Association of glucose-6-phosphate dehydrogenase deficiency with diabetes mellitus in ethnic groups of Singapore

N. Saha
From the Department of Physiology, Faculty of Medicine, University of Singapore, Singapore

SUMMARY Six hundred and nine male patients suffering from maturity onset diabetes mellitus, comprising 422 Chinese, 66 Malays, and 121 Indians, were investigated to determine the incidence of G6PD deficiency, ABO blood groups, and haemoglobin types, and these were compared with normal healthy controls. A positive association with a higher incidence of G6PD deficiency in diabetics was observed in Chinese and Indian patients. There was no significant difference in the frequencies of ABO blood groups and haemoglobin types between the patients and the controls in any of the ethnic groups studied.

The genetic association of diabetes mellitus has been studied in the past mainly by the relative incidence of blood groups and serum proteins (Craig and Wang, 1955; McConnell et al., 1956; Andersen and Lauritzen, 1960; Macafee, 1964; Berg et al., 1967; Klebe and Nielsen, 1972; Lambe et al., 1974), but the results, far from being in agreement, are rather conflicting. From an epidemiological study into the incidence of cancer and diabetes mellitus and glucose-6-phosphate dehydrogenase (G6PD) deficiency in different populations of the world, Kessler (1970) suggested a negative association of G6PD deficiency in cancer and a positive relationship in diabetes mellitus. Naik and Anderson (1971) observed a negative association of G6PD deficiency in cancer in American Negro patients, but only in the case of females. In an earlier study on a pooled sample of smaller size we failed to observe any association of G6PD deficiency and ABO blood groups in diabetes mellitus (Saha, 1971). The three ethnic groups in Singapore (Chinese, Malays, and Indians), who have different incidences of the disease, with a higher incidence among Indians compared with the other two (Cheah et al., 1972, 1975), provided an excellent opportunity to study the possible association of G6PD deficiency, ABO blood groups, and haemoglobin types in diabetes mellitus.

We present in this report the incidence of G6PD deficiency, ABO blood groups, and haemoglobin types in maturity onset diabetes mellitus compared with healthy controls in the three ethnic groups of Singapore.

Received for publication 16 February 1979
abnormal haemoglobins the series of Saha et al. (1973) were taken as healthy controls.

ABO blood grouping was carried out by slide tests using commercial antisera. G6PD deficiency was identified by the dye decoloration method of Motulsky and Campbell-Kraut (1961). Haemoglobin phenotypes were screened by paper electrophoresis using barbital buffer pH 8.6, ionic strength 0.025.

**Results and discussion**

**G6PD deficiency**

Table 1 shows the distribution of G6PD deficiency in diabetic patients and healthy controls in the three ethnic groups. The incidence of G6PD deficiency is significantly higher in diabetic Chinese and Indian patients (10.4% and 9.9%) compared to non-diabetic controls attending the diabetic clinic (5.0% and 2.9%) and published series (3.3% and 1.7%). The P values are 0.002 and 0.04, respectively, in the case of the former, and $0.16 \times 10^{-10}$ and 0.0001 in the case of the latter comparison. The relative risk of getting diabetes in G6PD deficient subjects is 2.2 and 3.4 in Chinese and 3.4 and 6.3 in Indians compared with non-deficient subjects in the diabetic clinic and population controls. This association of G6PD deficiency with diabetes mellitus holds up even when the three ethnic groups are combined (P = 0.007). Further, there is no significant heterogeneity between the two comparisons based on the two different controls in Chinese, Indians, and the combined group (P = 0.08, 0.59, and 0.15, respectively). There is no apparent significant difference in G6PD deficiency in the ethnic groups studied, and there is no significant difference in the case of Malays, which may be because of the small size of the sample.

In an earlier study we failed to observe any significant difference in the incidence of G6PD deficiency between diabetics and controls (Saha, 1971). This was probably because this was a pooled sample of all ethnic groups together. The present report suggests that there is an association of G6PD deficiency with diabetes mellitus which is in agreement with the hypothesis put forward by Kessler (1970). The higher incidence of G6PD deficiency among non-diabetics of the diabetic clinic compared to the published series (Vella, 1961; Saha and Banerjee, 1971a, b) may be the result of the presence of prediabetics in the series.

It has been reported that glucose tolerance may be altered in subjects with G6PD deficiency (Chamber mugam and Frumin, 1964) and the level of reduced glutathione in blood of diabetics is decreased (Illing et al., 1951). In view of the above findings one needs to guard against the possible inhibitory effect of diabetes on G6PD levels of red cells, indicating the screening test as deficient. However, Belfiore et al. (1974) reported an increase of G6PD activity in the liver of maturity onset diabetic subjects. Five of the diabetic patients of the present series showing G6PD deficiency on the first visit were followed up and they were found to be G6PD deficient on subsequent tests, even when their disease was under control. Therefore, it seems very unlikely that diabetes per se produces G6PD deficiency as detected by screening tests with brilliant cresyl blue dye. Because of the empirical nature of the dye decoloration test, it needs to be confirmed by parallel G6PD assay that diabetes by itself does not lower the activity of G6PD in red cells.

The present diabetic series is representative of the population of Singapore, as shown by the higher incidence of diabetes among Indians, which corroborates the findings of Cheah et al. (1972, 1975). In

<table>
<thead>
<tr>
<th>Ethnic origin</th>
<th>Diabetic clinic controls</th>
<th>Population controls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No tested</td>
<td>No deficient</td>
</tr>
<tr>
<td>Chinese</td>
<td>422</td>
<td>44</td>
</tr>
<tr>
<td>Malays</td>
<td>66</td>
<td>3</td>
</tr>
<tr>
<td>Indians</td>
<td>121</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>609</td>
<td>59</td>
</tr>
</tbody>
</table>

*Relative risk of getting diabetes of G6PD deficient compared with non-deficient.

$\chi^2$ for association, three ethnic groups combined using the diabetic clinic controls = 11.45, P = 0.007.

$\chi^2$ for heterogeneity between controls, 3.44, 0.8, and 3.75, respectively, for Chinese, Indians, and combined groups (P = 0.08, 0.59, and 0.15, respectively).

Table 1a Distribution of G6PD deficiency in diabetes mellitus

<table>
<thead>
<tr>
<th>Ethnic origin</th>
<th>Diabetic mellitus</th>
<th>Diabetic clinic controls</th>
<th>Population controls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No tested</td>
<td>No deficient</td>
<td>% deficient</td>
</tr>
<tr>
<td>Chinese</td>
<td>422</td>
<td>44</td>
<td>10-42</td>
</tr>
<tr>
<td>Malays</td>
<td>66</td>
<td>3</td>
<td>4-55</td>
</tr>
<tr>
<td>Indians</td>
<td>121</td>
<td>12</td>
<td>9-92</td>
</tr>
<tr>
<td>Total</td>
<td>609</td>
<td>59</td>
<td>9-69</td>
</tr>
</tbody>
</table>

*Relative risk of getting diabetes of G6PD deficient compared with non-deficient.

$\chi^2$ for association, three ethnic groups combined using the diabetic clinic controls = 11.45, P = 0.007.

$\chi^2$ for heterogeneity between controls, 3.44, 0.8, and 3.75, respectively, for Chinese, Indians, and combined groups (P = 0.08, 0.59, and 0.15, respectively).
view of the lack of association of G6PD deficiency with diabetes in Malay patients in the present series and in our earlier series (Saha, 1971), further investigations with larger samples are advisable to reach a definite conclusion. Further, it will be interesting to look into the phenotypic distribution of G6PD in diabetes mellitus in different populations, as there are many populations with a high incidence of diabetes but with low frequency of G6PD deficiency or none at all. The underlying significance of the association of G6PD deficiency with diabetes mellitus is not clear at the moment.

ABO BLOOD GROUPS

Table 2 shows the distribution of ABO blood groups in Chinese, Malay, and Indian patients compared to normal controls. There was no significant difference in the distribution of ABO blood groups between the patient and control series in any of the ethnic groups. There seems to be no real association present. The conflicting reports in the various published series may be because of the heterogeneity between patient and control series. The present study is unique in the sense that Singapore is served by only one blood bank and a parallel control series has been investigated blindly using non-diabetic patients attending the same clinic.

HEMoglobin TYPES

The incidence of abnormal haemoglobins in diabetic patients was: 0.24% in Chinese, 4.54% in Malays, and 0.83% in Indians, compared to 0.00% in Chinese, 3.45% in Malays, and 0.73% in Indians in the control series of the diabetic clinic, and 0.64% in Chinese, 5.52% in Malays, and 1.10% in Indians in the published series of Saha et al. (1973). All the abnormal haemoglobins were of phenotype AE. In the present series there was no significant difference in the incidence of abnormal haemoglobins between the patient and control series.

The author is grateful to the Medical Superintendent of the Tan Tock Seng Hospital, Singapore, for permission to carry out this study and to Professor E. N. Somerville for reading the manuscript.

References


Table 2  Distribution of ABO blood groups in diabetes mellitus

<table>
<thead>
<tr>
<th>Blood groups</th>
<th>Chinese</th>
<th>Malays</th>
<th>Indians</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Diabetes</td>
<td>Diabetic clinic controls</td>
<td>Controls*</td>
</tr>
<tr>
<td></td>
<td>No %</td>
<td>No %</td>
<td>No %</td>
</tr>
<tr>
<td>O</td>
<td>208 43.06 227 43.16 6644 43.53 27 40.91 30 44.84 2098 48.42</td>
<td>27 40.91 30 44.84 2098 48.42 51 42.15 56 40.88 1951 49.02</td>
<td>41 42-15 56 40.88 1951 49.02</td>
</tr>
<tr>
<td>A</td>
<td>136 28.16 144 27.38 3967 25.99 23 34.85 25 28.74 1369 25.07</td>
<td>23 34.85 25 28.74 1369 25.07 27 22-31 29 21-17 1051 21-02</td>
<td>27 22-31 29 21-17 1051 21-02</td>
</tr>
<tr>
<td>B</td>
<td>117 24.22 125 23.76 3814 24.99 12 18.18 23 26.44 1596 29.23</td>
<td>12 18.18 23 26.44 1596 29.23 17 22-31 29 21-17 1600 33.60</td>
<td>37 23-32 44 32.12 1600 33.60</td>
</tr>
<tr>
<td>AB</td>
<td>22 4.55 30 5.70 837 5.48 4 4.06 9 10.34 398 7.29 6 4.96 8 5.84 318 6-36</td>
<td>4 4.06 9 10.34 398 7.29 6 4.96 8 5.84 318 6-36</td>
<td>6 4.96 8 5.84 318 6-36</td>
</tr>
</tbody>
</table>

*Chan (1962)


Requests for reprints to Professor N. Saha, Faculty of Medicine, University of Khartoum, POB 102, Khartoum, Sudan.