



# Ambulant 24-h glucose rhythms mark calendar and biological age in apparently healthy individuals

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## Abstract

**Glucose metabolism marks health and disease and is causally inferred in the aging process. Ambulant continuous glucose monitoring provides 24-h glucose rhythms under daily life conditions. We aimed to describe ambulant 24-h glucose rhythms measured under daily life condition in relation to calendar and biological age in apparently healthy individuals. In the general population and families with propensity for longevity, we studied parameters from 24-h glucose rhythms; glucose levels; and its variability, obtained by continuous glucose monitoring. Participants were 21 young (aged 22–37 years), 37 middle-aged (aged 44–72 years) individuals from the general population, and 26 middle-aged (aged 52–74 years) individuals with propensity for longevity. All were free of diabetes. Compared with young individuals, middle-aged individuals from the general population had higher mean glucose levels (5.3 vs. 4.7 mmol L<sup>-1</sup>,  $P < 0.001$ ), both diurnally ( $P < 0.001$ ) and nocturnally ( $P = 0.002$ ). Glucose variability was higher in the middle-aged compared with the young (standard deviation 0.70 vs. 0.57 mmol L<sup>-1</sup>,  $P = 0.025$ ). Compared with middle-aged individuals from the general population, middle-aged individuals with propensity for longevity had lower overall mean glucose levels (5.2 vs. 5.4 mmol L<sup>-1</sup>,  $P = 0.047$ ), which were more different nocturnally (4.8 vs. 5.2 mmol L<sup>-1</sup>,  $P = 0.003$ ) than diurnally (5.3 vs. 5.5 mmol L<sup>-1</sup>,  $P = 0.14$ ). There were no differences in glucose variability between these groups. Results were independent of body mass index. Among individuals without diabetes, we observed significantly different 24-h glucose rhythms depending on calendar and biological age.**

**Key words:** aging; continuous glucose monitoring; endocrinology; Glucose metabolism; human; longevity.

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## Introduction

Insulin resistance and disturbances in glucose handling are highly prevalent with increasing age, and predict the incidence of many age-related diseases, including cardiovascular events, diabetes, cancer, and dementia (Facchini *et al.*, 2001; Stumvoll *et al.*, 2008; Ronnema *et al.*, 2009). The insulin-IGF-1 signaling pathway is causally related to the aging process in experimental models (reviewed in (van Heemst, 2010)). In human studies, long-lived individuals often seem protected against age-associated deteriorations in glucose metabolism. For example, centenarians show an enhanced insulin sensitivity similar to middle-aged individuals (Paolisso *et al.*, 1996). Moreover, middle-aged individuals with propensity for longevity have a lower prevalence of diabetes and metabolic syndrome at middle age, and – among individuals without diabetes – are more glucose tolerant and insulin sensitive compared with controls matched for age and environment (Westendorp *et al.*, 2009; Rozing *et al.*, 2010; Wijnsman *et al.*, 2011). These individuals also have a lower mortality compared with their birth cohort and may be considered biologically younger than individuals from the general population of similar calendar age (Schoenmaker *et al.*, 2006). Together, these findings suggest that preservation of efficient glucose handling might be one of the important mechanisms involved in reaching a healthy old age.

Studying glucose metabolism beyond the generally used screening methods, such as venous blood glucose measurements or glycated hemoglobin (HbA1c), often requires methods that are either nonphysiological or highly invasive, such as the oral glucose tolerance test and the hyperinsulinemic-euglycemic clamp study. In sharp contrast, continuous glucose monitoring is a minimally invasive method to calculate blood glucose concentration from interstitial fluid via a glucose sensor implanted in the subcutaneous tissue. As such, it enables dynamic ambulant monitoring under everyday-life conditions. Continuous glucose monitoring was introduced into clinical practice primarily to be used as a tool to lower HbA1c in patients with diabetes. Thus far, continuous glucose monitoring has rarely been used in research settings in individuals without diabetes. One recent study reports an association between increasing age and mean glucose levels obtained by continuous glucose monitoring (Zhou *et al.*, 2009). As continuous glucose monitoring generates almost three hundred glucose measurements daily, it allows for detailed characterization of 24-h glucose rhythms, for instance by studying mean diurnal or nocturnal glucose levels, or measures of glucose variability. As yet, it is unknown how these novel parameters derived from 24-h glucose rhythms relate to the aging process.

Here, we describe associations of 24-h glucose rhythms with calendar and biological age in individuals free of diabetes. We compare parameters of 24-h glucose rhythms between three

groups: young and middle-aged from the general population and middle-aged with propensity for longevity.

## Results

Table 1 shows the baseline characteristics of young individuals, middle-aged individuals from the general population, and middle-aged individuals with propensity for longevity. Mean age was slightly but nonsignificantly higher in the middle-aged with propensity for longevity compared with the middle-aged from the general population. In the individuals with propensity for longevity, the percentage of females was lower (39%) than in the groups of young and middle-aged from the general population (59% and 51%, respectively). All subsequent analyses were therefore adjusted for gender. In all groups, mean body mass index (BMI) was within normal range. All groups had on average similar number of continuous glucose monitoring readings.

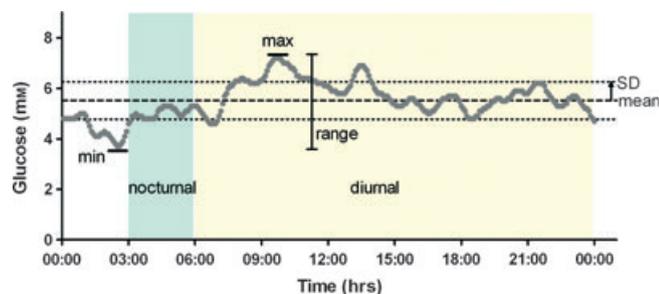
Figure 1 shows a representative 1-day example glucose rhythm of a middle-aged individual from the general population with depiction of several calculated parameters of mean glucose levels and variability.

To assess which parameters of 24-h glucose rhythm associated with calendar age, we first compared different parameters of 24-h glucose rhythms between young and middle-aged from the general population. Visual inspection of Fig. 2a reveals that compared with

**Table 1** Baseline characteristics

| Characteristics                                      | General population |             | Propensity for longevity |
|--|--------------------|-------------|--------------------------|
|  | Young              | Middle-aged | Middle-aged              |
| Number   | 21                 | 37          | 26                       |
| Female gender, <i>n</i> (%)                          | 13 (59.1)          | 19 (51.4)   | 10 (38.5)                |
| Age, years   | 26.9 (4.3)         | 60.6 (7.5)  | 63.7 (5.8)               |
| Weight, kg   | 69.9 (10.9)        | 76.0 (10.2) | 75.5 (12.2)              |
| Body mass index, kg m <sup>-2</sup>                  | 22.6 (1.9)         | 24.9 (3.1)  | 24.2 (3.3)               |
| Number of continuous glucose monitoring observations | 959 (126)          | 860 (101)   | 825 (15)                 |

Data represent mean with standard deviation unless stated otherwise. Number of continuous glucose monitoring observations represents number of readings per subject.

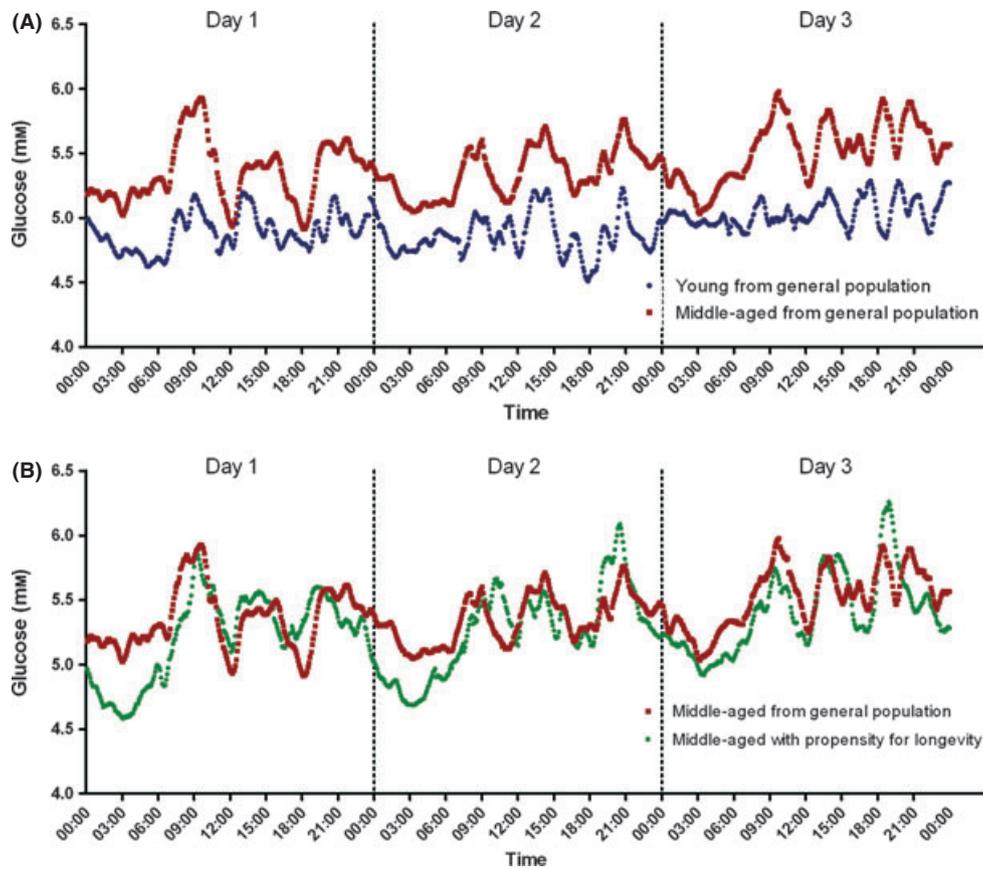


**Fig. 1** Representative result of 24 h of continuous glucose monitoring in a middle-aged individual from the general population. Data represent 5-min interval glucose levels. Nocturnal was defined as time between 03:00 and 06:00 hours. Diurnal was defined as time between 06:00 and 00:00 hours.

the group of young from the general population, the middle-aged had lower mean glucose levels during all time points. Table 2 depicts the differences in parameters of glucose levels (mean, diurnal, and nocturnal) as well as parameters of glucose variability such as range, total standard deviation, mean of daily differences, and continuous net glycemic action. After adjustment for gender, middle-aged individuals from the general population showed higher mean glucose levels compared with young (5.3 vs. 4.7 mmol L<sup>-1</sup>,  $P < 0.001$ ), as well as higher diurnal (5.5 vs. 4.9 mmol L<sup>-1</sup>,  $P < 0.001$ ) and higher nocturnal glucose levels (5.2 vs. 4.8 mmol L<sup>-1</sup>,  $P = 0.002$ ). Furthermore, middle-aged individuals had higher fasted glucose (5.2 vs. 4.7 mmol L<sup>-1</sup>,  $P = 0.001$ ) and a higher maximum glucose (7.8 vs. 6.9 mmol L<sup>-1</sup>,  $P = 0.003$ ), but similar minimum glucose levels. Glucose variability was higher in middle-aged individuals as measured by total standard deviation (0.70 vs. 0.57 mmol L<sup>-1</sup>,  $P = 0.025$ ), continuous net glycemic action over a 4-h period (0.90 vs. 0.70 mmol L<sup>-1</sup>,  $P = 0.009$ ), and mean of daily differences, although of borderline statistical significance (0.73 vs. 0.61 mmol L<sup>-1</sup>,  $P = 0.066$ ).

To test whether 24-h glucose rhythms mark differences in biological age, we compared parameters of 24-h glucose rhythms between middle-aged from the general population with middle-aged with propensity for longevity. Visual inspection of the cumulative curves in Fig. 2b reveals that middle-aged with the propensity for longevity showed lower glucose levels during nocturnal hours. Table 2 shows the differences in these parameters after adjustment for age and gender. The middle-aged with propensity for longevity showed significantly lower mean glucose levels (5.2 vs. 5.4 mmol L<sup>-1</sup>,  $P = 0.047$ ) which were driven by a significantly lower nocturnal glucose concentration (4.8 vs. 5.2 mmol L<sup>-1</sup>,  $P = 0.003$ ), and less outspoken differences in diurnal glucose levels (5.3 vs. 5.5 mmol L<sup>-1</sup>,  $P = 0.14$ ), in comparison with the middle-aged from the general population. Fasted glucose levels were also significantly lower in the middle-aged with the propensity for longevity (4.9 vs. 5.2 mmol L<sup>-1</sup>,  $P = 0.021$ ). No differences were found in any parameters of glucose variability between the groups.

We then explored whether the observed differences between groups could be explained by BMI. First, after adjustment for age and gender, we observed no association between BMI and parameters of 24-h glucose rhythms among the young and middle-aged from the general population. Next, we repeated the analyses in Table 2 now adjusting for BMI. Between the young and middle-aged from the general population, we found that the differences in mean glucose remained similar (4.9 vs. 5.4 mmol L<sup>-1</sup>,  $P < 0.001$ ), as did the other differences in parameters of 24-h glucose rhythms. Finally, we assessed whether the difference in nocturnal glucose between groups of middle-aged with propensity for longevity and the general population was dependent on BMI. After adjustment for BMI, the differences in nocturnal glucose between middle-aged with propensity for longevity and middle-aged from the general population remained similar (4.8 vs. 5.2 mmol L<sup>-1</sup>,  $P = 0.004$ ). As sensitivity analysis, further exclusion of two participants of the middle-aged from the general population who reached the criteria for obesity (BMI >30) also did not materially change this difference (4.8 vs. 5.2 mmol L<sup>-1</sup>,  $P = 0.006$ ).



**Fig. 2** (A,B) Mean glucose rhythms during 72 h of groups of (A) young ( $n = 21$ ) vs. middle-aged from the general population ( $n = 37$ ), and (B) middle-aged from the general population vs. middle-aged with propensity for longevity ( $n = 26$ ). Data points represent mean 5-min intervals of glucose levels.

## Discussion

The main findings of this study are twofold. First, we observed a significant difference in most parameters of 24-h glucose rhythms with different calendar age. Second, we observed lower mean glucose levels driven by nocturnal glucose levels in individuals with propensity for longevity compared with middle-aged individuals from the general population. Our findings may provide new insights into early markers of decrease in glucose handling and diabetes in relation to chronological and biological age.

Calendar age associated with all parameters of glucose levels and its variability in our study. Most previous studies using continuous glucose monitoring have focussed on the effect of glucose monitoring on therapeutic outcomes, such as the effect on HbA1c in type 1 or type 2 diabetics (Gandhi *et al.*, 2011; Pickup *et al.*, 2011). Others have assessed associations between glucose rhythms and disease in patients with diabetes (Colette & Monnier, 2007; Monnier *et al.*, 2007; Rizzo *et al.*, 2010; Di *et al.*, 2011; Siegelar *et al.*, 2011), or focussed on the role of glucose variability in patients in an intensive care unit (Egi *et al.*, 2006; Dossett *et al.*, 2008; Krinsley, 2008). Few studies have assessed glucose rhythms in nondiabetic individuals, and data on the relationship between aging and parameters of continuous glucose monitoring are scarce. In a Chinese study in over four hundred healthy lean individuals, 24-h

mean blood glucose levels were found to be higher with increasing age (Zhou *et al.*, 2009), and total standard deviation was also slightly higher with increasing age (Zhou *et al.*, 2011). However, other parameters were not reported in this study. A study in eighteen healthy subjects aged between 20- and 40 years old also found an increased mean blood glucose levels with increasing age (Derosa *et al.*, 2009). In the subset of nondiabetic subjects from the Juvenile Diabetes Study, this relationship was not seen (Fox *et al.*, 2010). However, in this particular study most participants were child or adolescent. In our study, in which we systematically studied 10 different parameters from 24-h glucose rhythms, we found higher overall mean glucose levels and standard deviation in middle-aged compared with young individuals. Moreover, we found that these differences were found in both diurnal and nocturnal glucose levels, and in maximum, but not minimum, glucose levels. These findings suggest that, with increasing calendar age in individuals without diabetes, there is a deterioration of overall glucose handling. This could be reflected by gradual loss of both the glucose 'thermostat', i.e. the low glucose threshold the body aims at keeping stable as well as the variability around this threshold, which could reflect a loss of ability to adequately respond to stimuli like the insulin response upon meals.

Earlier, in the Leiden Longevity study, we found differences in nonfasting glucose levels, glucose tolerance, and insulin sensitivity

**Table 2** Differences in parameters of 24-h glucose rhythms between study groups of different calendar and biological age

|   | General population     |                              | Propensity for longevity<br>Middle-aged<br><i>n</i> = 26 | <i>P</i> -value <sup>‡</sup> | <i>P</i> -value <sup>§</sup> |
|---|------------------------|------------------------------|--|------------------------------|------------------------------|
|   | Young<br><i>n</i> = 21 | Middle-aged<br><i>n</i> = 37 |  |                              |                              |
| Glucose levels  |                        |                              |  |                              |                              |
| Overall mean glucose                                  | 4.91                   | 5.41                         | 5.19   | <b>&lt;0.001</b>             | <b>0.047</b>                 |
| 95% C.I.  | 4.73–5.07              | 5.28–5.54                    | 5.03–5.34  |                              |                              |
| Diurnal glucose (06:00–00:00 hrs)                     | 4.93                   | 5.48                         | 5.32   | <b>&lt;0.001</b>             | 0.14                         |
| 95% C.I.  | 4.75–5.11              | 5.35–5.61                    | 5.16–5.48  |                              |                              |
| Nocturnal glucose (03:00–06:00 hrs)                   | 4.80                   | 5.17                         | 4.80   | <b>0.002</b>                 | <b>0.004</b>                 |
| 95% C.I.  | 4.61–5.00              | 5.03–5.32                    | 4.62–4.97  |                              |                              |
| Mean fasted glucose                                   | 4.73                   | 5.15                         | 4.87   | <b>0.001</b>                 | <b>0.021</b>                 |
| 95% C.I.  | 4.52–4.95              | 5.00–5.31                    | 4.68–5.06  |                              |                              |
| Glucose variability                                   |                        |                              |  |                              |                              |
| Minimum   | 3.45                   | 3.59                         | 3.50   | 0.37                         | 0.72                         |
| 95% C.I.  | 3.10–3.70              | 3.40–3.78                    | 3.27–3.72  |                              |                              |
| Maximum   | 6.89                   | 7.80                         | 7.86   | <b>0.003</b>                 | 0.87                         |
| 95% C.I.  | 5.40–7.38              | 7.43–8.16                    | 7.41–8.30  |                              |                              |
| Range   | 3.44                   | 4.21                         | 4.36   | <b>0.045</b>                 | 0.79                         |
| 95% C.I.  | 2.82–4.06              | 3.74–4.67                    | 3.80–4.92  |                              |                              |
| Total standard deviation (SDt) <sup>†</sup>           | 0.57                   | 0.70                         | 0.72   | <b>0.025</b>                 | 0.78                         |
| 95% C.I.  | 0.49–0.66              | 0.62–0.78                    | 0.63–0.82  |                              |                              |
| Continuous net glycaemic action (CONGA4) <sup>†</sup> | 0.70                   | 0.90                         | 0.90   | <b>0.009</b>                 | 1.00                         |
| 95% C.I.  | 0.60–0.81              | 0.80–1.01                    | 0.79–1.04  |                              |                              |
| Mean of daily differences (MODD) <sup>†</sup>         | 0.61                   | 0.73                         | 0.71   | 0.066                        | 0.73                         |
| 95% C.I.  | 0.53–0.71              | 0.63–0.82                    | 0.62–0.81  |                              |                              |

Data represent means with 95% confidence intervals in mmol L<sup>-1</sup>.

<sup>†</sup>Geometric means due to skewness of data.

<sup>‡</sup>*P*-value for difference between young and middle-aged from general population, with adjustment for gender.

<sup>§</sup>*P*-value for difference between middle-aged from general population and middle-aged with propensity for longevity, with adjustment for age and gender.

The bold text marks statistical significance.

in offspring of nonagenarian sibling compared with controls (Westendorp *et al.*, 2009; Rozing *et al.*, 2010; Wijnsman *et al.*, 2011), reflecting differences in insulin-dependent glucose metabolism. Our main finding now is a difference in a fasted state at night time during sleep which reflects a noninsulin-dependent glucose level. Despite prolonged fasting during night time, earlier studies show that nocturnal glucose levels remain stable or fall only minimally, contrasting with day time fasting during which glucose levels fall more prominently (Cauter *et al.*, 1991). This shows that counterregulatory mechanisms operate during the night to prevent glucose levels from falling. One of these is growth hormone, the production of which is induced during sleep onset. This, in combination with decreased glucose utilization, results in increasing glucose levels during the beginning of the night (Cauter *et al.*, 1991). In the second half of the night, glucose levels return to baseline, potentially due to attenuation of the inhibiting effect of growth hormone on tissue glucose uptake (Moller *et al.*, 1989), increased glucose utilization during REM-sleep and waking periods (Scheen *et al.*, 1996), or as a delayed response to low cortisol levels in the late evening and early night (Plat *et al.*, 1996). Potentially, alterations in sleeping patterns in hormonal regulation might explain the lower nocturnal glucose in the end of the night related to biological age in our study. Furthermore, individuals with propensity for longevity might represent a rare phenotype

that is specifically characterized by overall enhanced glucose metabolism through mechanisms that differ from the etiology of metabolic disturbances in the general population, such as physical inactivity or obesity. Earlier we found that neither the genetic burden of disease susceptibility genes in general (Beekman *et al.*, 2010), nor diabetes risk alleles (Mooijaart *et al.*, 2011), explained the observed differences in glucose metabolism. In addition, middle-aged individuals with propensity for longevity have shown not to differ in environmental factors related to metabolism, such as body composition or physical activity or other lifestyle parameters such as smoking, compared with controls from the general population (Rozing *et al.*, 2010). Speculating further, perhaps the explanation of our findings could be found in other mammals with the longevity phenotype, which have shown for example enhanced fatty acid over glucose oxidation, lower core body temperature, and higher metabolic rate (Westbrook *et al.*, 2009). In line with these findings we reported in the same study population that the middle-aged individuals had lower levels of intramyocellular lipid content, which may be the result of decreased muscle fatty acid oxidation (Wijnsman *et al.*, 2012). Further research should investigate whether differences in circadian hormone rhythms, sleep quality, or differences in metabolic rate can explain our findings of nocturnal differences in glucose related to familial longevity.

In this study we aimed to assess glucose rhythms in a setting that optimally resembles daily life. Therefore, we did not record, or standardize on, food intake or physical activity in detail. Based on these methods, our results are of descriptive nature. Physical activity is a powerful modulator of glucose excursions, also on very short term (Mikus *et al.*, 2012a,b). Therefore, differences in physical activity patterns with age might be an important lifestyle factor that could have modulated our findings. We aimed to minimize the influence of differences in body fat on the observed relations between glucose rhythms and age by further adjusting for residual differences in BMI, but we cannot rule out the possibility that differences in other body fat parameters could account for the observed results. Further study should elucidate the role of physical activity and detailed body composition in 24-h glucose rhythms. In this study glucose variability was expressed using SD, CONGA4, and MODD. We do not report on another commonly used parameter for glucose variability, mean amplitude of glycemic excursion (MAGE) (Service *et al.*, 1970). MAGE was not specifically designed for CGM and uses arbitrary cut-off points, which might wrongfully ignore smaller glucose excursions. Other measures that do take into account all glucose excursions, such as CONGA and SD, show strong correlations ( $r > 0.85$ ) with MAGE (Rodbard, 2009; Borg *et al.*, 2010; Siegelaar *et al.*, 2010), indicating that reporting MAGE does not yield additive information. Furthermore, SD and CONGA are less difficult to compute with the large number of data obtained with CGM and easier to explain to patients and colleague. For these reasons, we believe MAGE not to be an important parameter for the analysis of CGM and chose not to report on it in this study. A limitation of CGM is the time lag between blood glucose and interstitial glucose levels, estimated to be within 5 and 15 min, which could lead to inaccuracies between CGM readings and actual blood glucose levels. Furthermore, calibration should ideally be performed when glucose levels are steady state, which we have tried to optimize by instructing participants to measure capillary glucose before meals.

Strength of our study is that we have used a systematic approach to analyze different parameters of 24-h glucose rhythms, yielding a detailed analysis of mean glucose levels and variability. Furthermore, we used a unique cohort to study determinants of familial longevity using the Leiden Longevity Study. Using married couples, we have included individuals different in propensity for longevity, but similar in lifestyle factors. Furthermore, different subcohorts from this study population have consistently shown better glucose handling in middle-aged offspring of long-lived families compared with their partners, which strengthens the reliability of our findings of better glucose handling in relation to familial longevity and biological age. Moreover, we are, to our knowledge, the first to have used continuous glucose monitoring to study glucose rhythms in relation to familial longevity.

We have successfully used continuous glucose monitoring in healthy individuals to describe associations between glucose rhythms and calendar and biological age. Further studies should use continuous glucose monitoring to study glucose metabolism in normal daily life. Moreover, parameters of continuous glucose monitoring should be used to monitor the effects of interventions aimed at improving glucose metabolism at a larger scale and

further unravel the associations between glucose metabolism and healthy aging.

## Methods

### Participants

To study the relation between 24-h glucose rhythms and biological age, we included participants with propensity for longevity from the Leiden Longevity Study (LLS). The LLS comprises 421 families, whose characteristics have been more extensively described earlier (Schoenmaker *et al.*, 2006). Briefly, families were recruited if at least two long-lived siblings were alive and were 89 years or older for men and 91 years or older for women. There were no selection criteria on health or demographic characteristics. Because no proper controls exist for this age group, for further studies the offspring of these long-lived nonagenarians was recruited. These middle-aged individuals carry on average 50% of the genetic advantage of their long-lived parent and were shown to have a 35% lower mortality rate compared with their birth cohort (Schoenmaker *et al.*, 2006). Their partners with whom most have had a relationship and shared environment for decades were included as population-based environment matched middle-aged individuals.

To study the association between 24-h glucose rhythms and calendar age, we recruited from the medical faculty a group of healthy lean volunteers to represent subjects with a low calendar age, i.e. young individuals.

In total, we included 21 young healthy individuals. From long-lived families we included 26 middle-aged individuals with propensity for longevity. We included 26 middle-aged partners of the individuals from long-lived families, plus an additional 11 lean, middle-aged individuals. All middle-aged participants had participated in another study involving 7 Tesla MRI, for which they were screened on major health criteria, and were all considered apparently healthy. All were free of diabetes. The Medical Ethical Committee of the Leiden University Medical Centre approved the study, and informed consent was obtained from all subjects.

### Continuous glucose monitoring

The Mini-Med<sup>®</sup> Continuous glucose monitoring System (Medtronic MiniMed Inc., Northridge, CA, USA) was applied. A glucose sensor (Sof-Sensor<sup>®</sup>; Medtronic MiniMed Inc.) was inserted into the subcutaneous abdominal fat tissue to monitor glucose levels of interstitial fluid for four consecutive days. Participants were engaged in their normal daily activities throughout the whole period. For calibration purposes, participants were instructed to perform self-monitoring of capillary blood glucose four times daily using a handheld glucose meter (Bayer CONTOUR<sup>®</sup>). Participants were instructed to record at least three calibration readings the first day and four calibration readings during day 2, 3, and 4. During the study period, participants registered information on time of food intake.

Results were considered valid if at least two valid calibrations were performed on day 1, and at least three valid calibrations were performed on day 2, 3, and 4.

## Anthropometrics

During the visit height and weight were measured, and BMI was calculated.

## Calculations

From the recordings of the 24-h glucose rhythms we derived parameters of mean glucose levels: the overall mean glucose levels, mean nocturnal glucose levels (03:00–06:00), mean diurnal glucose levels (06:00–00:00), minimum and maximum glucose levels, and fasted glucose levels. Nocturnal hours were defined as such to optimally include resting hours without potential active or feeding behavior. Furthermore, we assessed parameters of glucose variability: range, total standard deviation (SD), mean of daily differences (MODD), and continuous overall net glycemic action over a 4-h period (CONGA4). Fasted glucose was defined as the mean of the first daily self-monitored capillary blood glucose measurements before breakfast. The MODD describes the between-day variability, calculated as the mean of the absolute difference of glucose values obtained at exactly the same time of day, from two consecutive days. The CONGA-n was defined as the standard deviation of the differences between the current observation and the observation n-hour previously (Rodbard, 2009). For accuracy reasons (according to manufacturers instruction), all continuous glucose values from the first hours until midnight of the first day of measurement were excluded. For all analyses, SPSS software (version 17.0) was used. Comparisons between groups were calculated using ANOVA with adjustment for gender and calendar age, when appropriate, and additional adjustment for BMI. A *P*-value <0.05 was considered statistically significant.

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## Author Contributions

All authors had full access to all data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis. All authors contributed significantly to the design, performance, analysis, and/or drafting of the manuscript. No conflicts of interest are reported.

## References

Beekman M, Nederstigt C, Suchiman HE, Kremer D, van der Breggen R, Lakenberg N, Alemayehu WG, de Craen AJ, Westendorp RG, Boomsma DI, de Geus EJ, Houwing-Duistermaat JJ, Heijmans BT, Slagboom PE (2010) Genome-wide association study (GWAS)-identified disease risk alleles do not compromise human longevity. *Proc. Natl Acad. Sci. USA* **107**, 18046–18049.

Borg R, Kuenen JC, Carstensen B, Zheng H, Nathan DM, Heine RJ, Nerup J, Borch-Johnsen K, Witte DR (2010) Associations between features of glucose exposure and A1C: the A1C-Derived Average Glucose (ADAG) study. *Diabetes* **59**, 1585–1590.

Cauter v, Blackman JD, Roland D, Spire JP, Refetoff S, Polonsky KS (1991) Modulation of glucose regulation and insulin secretion by circadian rhythmicity and sleep. *J. Clin. Invest.* **88**, 934–942.

Colette C, Monnier L (2007) Acute glucose fluctuations and chronic sustained hyperglycemia as risk factors for cardiovascular diseases in patients with type 2 diabetes. *Horm. Metab. Res.* **39**, 683–686.

Derosa G, Salvadeo SA, Mereu R, D'Angelo A, Ciccarelli L, Piccinni MN, Ferrari I, Gravina A, Maffioli P, Tinelli C (2009) Continuous glucose monitoring system in free-living healthy subjects: results from a pilot study. *Diabetes Technol. Ther.* **11**, 159–169.

Di FA, Picconi F, Di SP, Giordani I, Malandrucio I, Maggio P, Palazzo P, Sgreccia F, Peraldo C, Farina F, Fragele G, Frontoni S (2011) Impact of glycemic and blood pressure variability on surrogate measures of cardiovascular outcomes in type 2 diabetic patients. *Diabetes Care* **34**, 1605–1609.

Dossett LA, Cao H, Mowery NT, Dortch MJ, Morris JM Jr, May AK (2008) Blood glucose variability is associated with mortality in the surgical intensive care unit. *Am. Surg.* **74**, 679–685.

Egi M, Bellomo R, Stachowski E, French CJ, Hart G (2006) Variability of blood glucose concentration and short-term mortality in critically ill patients. *Anesthesiology* **105**, 244–252.

Facchini FS, Hua N, Abbasi F, Reaven GM (2001) Insulin resistance as a predictor of age-related diseases. *J. Clin. Endocrinol. Metab.* **86**, 3574–3578.

Fox LA, Beck RW, Xing D (2010) Variation of interstitial glucose measurements assessed by continuous glucose monitors in healthy, nondiabetic individuals. *Diabetes Care* **33**, 1297–1299.

Gandhi GY, Kovalaske M, Kudva Y, Walsh K, Elamin MB, Beers M, Coyle C, Goalen M, Murad MS, Erwin PJ, Corpus J, Montori VM, Murad MH (2011) Efficacy of continuous glucose monitoring in improving glycemic control and reducing hypoglycemia: a systematic review and meta-analysis of randomized trials. *J. Diabetes Sci. Technol.* **5**, 952–965.

van Heemst D (2010) Insulin, IGF-1 and longevity. *Aging Dis.* **1**, 147–157.

Krinsley JS (2008) Glycemic variability: a strong independent predictor of mortality in critically ill patients. *Crit. Care Med.* **36**, 3008–3013.

Mikus CR, Oberlin DJ, Libla J, Boyle LJ, Thyfault JP (2012a) Glycaemic control is improved by 7 days of aerobic exercise training in patients with type 2 diabetes. *Diabetologia* **55**, 1417–1423.

Mikus CR, Oberlin DJ, Libla JL, Taylor AM, Booth FW, Thyfault JP (2012b) Lowering physical activity impairs glycemic control in healthy volunteers. *Med. Sci. Sports Exerc.* **44**, 225–231.

Moller N, Butler PC, Antsiferov MA, Alberti KG (1989) Effects of growth hormone on insulin sensitivity and forearm metabolism in normal man. *Diabetologia* **32**, 105–110.

Monnier L, Colette C, Leiter L, Ceriello A, Hanefeld M, Owens D, Tajima N, Tuomilehto J, Davidson J (2007) The effect of glucose variability on the risk of microvascular complications in type 1 diabetes. *Diabetes Care* **30**, 185–186.

Mooijaart SP, van Heemst D, Noordam R, Rozing MP, Wijnsman CA, De Craen AJ, Westendorp RG, Beekman M, Slagboom PE (2011) Polymorphisms associated with type 2 diabetes in familial longevity: the Leiden Longevity Study. *Aging* **3**, 55–62.

Paolisso G, Gambardella A, Ammendola S, D'Amore A, Balbi V, Varricchio M, D'Onofrio F (1996) Glucose tolerance and insulin action in healthy centenarians. *Am. J. Physiol.* **270**, E890–E894.

Pickup JC, Freeman SC, Sutton AJ (2011) Glycaemic control in type 1 diabetes during real time continuous glucose monitoring compared with self monitoring of blood glucose: meta-analysis of randomised controlled trials using individual patient data. *BMJ* **343**, d3805.

Plat L, Byrne MM, Sturis J, Polonsky KS, Mockel J, Fery F, Van Cauter E (1996) Effects of morning cortisol elevation on insulin secretion and glucose regulation in humans. *Am. J. Physiol.* **270**, E36–E42.

Rizzo MR, Marfella R, Barbieri M, Boccardi V, Vestini F, Lettieri B, Canonico S, Paolisso G (2010) Relationships between daily acute glucose fluctuations and cognitive performance among aged type 2 diabetic patients. *Diabetes Care* **33**, 2169–2174.

Rodbard D (2009) New and improved methods to characterize glycemic variability using continuous glucose monitoring. *Diabetes Technol. Ther.* **11**, 551–565.

Ronnemaa E, Zethelius B, Sundelof J, Sundstrom J, Degerman-Gunnarsson M, Lannfelt L, Berne C, Kilander L (2009) Glucose metabolism and the risk of Alzheimer's disease and dementia: a population-based 12 year follow-up study in 71-year-old men. *Diabetologia* **52**, 1504–1510.

- Rozing MP, Westendorp RG, de Craen AJ, Frolich M, de Goeij MC, Heijmans BT, Beekman M, Wijsman CA, Mooijaart SP, Blauw GJ, Slagboom PE, van Heemst D (2010) Favorable glucose tolerance and lower prevalence of metabolic syndrome in offspring without diabetes mellitus of nonagenarian siblings: the Leiden longevity study. *J. Am. Geriatr. Soc.* **58**, 564–569.
- Scheen AJ, Byrne MM, Plat L, Leproult R, Van Cauter E (1996) Relationships between sleep quality and glucose regulation in normal humans. *Am. J. Physiol.* **271**, E261–E270.
- Schoenmaker M, de Craen AJ, de Meijer PH, Beekman M, Blauw GJ, Slagboom PE, Westendorp RG (2006) Evidence of genetic enrichment for exceptional survival using a family approach: the Leiden Longevity Study. *Eur. J. Hum. Genet.* **14**, 79–84.
- Service FJ, Molnar GD, Rosevear JW, Ackerman E, Gatewood LC, Taylor WF (1970) Mean amplitude of glycemic excursions, a measure of diabetic instability. *Diabetes* **19**, 644–655.
- Siegelaar SE, Holleman F, Hoekstra JB, DeVries JH (2010) Glucose variability; does it matter? *Endocr. Rev.* **31**, 171–182.
- Siegelaar SE, Barwari T, Kulik W, Hoekstra JB, DeVries HJ (2011) No relevant relationship between glucose variability and oxidative stress in well-regulated type 2 diabetes patients. *J. Diabetes Sci. Technol.* **5**, 86–92.
- Stumvoll M, Goldstein BJ, van Haften TW (2008) Type 2 diabetes: pathogenesis and treatment. *Lancet* **371**, 2153–2156.
- Westbrook R, Bonkowski MS, Strader AD, Bartke A (2009) Alterations in oxygen consumption, respiratory quotient, and heat production in long-lived GHRKO and Ames dwarf mice, and short-lived bGH transgenic mice. *J. Gerontol. A Biol. Sci. Med. Sci.* **64**, 443–451.
- Westendorp RG, van Heemst D, Rozing MP, Frolich M, Mooijaart SP, Blauw GJ, Beekman M, Heijmans BT, de Craen AJ, Slagboom PE (2009) Nonagenarian siblings and their offspring display lower risk of mortality and morbidity than sporadic nonagenarians: the Leiden Longevity Study. *J. Am. Geriatr. Soc.* **57**, 1634–1637.
- Wijsman CA, Rozing MP, Streefland TC, le Cessie S, Mooijaart SP, Slagboom PE, Westendorp RG, Pijl H, van Heemst D (2011) Familial longevity is marked by enhanced insulin sensitivity. *Aging Cell* **10**, 114–121.
- Wijsman CA, van Opstal AM, Kan HE, Maier AB, Westendorp RG, Slagboom PE, Webb AG, Mooijaart SP, Van Heemst D (2012) Proton magnetic resonance spectroscopy shows lower intramyocellular lipid accumulation in middle-aged subjects predisposed to familial longevity. *Am. J. Physiol. Endocrinol. Metab.* **302**, E344–E348.
- Zhou J, Li H, Ran X, Yang W, Li Q, Peng Y, Li Y, Gao X, Luan X, Wang W, Jia W (2009) Reference values for continuous glucose monitoring in Chinese subjects. *Diabetes Care* **32**, 1188–1193.
- Zhou J, Li H, Ran X, Yang W, Li Q, Peng Y, Li Y, Gao X, Luan X, Wang W, Jia W (2011) Establishment of normal reference ranges for glycemic variability in Chinese subjects using continuous glucose monitoring. *Med. Sci. Monit.* **17**, CR9–CR13.