

Assessment of serum nesfatin-1 level, cardiovascular parameters, and metabolic risk factors among obese and non-obese adults

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Abstract

The study assessed the association between serum Nesfatin-1 level and cardiometabolic risk factors among obese and non-obese adults to identify cardiovascular abnormalities associated with obesity and explore potential correlations with Nesfatin-1 levels. A comparative descriptive design and purposive sampling technique was used to recruit participants at the Department of Family Medicine, Ekiti State University Teaching Hospital, Ado-Ekiti, Ekiti State. Between June 2022 and January 2023, 120 participants, were divided based on their body mass index into two; Group A ($BMI > 30.0 \text{ kg/m}^2$) and Group B ($BMI 18.5-24.9 \text{ kg/m}^2$). Clinical and demographic parameters were obtained through a structured questionnaire, and anthropometric measurements were taken. Serum nesfatin-1, leptin, and tumour necrosis factor alpha were quantitatively assayed. Fasting blood glucose, total cholesterol, and low density lipoprotein were determined. Results: The mean serum nesfatin-1 (ng/mL), leptin (ng/mL) high density lipoprotein (mmol/L) and tissue necrosis factor-alpha (pg/mL) levels were significantly lower ($t = -4.256$; $p = 0.001$ and $t = -5.106$; $p = 0.054$, $t = -5.282$; $p = 0.001$) in the obese participants (4.25 ± 0.45 , 6.22 ± 0.92 , 0.854 ± 0.57 , 49.76 ± 2.54 respectively) when compared with the non-obese participants (4.64 ± 0.55 , 6.56 ± 0.50 , 0.942 ± 0.077 , 55.67 ± 4.81 respectively). A strong positive correlation existed between total cholesterol ($r = 0.290$; $p = 0.025$), low density lipoprotein ($r = 0.205$; $p = 0.116$), triglyceride ($r = -0.157$; $p = 0.231$) and systolic blood pressure ($r = 0.075$; $p = 0.05$) with serum nesfatin-1 among obese participants. A strong positive correlation was also observed between serum nesfatin-1 with fasting blood glucose and tumour necrosis factor-alpha ($r = 0.041$, $p = 0.756$; $r = 0.070$, $p = 0.592$ respectively) in obese participants. Conclusion: Nesfatin-1 plays a role in the development of cardiovascular and metabolic diseases and hence could be regarded as a potential biomarker for metabolic and cardiovascular risk in obesity.

Keywords: Nesfatin-1, Cardiometabolic risks, Tumour necrosis factor-alpha, Obesity

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1. Introduction

The excess growth of body fat tissue is one of the characteristics found in obese individuals and is sporadically

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becoming a serious global epidemic health challenge that plagues millions of children and adults across the globe (Bastarrachea et al., 2004). Research has confirmed that the major regulator of energy homeostasis is the adipose tissue (Zou et al., 2018a). However, adipose tissue will grow and expand excessively when intake and expenditure of energy are out of balance (Spiegelman and Flier, 2001). Obesity is a disorder that is brought about by interplay of numerous genetic, nutritional, lifestyle, and environmental variables (Mohamed et al., 2014). The primary pathogenesis of obesity involves controlling cellular processes and physical inactivity to either an increase in appetite or a decrease in calorie usage. This dysregulation causes an excessive adiposities formation to occur, which elevates cytokine release and results in the manifestation of the circulatory complications. Hyperlipidemia, atherosclerosis, and anomalies of the cardiovascular system are linked to these complications. Adipose tissue increases significantly as a result of obesity, and this increase in adipose tissue necessitates an increased metabolism rate. Effectively, there is a corresponding increase in the size or number of blood vessels (Tahergorabi and Khazaei, 2012). Being overweight negatively affects blood flow as well as the structure and function of cardiac arteries due to increases in total blood volume and cardiac output (Lavie et al., 2009). Furthermore, cardiac output, cardiac stroke volume, and heart rate all have a linear connection. As a result, those who have a high BMI are prone to have an increase in heart workload than people who are of normal weight (Lavie et al., 2009). Therefore, controlling obesity is crucial for preventing and treating these associated conditions. Other conditions attributed with over weight include diabetes mellitus, cardiovascular with motion diseases. Likewise, it possesses a consequential impact on such person's social, financial and psychological status which tends to cause depression (Oh et al., 2009).

Emerging cardiovascular risk factors have been identified, one of which is a 82-equino acid peptide called nesfatin-1, discovered by Oh et al. (2006). The hormone circulates extensively in the nervous system both the central and the peripheral (Stengel et al., 2011; Mohan and Unniappan, 2012). It had been proven to play a major role modulating food intake with lipid metabolism, preventing fat buildup, promoting lipid breakdown, and generally inhibiting the onset of lipid-related disorders like obesity and metabolic syndrome (Jing et al., 2024). It significantly impacts the relationship between dietary intake and a body mass index. It contributes crucially in controlling appetite and storage of fat. Increased Nesfatin-1 in the hypothalamus relates with a decrease in hunger, "a sense of fullness," and an elevated probability of a loss in weight and body fat (Oh et al., 2006). Nesfatin-1 concentration in circulation had been found to be abnormal in heart diseases (Ramesh et al., 2017). Additionally, higher blood lipids and lipoproteins are associated to obesity (Gantulga et al., 2012). Heightened levels of triglycerides, VLDL, Apo B, and non-HDL-C are among the lipid imbalances frequently observed in people suffering from obesity (Bays et al., 2013). Generally, HDL-C and Apo A-I levels are low (Grundy and Vega, 1998). Most of the time, LDL-C levels are within the normal range, but there is an elevation in the small dense LDL level, which leads to a rise in the number of LDL particles (Friedemann et al., 2012). The small dense LDL particles are assumed to be more pro-atherogenic compared to the large LDL particles for a variety of reasons (Expert Panel on Detection, 2001). A rise in abnormal lipid levels which is related to an increased BMI.

Morbidity and mortality are significantly impacted by obesity. Nesfatin-1, a regulator of body mass and appetite, is one of the pathophysiological elements of obesity. The purpose of this research is to examine the correlation between serum nesfatin-1 level, with the anthropometric indices, cardiovascular parameters, and other metabolic risk factors in obese and non-obese adults in Nigeria because there have been very few studies that have looked at the relationship between serum nesfatin-1 levels and cardio metabolic risk factors among obese with non-obese individuals.

2. Materials and methodology

2.1. Materials

Height and weight of all participants were measured to the nearest 0.1 cm and 0.1 kg respectively using Wunder RE300 digital scale. Waist, neck and hip circumferences were assessed with a tape measure. The subject stood with feet closed together, the tape was placed mid-point between subcostal and supriliac landmark for the measurement of waist circumference while for the hip circumference, the tape was placed on the greater trochanter with the tape parallel to the floor. The neck circumference measurement was done between the mid-cervical spine and mid anterior neck just below the laryngeal prominence with head in the

Frankfurt plane. The body mass index was calculated using Quetelet Formula and classified using WHO class.

At a sitting position after 5 minutes of rest, the systolic blood pressure, diastolic blood pressure and pulse rate were measured using a validated digital blood pressure monitor (OMRON). Measurement of resting blood pressure and pulse rate was done three times, two minutes apart. Mean arterial blood pressure, pulse pressure and rate pressure product were derived from the resting blood pressure figures.

2.2. Study area

The participants included the patients that attended the outpatient unit of Department of Family Medicine, Ekiti State University Teaching Hospital, Ado-Ekiti, Ekiti State for follow-up. The study included participants who met the study inclusion criteria and gave their consent. Clinical and demographic characteristics such as age, gender, marital status, and occupation were gathered using a pre-tested structured interview questionnaire. The Ethics and Research Committee of Ekiti State University Teaching Hospital Ado-Ekiti, Ekiti state, was sought and granted ethical clearance.

2.3. Study population and period of study

A total of 120 participants were chosen based on their Body Mass Index (BMI). The chosen participants were divided into two; Group A sixty participants with $BMI \geq 30.0 \text{ kg/m}^2$ and Group B sixty participants with BMI between 18.5 and 24.9 kg/m^2 . This study was carried out for duration of three (3) weeks (February-April). At least 6 samples and filled questionnaires were collected per day centrifuged and serum separated for analysis

2.4. Inclusion criteria

The Inclusion criteria for group A is a $BMI \geq 30.0 \text{ kg/m}^2$ and age range of 18-65 years while the inclusion criteria for group B is a BMI of 18.5-24.9 kg/m^2 and age range of 18-65 years.

2.5. Exclusion criteria

Exclusion criteria for both groups include Age < 18 years or > 65 years, patients that are critically ill, pregnant or lactating mothers.

2.6. Data collection

A structured questionnaire was designed and administered to the participants to obtain relevant demographic information and clinical characteristics

2.7. Administration of questionnaires

Well structured and approved questionnaires were given to consented participants to provide information on their socio-demography and health status. Confidentiality was maintained as no details related to participant's identity were used.

2.8. Anthropometry measurements and laboratory evaluations

All participants underwent physical examinations and laboratory evaluations. Height was measured with a standard stadiometer (OMRI height meter). Weight and height were recorded to the nearest 0.1 kg and 0.1 cm, respectively. Blood samples for glucose, lipid profile Tumour necrosis factor-alpha leptin and nesfatin-1 were taken after 10-12 h overnight fasting. Cut-off points for abnormal lipid levels (Total Cholesterol [TC] $\geq 200 \text{ mg/dL}$, Low-Density Lipoprotein Cholesterol [LDL-C] $\leq 130 \text{ mg/dL}$, High-Density Lipoprotein Cholesterol [HDL-C] $\leq 35 \text{ mg/dL}$, and Triglycerides [TG] $\geq 150 \text{ mg/dL}$) were from the Third Report of the National Cholesterol Education Program ([Expert Panel on Detection, 2001](#)) and the American Diabetes Association ([American Diabetes, 2003](#)). Dyslipidemia was defined as presence of one or more abnormal serum lipid levels.

2.9. Sample collection

Overnight fasted participants were allowed to sit comfortably, the arm was gently palpated to identify suitable

vein and also to assess the suitability such as being bouncy, soft, straight and capable of refilling when compressed with a large lumen and well supported. A tourniquet was applied to the upper arm approximately 7-10 cm away from the chosen site, the radial pulse must still be palpable. The site was then cleaned with methylated spirit swab and allowed to dry before the insertion of the needle. A total of 10 ml of blood sample was withdrawn into plain sample bottles allowed to clot for one hour at room temperature, after full clot retraction the sample is then centrifuged at 4500 rpm for 5 minutes at 4 °C. The serum is then extracted and stored at -20 °C (Algul et al., 2016) until analyzed according to the manufacturer protocols.

For plasma sample, the blood was collected in an EDTA bottle, allowed to clot for one hour and then centrifuged at 3000 rpm for 10 minutes. Plasma concentrations of nesfatin-1 were measured in duplicate and 10 replicates per Enzyme-Linked Immunosorbent Assay (ELISA) plate were used as internal quality controls. Human plasma nesfatin-1 levels were measured using a commercially available ELISA kit (Innovative Research USA) according to the manufacturer's instructions. The assay has a detection sensitivity of 7.8 pg/ml and Optical density value for each well were determined at once with a micro-plate reader set at 450 nm.

For lipid analysis, the blood sample (4 ml) was collected into lithium heparin bottle. Plasma total cholesterol, high- and low-density lipoprotein cholesterol and triglyceride concentrations were determined using Abell-Kendall protocol. For glucose analysis, the blood sample (3 ml) was collected into fluoride oxalate bottle while the plasma glucose were determined using glucose oxidase method.

Data obtained was analyzed using descriptive and inferential statistics A P-value of ≤ 0.05 was taken as statistically significant.

3. Results and discussion

3.1. Results

Table 1 shows serum biochemical parameters between obese and non-obese participants Table 1. The comparative study between Group A and Group B revealed statistically significant differences on most of the biochemical parameters ($p < 0.001$). There was a significant increase in the levels of nesfatin-1 (4.64 ± 0.55 ng/mL), leptin (6.56 ± 0.50 ng/mL), TNF- α (55.67 ± 4.81 ng/mL), total cholesterol (3.68 ± 1.86 mmol/L), VLDL (1.74 ± 0.45 mmol/L), HDL (0.942 ± 0.77). On the other hand Group B (4.45 ± 0.62 mmol/L) had a low fasting blood glucose than Group A (5.23 ± 0.65 mmol/L). There was no significant difference in the levels of triglycerides between groups and thus was excluded.

Table 1: Serum biochemical parameters between obese and non-obese participants

	Group A (n = 60)	Group B (n = 60)	t	p-value
Nesfatin-1 (ng/mL)	4.25 ± 0.45	4.64 ± 0.55	-4.256	<0.001*
FBG (mmol/L)	5.23 ± 0.65	4.45 ± 0.62	-1.181	<0.001*
Leptin (ng/mL)	6.22 ± 0.92	6.56 ± 0.50	-5.106	<0.001*
TNF- α (ng/mL)	49.76 ± 2.54	55.67 ± 4.81	-5333	<0.001*
Cholesterol (mmol/L)	3.55 ± 0.42	3.68 ± 1.86	8.670	<0.001
TAG (mmol/L)	8.16 ± 0.48	8.15 ± 0.76	0.000	1.000
VLDL (mmol/L)	1.73 ± 0.09	1.74 ± 0.45	5.067	<0.001
HDL (mmol/L)	0.854 ± 0.57	0.942 ± 0.77	-5.282	<0.001*
LDL (mmol/L)	2.52 ± 0.70	2.57 ± 1.98	11.151	<0.001

Note: Significant p-value < 0.05 .

According to Table 2, Lipid profile increases or decreases in response to changes in serum nesfatin-1 (except for LDL in obese and TG in non-obese), p-value < 0.05 .

Table 3 shows that, the waist-hip ratio was the only ratio that was statistically significant in both groups. Waist-hip ratio was significantly but weakly correlated in Group A ($r = 0.062$, $p = 0.001$). On the same note, waist-hip ratio had a weak and significant negative relationship in Group B ($r = -0.032$, $p = 0.012$). The other

Table 2: Relationship of nesfatin-1 with indices of lipid profile among obese and non-obese participants

Parameters	Group A (n = 60)		Group B (n = 60)	
	r	p-value	r	p-value
Cholesterol (mmol/L)	0.290	0.025*	0.093	0.001*
TG (mmol/L)	-0.157	0.231	0.041	0.001*
VLDL (mmol/L)	0.065	0.621	0.041	0.001*
HDL (mmol/L)	0.154	-0.239	-0.106	0.01
LDL (mmol/L)	0.205	0.116	0.144	0.001*

Note: Lipid profile increases or decreases in response to changes in serum nesfatin-1 (except for LDL in obese and TAG in non-obese), p-value < 0.05.

Table 3: Relationship of nesfatin-1 with anthropometric indices among obese and non-obese participants

Anthropometric parameters	Group A (n = 60)		Group B (n = 60)	
	r	p-value	r	p-value
Body mass index (kg/m ²)	-0.067	0.600	0.106	0.420
Hip circumference (cm)	0.112	0.392	0.151	0.251
Waist circumference (cm)	-0.082	0.532	0.532	0.611
Waist/Hip ratio	0.062	0.001	-0.032	0.012
Neck circumference (cm)	-0.173	0.186	-0.133	0.312

Note: A positive correlation (r=0.112, p = 0.392) in obese and (r = 0.151; p = 0.251) in non-obese, p-value < 0.05.

anthropometric parameters measured in Table 3 did not have quite significant associations and hence were not included in this summary.

Table 4 demonstrates that only in Group A statistically significant correlations were found between systolic blood pressure and all other variables (r = 0.075, p = 0.05). Besides, pulse pressure was weakly negatively correlated with (r = -0.084, p = 0.050) in Group A. There were no statistically significant correlations between the indices of blood pressure of Group B, and other parameters evaluated in both groups were not significant.

Table 4: Relationship of nesfatin-1 with indices of blood pressure factors among obese and non-obese participants

Indices of blood pressure	Group A (n = 60)		Group B (n = 60)	
	r	p-value	r	p-value
SBP (mmHg)	0.075	0.05*	0.050	0.702
PR (beats/minute)	0.020	0.881	-0.059	0.653
DBP (mmHg)	0.012	0.928	0.157	0.232
MAP (mmHg)	0.067	0.608	0.241	0.064
PP (mmHg)	-0.084	0.050	-0.093	0.479

Note: A weak positive significant correlation with nesfatin in non-obese SBP (r = 0.075; p ≥ 0.05), and a negative correlation with pulse pressure (p = -0.084; p < 0.05), p-value < 0.05.

In Table 5, analysis of the relationship between the measured biochemical parameters and the outcome variables revealed that there were no significant correlations between them in both Group A and Group B (p > 0.05). Precisely, fasting blood glucose, leptin, and TNF- α did not achieve significant associations in either group and thus gave no meaningful correlation coefficients to interpret. Accordingly, Table 5 has shown no

significant correlation between the measured biochemical markers and the variables under study in both groups.

Table 5: Relation of nesfatin-1 with biochemical parameters among obese and non-obese participants

Biochemical parameters	Group A (n = 60)		Group B (n = 60)	
	R	p-value	r	p-value
FBG (mmol/L)	0.041	0.756	0.110	0.420
Leptin (ng/mL)	-0.102	0.437	-0.209	0.109
TNF (ng/mL)	-0.070	0.592	0.091	0.491

Note: Significant p - 0.05.

According to Table 6, the mean index of body mass showed a moderate level of negative correlation ($r = -0.347$, $p < 0.001$), i.e., an increase in body mass was strongly linked with a drop in blood pressure indices. Central adiposity is also relevant as the correlation between the waist circumference and the other variables ($r = -0.300$, $p = 0.001$) was significant and negative. In the same way, the circumference of the neck was significantly negatively correlated ($r = -0.326$, $p < 0.001$). The waist-hip circumference ratio had a low but significant positive correlation ($r = 0.024$, $p = 0.001$). Of the parameters in biochemistry, tumur necrosis factor-a was positively correlated with blood pressure indices ($r = 0.473$, $p = 0.001$), meaning that tumur necrosis factor-a plays a significant role in inflammation. There was a weak and significant correlation between the levels of triglycerides ($r = 0.030$, $p = 0.001$). There was also a high and statistically significant positive correlation with low-density lipoprotein cholesterol ($r = 0.652$, $p = 0.002$), showing that atherogenic lipid profiles and blood pressure indices have a significant relationship.

Table 6: Correlation of serum nesfatin-1 level with cardio metabolic risk factors among the study participants

Indices of blood pressure	Participants (n = 120)	
	R	p-value
Body mass index (kg/m ²)	-0.347**	0.000
Fasting blood glucose (mmol/L)	-0.131	0.152
Hip circumference (cm)	-0.132	0.151
Waist circumference (cm)	-0.300*	0.001
Waist/Hip circumference	0.024	0.001
Neck circumference (cm)	-0.326**	<0.001
Systolic blood pressure (mmHg)	-0.083	0.369
Pulse pressure (mmHg)	-0.173	0.059
Diastolic blood pressure (mmHg)	0.005	0.953
Mean arterial pressure (mmHg)	0.043	0.641
Tumour necrosis factor- α (ng/mL)	0.473**	0.001
Leptin (ng/mL)	0.431**	0.054
Triglyceride (mmol/L)	0.030	0.001
Total cholesterol (mmol/L)	0.554	0.259
High density lipoprotein (mmol/L)	0.429	0.329
Low density lipoprotein (mmol/L)	0.652	0.002

Note: Significant p - 0.05.

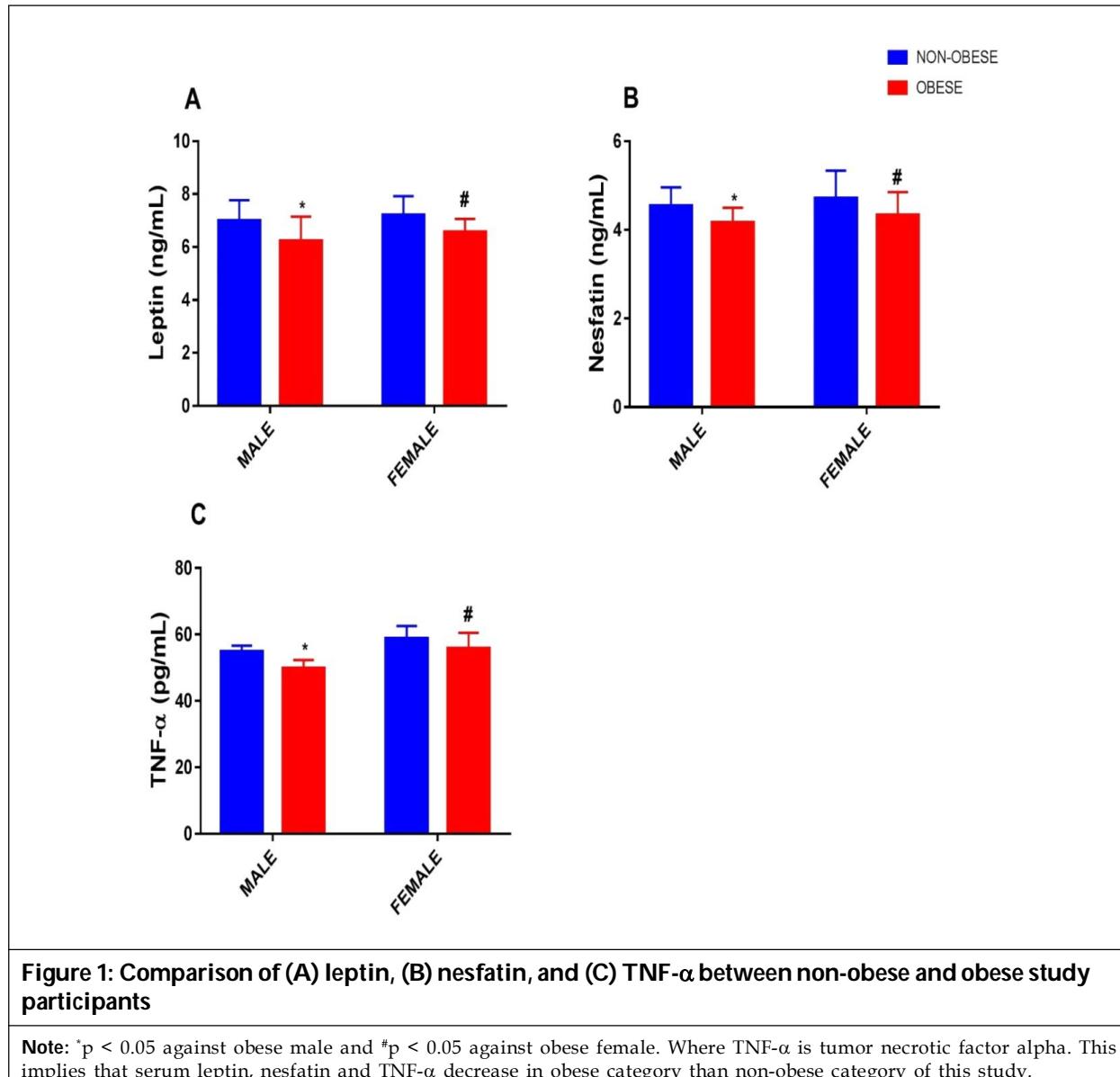


Figure 1: Comparison of (A) leptin, (B) nesfatin, and (C) TNF- α between non-obese and obese study participants

Note: * $p < 0.05$ against obese male and # $p < 0.05$ against obese female. Where TNF- α is tumor necrotic factor alpha. This implies that serum leptin, nesfatin and TNF- α decrease in obese category than non-obese category of this study.

3.2. Discussion

The purpose of this study was to compare the relationship between serum nesfatin-1 level to cardiovascular parameters and metabolic risk factors in obese and non-obese adults. Obesity was shown to be associated with many diseases such as cardiovascular diseases, T2 DM, sleep apnea, hypertension and cancer or can even trigger these diseases, for this reasons it is essential to develop new treatment strategies to reduce its prevalence. Nesfatin-1 is one of the emerging cardiovascular risk factors (Oh *et al.*, 2006). Currently, it is being considered as a potential new anti-obesity treatment (Finelli *et al.*, 2014).

The findings of this study revealed that there was a significant decrease in serum nesfatin-1 level when comparing with the parameters of obesity such as body mass index ($r = -0.067$; $p = 0.600$), waist circumference ($r = -0.082$; $p = 0.532$) and neck circumference ($r = -0.173$; $p = -0.186$) which depicted a strong negative but non-significance correlation with serum nesfatin-1 among the obese participants while the hip circumference shows a positive correlation ($r = 0.112$, $p = 0.392$) in obese and ($r = 0.151$; $p = 0.251$) when compared with non-obese participants. This was also the pattern of earlier reported studies among obese children (Abaci *et al.*, 2013). The same pattern was also reported by (Tsuchiya *et al.*, 2010; Li *et al.*, 2010) who found a negative correlation between serum nesfatin-1 levels and Body Mass Index in healthy individuals. This findings may have confirmed the role of nesfatin-1 as an anorexigenic peptide which had been linked to appetite regulation, weight loss, and/or malnutrition, it helps the body to regulate and balance food intake and energy expenditure through the regulatory center for energy balance in the hypothalamus (Saldanha *et al.*, 2012).

This is one of the few studies that have been conducted to assess the association between serum nesfatin-1 levels and cardiometabolic risk factors among obese and non-obese adults, according to a review of published publications. Previous research found a negative correlation between serum nesfatin-1 levels and BMI (Shin-Hee et al., 2019). According to this data, adults with obesity who have low nesfatin-1 levels may have uncontrollably high food intake. Nesfatin-1 may play a role in energy balance, according to animal research. According to Oh et al., obesity and overweight could result from a lack of nesfatin-1 function in vivo (Oh et al., 2006).

In contrast, some research in the adult population discovered a link between Body Mass Index and serum nesfatin-1 levels in children who are obese. Also some study in the adult population discovered a link between BMI and serum nesfatin-1 levels (Tan et al., 2011; Ramanjaneya et al., 2010). In children who are obese, Anwar et al. discovered a positive relationship between serum nesfatin-1 and BMI SDS (Anwar et al., 2014). These inconsistencies could be caused by variations in evaluation techniques (such as sandwich-type ELISA, which only recognizes nesfatin-1, vs ELISA for NUCB2 and nesfatin-1 experimental conditions, commercial kits, and populations might contribute to these discrepancies. Also when nesfatin-1 was chronically infused into the third ventricle of rats. It consistently decreased body weight growth. Meanwhile, persistent intracerebroventricular treatment of antibodies directed against the gene producing nesfatin/NUCB2 causes rats to gain weight (Oh et al., 2006). Nesfatin-1 may affect hunger through a central mechanism since it can cross the blood-brain barrier through an unsaturable mechanism (Pan et al., 2007; Price et al., 2007). According to a study, nesfatin-1 decreases food intake in all mice, including obese ones with leptin gene knockdowns. This discovery demonstrates nesfatin-1's effectiveness in suppressing appetite since it operates outside of the leptin pathway (Oh et al., 2006). These data indicated that nesfatin-1 plays a role in body weight regulation as well as the physiological control of feeding behavior in rats (Samani et al., 2019). Contrary to the conclusions of this study, it was claimed that there was no significant relationship between body mass index and nesfatin-1. The lifestyle of the subjects and their race may be the reason why this study contradicts prior investigations in which low levels of nesfatin-1 were found in obese individuals and those of the non-obese

In this study of obese participants, Total Cholesterol (TC), Very Low Density Lipoprotein (VLDL) and High Density Lipoprotein (HDL) revealed a very strong positive and significant correlation with serum nesfatin-1, except for Low Density Lipoprotein (LDL) and Triglyceride (TG) which shows a strong negative association in obese participants showing that this group is more susceptible to cardiovascular illnesses (Blanco et al., 2018).

Previous research has demonstrated the role of nesfatin-1 hormone in regulating lipid metabolism and food intake, inhibiting fat build up and decomposition, and generally preventing the onset of lipid-related diseases such as obesity and metabolic syndrome.

The TG/HDL-C (surrogate marker of cardio metabolic dyslipidemia: small-dense LDL) and TC/HDL-C indexes have been suggested as potential markers to determine atherogenic risk (Altincik and Sayin, 2018; Çatlı et al., 2015). Yin, et al. demonstrated that nesfatin-1 regulates peripheral lipid accumulation and hepatic lipid metabolism in mice in addition to its involvement in insulin and glucose metabolism (Yin et al., 2015) and Tekin, et al. associated the metabolic syndrome's elements and nesfatin-1 to them (Tekin et al., 2019).

The multicenter study of Pathobiological Determinants of Atherosclerosis in Youth (PDAY) focuses on the association between risk factors and atherosclerosis in adolescents and young adults. In this cohort, lesions in the right coronary artery were negatively correlated with HDL-C and positively associated with non-HDL cholesterol (Wissler, 1991).

With regard to triglyceride concentrations, this study revealed significant differences between the two study groups, whereas HDL-C only revealed significant differences between the non-obese group. In the obese group, there was a positive correlation between nesfatin-1 and triglycerides as well as the TG/HDL-C and TC/HDL-C indexes, which may indicate a role for nesfatin-1 as a cardiovascular risk factor.

These results differ from what Abaci et al. (2013) and by Kim et al. (2009) reported in teenagers who did not find a connection between nesfatin-1 and triglycerides. Since this study group consisted of adults and the other groups included children as young as 5, the discrepancies in the outcomes can be attributed to age disparities.

This study showed a strong positive correlation between nesfatin-1 and Mean arterial pressure and pulse pressure among the obese subjects. Additionally, there was a strong positive correlation between pulse pressure and mean arterial pressure. Other factors did not significantly correlate. This may be due to the distribution of nesfatin-1 mRNA protein in the central nervous system, where the neurons that produce vasopressin, corticotrophin releasing hormone, POMC, Oxytocin, melanin concentrating hormone, and many other substances are also located. These results suggest that nesfatin-1 may also play a role in cardiovascular control and other processes (Foo et al., 2008). These findings imply that nesfatin-1 may also be involved in the regulation of the heart and other systems (Yosten and Samson, 2009). According to prior research, administering nesfatin-1 intravenously increased blood pressure and interfered with the smooth muscle cells' ability to relax after being exposed to sodium nitroprusside (Yamawaki et al., 2012).

This study's findings demonstrate a positive and significant relationship between serum nesfatin-1 and serum TNF- α in obese participants demonstrating that TNF- α levels are significantly correlated in these people. TNF- α is substantially linked with serum nesfatin-1 and leptin. This is in keeping with their findings (Çatlı et al., 2015). However, there was no discernible relationship between the TNF- α and the anorexigenic hormones in the non-obese participants. This may be due to the link between adipose tissue and inflammation that is chronic and releases cytokines such as TNF- α . This pro-inflammatory condition can lead to disorders like metabolic syndrome, which is an accumulation of cardio-metabolic risk factors including obesity. Study have shown that obesity causes an increase in pro-inflammatory cytokines and macrophage infiltration of the expanded adipose tissue (Roberts et al., 2010). Disorders like metabolic syndrome, which is an accumulation of cardio-metabolic risk factors including obesity, can be caused by this pro-inflammatory state. Increased levels of pro-inflammatory cytokines and macrophage infiltration of the enlarged adipose tissue are brought on by obesity (Maedler et al., 2009; Drevon, 2005). TNF level in the plasma has been discovered to be greater in obese people, proving a link between raised level of TNF and obesity, according to studies (Ohashi et al., 2010). TNF- α levels were shown to be high in the adipose tissue of obese mice in a study, demonstrating that there is an increase in cytokine release in settings when obesity is present. TNF is frequently elevated in pathophysiological conditions in adipose tissues (Tzanavari et al., 2010). The outcome of this investigation also revealed that none of the metabolic hormones and TNF- α were significantly correlated in the subjects. This result differs with one by Çatlı et al. (2015), which found a link between the inflammatory markers and metabolic hormones (nesfatin-1 and Leptin).

4. Conclusion

This study showed that Serum level of nesfatin-1 was negatively correlated with cardio metabolic risk factors such as body mass index, neck circumference and waist circumference with a strong positive correlation with mean arterial pressure and pulse pressure among the obese subjects. Additionally, there was a positive correlation between nesfatin-1 and triglycerides as well as the TG/HDL-C and TC/HDL-C indexes, which may indicate a role for nesfatin-1 as a cardiovascular risk factor. These findings suggests that nesfatin-1 could play a role in the development of cardiovascular and metabolic diseases and hence can be regarded as a potential biomarker for cardiovascular and metabolic risk especially in the obese individual.

Recommendation

This study could pave ways for further exploration into the clinical significance of nesfatin-1 in the treatment of obesity and also as a potential biomarker of cardio metabolic disorders.

Disclaimer (Artificial Intelligence)

We declared that NO generative AI technologies such as Large Language Models (ChatGPT, COPILOT, etc.) and text-to-image generators have been used during writing or editing of manuscript.

Consent

Participants consent were collected and preserved.

Ethical approval

Ethical clearance was obtained from Ethics and Research Committee of the Ekiti State University Teaching Hospital, Ado-Ekiti.

Acknowledgment

The outpatient department of family Medicine Unit of Ekiti State University Teaching Hospital, Ado-Ekiti. Team for their cooperation during my research work.

References

Abaci, A., Catli, G., Anik, A. et al. (2013). The relation of serum nesfatin-1 level with metabolic and clinical parameters in obese and healthy children. *Pediatr Diabetes*, 14: 189-95.

Algul, S., Ozkan, Y. and Ozcelik, O. (2016). Serum nesfatin-1 levels in patients with different glucose tolerance levels. *Physiol Res*, 65(6): 979-985.

Altincik, A. and Sayin, O. (2018). Serum nesfatin-1 levels in girls with idiopathic central precocious puberty. *Journal of Clinical Research in Pediatric Endocrinology*, 10(1), 8-12.

American Diabetes, A. (2003). Management of dyslipidemia in children and adolescents with diabetes. *Diabetes Care*, 26: 2194-7.

Anwar, G.M., Yamamah, G., Ibrahim, A., El-Lebedy, D., Farid, T.M. and Mahmoud, R. (2014). Nesfatin-1 in childhood and adolescent obesity and its association with food intake, body composition and insulin resistance. *Regulatory Peptides*, 188: 21-24.

Bastarrachea, R.A., Cole, S.A. and Comuzzie, A.G. (2004). Genómica de la regulación del peso corporal: mecanismos moleculares que predisponen a la obesidad [Genomics of body weight regulation: Unraveling the molecular mechanisms predisposing to obesity].

Bays, H.E., Toth, P.P., Kris-Etherton, P.M., Abate, N., Aronne, L.J., Brown, W.V. et al. (2013). Obesity, adiposity, and dyslipidemia: A consensus statement from the National Lipid Association. *Journal of Clinical Lipidology*, 7(4): 304-383.

Blanco, A.M., Velasco, C., Bertucci, J.I., Soengas, J.L. and Unniappan, S. (2018). Nesfatin-1 regulates feeding, glucosensing and lipid metabolism in rainbow trout. *Front. Endocrinol.*, 9: 484.

Çatlı, G., Anýk, A., Küme, T., Çalan, O.G., Dündar, B.N. et al. (2015). Serum nesfatin-1 and leptin levels in non-obese girls with premature thelarche. *Journal of Endocrinology Investigations*, 38: 909-913.

Drevon, C.A. (2005). Fatty acids and expression of adipokines. *Biochimica et biophysica acta*, 1740(2): 287-292.

Expert Panel on Detection, E. (2001). Treatment of high blood cholesterol in a executive summary of the third report of the National Cholesterol Education Program (NCEP) expert panel on detection, evaluation, and treatment of high blood cholesterol in adults (Adult treatment panel III). *JAMA*, 285: 2486-97.

Finelli, C., Martelli, G., Rossano, R., Padula, M.C., La Sala, N., Sommella, L. and Tarantino, G. (2014). Nesfatin-1: Role as possible new anti-obesity treatment. *EXCLI Journal*, 13: 586-591.

Foo, K., Brismar, H. and Broberger, C. (2008). Distribution and neuropeptide coexistence of nucleobindin-2 mRNA/nesfatin-like immunoreactivity in the rat CNS. *Neuroscience*, 156: 563-579.

Friedemann, C., Heneghan, C., Mahtani, K., Thompson, M., Perera, R. and Ward, A.M. (2012). Cardiovascular disease risk in healthy children and its association with body mass index: Systematic review and meta analysis. *British Medical Journal*, 345: e4759.

Gantulga, D., Maejima, Y., Nakata, M. and Yada, T. (2012). Glucose and insulin induce Ca²⁺ signaling in nesfatin-1 neurons in the hypothalamic paraventricular nucleus. *Biochemical and Biophysical Research Communications*, 420: 811-815.

Grundy, S.M. and Vega, G.L. (1998). Hypertriglyceridemia: Causes and relation to coronary heart disease-seminar. *Thrombo. Hemost*, 14: 249-64.

Jing, J., Zhang, Z., Su, L., Gao, C., Guo, A., Liu, X., Wang, H., Zhang, X., Liu, Y., Comi, G., Waubant, E., Shi, F.D. and Tian, D.C. (2024). **Central vein sign and trigeminal lesions of multiple sclerosis visualised by 7T MRI.** *Journal of Neurology, Neurosurgery, and Psychiatry*, 95(8): 761-766.

Kim, J., Sun, S., Lee, D., Youk, H. and Yang, H. (2019). **Gonadotropin regulates NUCB2/nesfatin-1 expression in the mouse ovary and uterus.** *Biochemical and Biophysical Research Communications*, 513(3): 602-607.

Lavie, C.J., Milani, R.V. and Ventura, H.O. (2009). **Obesity and cardiovascular disease: Risk factor, paradox, and impact of weight loss.** *Journal of the American College of Cardiology*, 53(21): 1925-1932.

Li, Q.C., Wang, H.Y., Chen, X. et al. (2010). **Fasting plasma levels of nesfatin-1 in patients with type 1 and type 2 diabetes mellitus and the nutrient-related fluctuation of nesfatin-1 level in normal humans.** *Regulatory Peptides*, 159: 72-7.

Maedler, K., Dharmadhikari, G., Schumann, D.M. and Størling, J. (2009). **Interleukin-1 beta targeted therapy for type 2 diabetes.** *Expert Opinion on Biological Therapy*, 9(9): 1177-1188.

Mohamed, G.A., Ibrahim, S.R.M., Elkhayat, E.S. and El Dine, R.S. (2014). **Natural anti-obesity agents.** *Bulleting of Faculty of Pharmacology*, 52: 269-284, Cairo University.

Mohan, H. and Unniappan, S. (2012). **Ontogenic pattern of nucleobindin-2/nesfatin-1 expression in the gastroenteropancreatic tissues and serum of sprague dawley rats.** *Regul. Pept.*, 175: 61-69. doi: 10.1016/j.regpep.2012.02.006.

Oh, I., Shimizu, H., Satoh, T., Okada, S., Adachi, S.I. et al. (2006). **Identification of nesfatin-1 as a satiety molecule in the hypothalamus.** *Nature*, 443: 709-712.

Oh, S., Kim, K.S., Chung, Y.S., Shong, M. and Park, S.B. (2009). **Anti-obesity agents: A focused review on the structural classification of therapeutic entities.** *Current Tropical Medical Chemistry*, 9: 466-481.

Ohashi, K., Parker, J.L., Ouchi, N. et al. (2010). **Adiponectin promotes macrophage polarization toward an antiinflammatory phenotype.** *J Biol Chem*, 285(9): 6153-6160.

Pan, W., Hsueh, H. and Kastin, A.J. (2007). **Nesfatin-1 crosses the blood-brain barrier without saturation.** *Peptides*, 28: 2223-8.

Price, T.O., Samson, W.K., Niehoff, M.L. et al. (2007). **Permeability of the bloodbrain barrier to a novel satiety molecule nesfatin-1.** *Peptides*, 28: 2372-81.

Ramanjaneya, M., Chen, J., Brown, J.E., Tripathi, G., Hallschmid, M. et al. (2010). **Identification of nesfatin-1 in human and murine adipose tissue: A novel depot-specific adipokine with increased levels in obesity.** *Endocrinology*, 151: 3169-3180.

Ramesh, N., Gawli, K., Pasupuleti, V.K. and Unniappan, S. (2017). **Metabolic and cardiovascular actions of nesfatin-1: Implications in health and disease.** *Current Pharmaceutical Design*, 23(10): 1453-1464.

Roberts, D.L., Dive, C. and Renahan, A.G. (2010). **Biological mechanisms linking obesity and cancer risk: New perspectives.** *Annu Rev Med.*, 61: 301-316.

Saldanha, J.F., Carrero, J.J., Lobo, J.C., Stockler-Pinto, M.B., Leal, V.O., Calixto, A., Geloneze, B. and Mafra, D. (2012). **The newly identified anorexigenic adipokine nesfatin-1 in hemodialysis patients: Are there associations with food intake, body composition and inflammation?** *Regulatory peptides*, 173(1-3): 82-85.

Samani, S.M., Ghasemi, H., Bookani, K.R. and Shokouhi, B. (2019). **Serum nesfatin-1 level in healthy subjects with weight-related abnormalities and newly diagnosed patients with type 2 diabetes mellitus – A case-control study.** *Acta Endocrinol.*, XV: 69-73. doi: 10.4183/aeb.2019.69.

Shin-Hee Kim., MDa Moon., Bae Ahn., MDb Won., Kyoung Cho, MDc Kyoung et al. (2019). **The relation of serum nesfatin-1 level with anthropometric and metabolic parameters in children and adolescents. A Prospective Observational Study Medicine**, 98: 19(e15460).

Spiegelman, B.M. and Flier, J.S. (2001). **Obesity and the regulation of energy balance.** *Cell*, 104(4): 531-43.

Stengel, A., Goebel-Stengel, M., Jawien, J., Kobelt, P., Taché, Y. and Lambrecht, N.W. (2011). *Lipopolysaccharide increases gastric and circulating NUCB2/nesfatin-1 concentrations in rats*. *Peptides*, 32: 1942-1947.

Tahergorabi, Z. and Khazaei, M. (2012). *A review on angiogenesis and its assays*. *Iranian Journal of Basic Medical Sciences*, 15(6): 1110-1126.

Tan, B.K., Hallschmid, M., Kern, W., Lehnert, H. and Randeva, H.S. (2011). *Decreased cerebrospinal fluid/plasma ratio of the novel satiety molecule, nesfatin-1/NUCB-2, in obese humans: Evidence of nesfatin-1/NUCB-2 resistance and implications for obesity treatment*. *The Journal of Clinical Endocrinology and Metabolism*, 96(4): E669-E673.

Tekin, T., Cicek, B. and Konyaligil, N. (2019). *Regulatory peptide nesfatin-1 and its relationship with metabolic syndrome*. *The Eurasian Journal of Medicine*, 51(3): 280-284.

Tsuchiya, T., Shimizu, H.Y., Amada, M., Osaki, A., Oh, I.S., Ariyama Y., Takahashi, H., Okada, S., Hashimoto, K. and Satoh, T. (2010). *Fasting concentrations of nesfatin-1 are negatively correlated with body mass index in non-obese males*. *Clinical Endocrinology*, 73: 484-490.

Tzanavari, T., Giannogonas, P. and Karalis, K.P. (2010). *TNF-alpha and obesity*. *Current Directions in Autoimmunity*, 11: 145-156.

Wissler, R.W. (1991). *Update on the pathogenesis of atherosclerosis*. *The American Journal of Medicine*, 91(1B): 3S-9S.

Yamawaki, H., Takahashi, M. et al. (2012). *A novel adipocytokine, nesfatin-1 modulates peripheral arterial contractility and blood pressure in rats*. *Biochemical and Biophysical Research Communications*, 418(4): 676-681.

Yin, Y., Li, Z., Gao, L., Li, Y., Zhao, J. and Zhang, W. (2015). *AMPK-dependent modulation of hepatic lipid metabolism by nesfatin-1*. *Molecular and Cellular Endocrinology*, 417: 20-26.

Yosten, G.L. and Samson, W.K. (2009). *Nesfatin-1 exerts cardiovascular actions in brain: Possible interaction with the central melanocortin system*. *American Journal of Physiology- Regulatory, Integrative and Comparative Physiology*, 297(2): R330-R336.

Zou, Y.H., Ma, X.Q., Wu, C. et al. (2018a). *Effect of anti-obesity drug on cardiovascular risk factors: A systematic review and meta-analysis of randomized controlled trials*. *PLoS One*, 7: e39062.