Males (n=251)   | Females (n=221)  | p value         |
| Age (years)     | 8.01 (0.69)     | 8.00 (0.68)     | 0.823 |
| Weight (kg)     | 20.9 (2.71)     | 20.7 (2.70)     | 0.409 |
| Height (cm)     | 121.7 (8.94)    | 121.6 (5.99)    | 0.169 |
| BMI (kg/m²)     | 14.00 (1.01)    | 13.89 (1.04)    | 0.266 |
| MUAC (mm)       | 160.4 (15.1)    | 165.6 (13.3)    | ≤0.0001 |
| Weight for age Z score | −1.63 (1.01) | −1.53 (0.83) | 0.253 |
| Height for age Z score  | −1.00 (0.86) | −0.89 (0.94) | 0.184 |
| BMI for age Z score       | −1.44 (0.92)   | −1.42 (0.77)    | 0.822 |
| Plasma leptin (ng/ml)   | 1.83 (0.48)    | 2.36 (0.91)     | ≤0.0001 |

Figure 1

Deciles of plasma leptin by gender. Data are presented as the mean per decile group of the cohort.
were no significant differences between the males and females for weight and height, but the MUAC was significantly greater in the female children. The mean (SD) leptin concentration was 2.08 (0.76) ng/ml. Leptin concentrations were significantly greater in the female children (2.36 (0.91) vs 1.83 (0.48), p = 0.0001). Figure 1 shows the leptin concentrations by deciles of leptin for the genders separately. The female children in the study showed a significantly greater range of values than the males (females 0.86–9.31 ng/ml; males 0.97–3.47 ng/ml).

Leptin concentrations were positively associated with MUAC (p ≤ 0.0001), positively associated with BMI for age Z scores (p ≤ 0.0001), but not associated with height for age Z scores (p = 0.079) (fig 2). The observed gender difference remained significant after adjustment for MUAC and BMI for age standard deviation scores (p ≤ 0.0001). Plasma leptin concentrations were not significantly associated to the age of the children within the narrow age range studied (p = 0.24).

**Leptin and immune function**

None of the measures of immune or mucosal function were significantly related to plasma leptin concentrations for either the male, or the female children in the study. Results are illustrated by deciles of leptin concentration for female subjects only, as they showed the greater range of leptin. Figure 3 shows the vaccination responses (rabies response after the first dose of the vaccine, and serotypes 1, 5, and 23 responses to the pneumococcal vaccine). Figure 4 shows the CMI response, lactulose/mannitol ratio, salivary sIgA, and ACT levels. There was a similar absence of any relation in the boys and when the sexes were combined.

**DISCUSSION**

The children in this study were suffering from moderate to moderately severe protein energy undernutrition (being both underweight and short), with mean BMI for age standard deviation scores of –1.44 and –1.42 for the males and females.
respectively. A quarter of the children had a BMI for age below −2 Z scores. Such patterns are quite typical for rural children in many areas of the developing world. The corresponding plasma leptin concentrations were 1.83 ng/ml for the males and 2.36 ng/ml for the females. Consistent with previous studies, plasma leptin concentrations were significantly related to the measures of body fat (MUAC and BMI for age Z scores), but not to the measure of stature (height for age Z scores). The Gambian leptin concentrations were considerably lower than those reported in previous studies from well nourished children of a similar age.

For example, the median plasma leptin concentrations of 8–10 year old Italian children (also assayed using the Linco kit) were sixfold higher at 11.1 and 13.8 ng/ml for males and females respectively. Corresponding BMI Z scores (also calculated using the LMS method of Cole) for the Italian children were +1.06 and +0.82.

In this study antibody responses to both the pneumococcal and the rabies vaccine were significantly greater in the female children (data not presented). Their greater fat mass and higher circulating leptin may have a role to play in this improved response. However, this did not emerge from correlation analysis of plasma leptin with the range of in vivo indices of immune function used, all of which are variably dependent on T cell function, but also include significant elements of B cell and macrophage function. Most responses were probably secondary but there was also no association with the first dose of rabies vaccine, which can be assumed to be a novel antigen to most, if not all, of the subjects. The lack of association was not accounted for by the confounding effect of infection in stimulating leptin secretion, as there was no relation with an acute phase reactant (α, antichymotrypsin). A type II statistical error can also be eliminated as the sample size was very large and the precision of the vaccine responses was sufficient to detect significant age trends for vaccine responses, even within the narrow age group studied (data not presented here).

This suggests that in humans leptin concentrations as low as one sixth of those found in well nourished children do not significantly suppress protective cognate immunity; a finding that is consistent with the majority of published data on the physiology of leptin secretion and its relation to infection and immunity.

Humans and mice genetically deficient in leptin do not have major susceptibility to infection or opportunistic infections. One human kindred shows an excess of death from infections in childhood, but no consistent immunodeficiency was detected or shown in mice. However, there are convincing data that leptin has direct activity on thymocytes and circulating mature T cells. Low concentrations of leptin are responsible for the reduced size and cellularity of the thymus in the ob/ob mouse, and starvation induced thymic involution in normal mice. In both cases this can be shown to be caused by increased apoptosis in CD4+ T cells, which is reversed by exogenous leptin. mRNA of the leptin receptor isoform responsible for intracellular signalling is expressed in highly purified resting human CD4+ T cells. This is reflected in effects of leptin (sometimes at supraphysiological concentrations) on

![Figure 3](http://adc.bmj.com/blob/10.1136/adc.87.3.192/fig3.png)
T cell function in vitro, mainly confined to naïve cells and primary responses.

The inhibitory effect of low leptin concentrations on murine thymopoiesis and human in vitro T cell responses does not translate into compromised specific immune responses in these malnourished children. This may partly be because leptin mainly affects the proliferation of naïve T cells, and most of the subjects will have had exposure to pneumococcal polysaccharide and the antigens used to assess CMI. However, at least one primary specific response is also preserved as the first dose of rabies vaccine was a novel (naïve) antigen. Ninety-four per cent of subjects made a protective response after the first dose and 99.6% after two doses.

One interpretation consistent with these data and with the emerging role of leptin as a major regulator of energy expenditure is that malnutrition-induced hypoleptinaemia inhibits non-essential physiological processes as suggested previously. However, though this may include thymopoiesis, which in postnatal life is mainly concerned in maintaining an already established T cell repertoire in an energy inefficient way, it does not appear to include the inhibition of secondary immune responses. Secondary responses are relatively parsimonious in energy utilisation as they involve expansion of a limited number of clones of memory T and B cells. Even some primary responses requiring the expansion of a limited number of specific precursors are preserved. This supports the apparently inconsistent findings that thymic involution is an exquisite barometer of starvation with the lack of evidence of a significant T cell immunodeficiency in malnutrition, and is consistent with an immune system which has evolved during intermittent periods of starvation on a hunter-gatherer population.

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Leptin, malnutrition, and immune response in rural Gambian children

197


