The double glucagon test, a new liver function test

H. VERHAEGEN
M.D.

M. L. VERHAEGEN-DECLERCQ
M.D.

A. de BEUKELAER
M.D.

F. KRUG
M.D.

Department of Internal Medicine,
St Bartholomew's Hospital, Merksem, Antwerp, Belgium

Summary
A double glucagon test was performed in 100 patients and seventeen control subjects. Two intravenous doses of glucagon (1 mg) were administered at a 1-hr interval. Glucose was determined before the first injection and 20, 25 and 30 min after both doses, and the increases after each successive dose were added up.

In normal persons, the total increase in glycaemia was higher in the second than in the first hour and reached at least 110 mg. Normal values were found in cases of obstructive jaundice, cholelithiasis and adult diabetes, and abnormal values in patients with infective hepatitis, liver congestion and cirrhosis.

The double glucagon test was found to be very useful for the differential diagnosis of liver cell impairment and hepatic obstruction.

Introduction
Glucagon increases hepatic glycogenolysis by activating the phosphorylating enzymes by which glycogen is converted into glucose (Sutherland & Cori, 1951; Van Itally & Bentley, 1955). Considering that the glycogen content of the diseased liver is usually low and that glucagon apparently does not induce muscular glycogenolysis but only hepatic glycogenolysis, the possibility of a new liver function test was envisaged.

Subjects
The study included 100 patients (fifty-three men and forty-seven women, age range 20–74 years), most of them with jaundice. Their diagnoses are presented in Table 1 and some additional information is given below. In three of the patients with obstructive jaundice the symptoms lasted for several weeks. Two of the patients with acute hepatitis displayed a cholestatic component with marked increase in alkaline phosphatase. Four of the nine patients with cholecystitis, but none of them, suffered from obstructive jaundice. Patients with hepatic precoma were excluded because of the risk of severe hypoglycaemia which might speed the onset of coma.

In addition, a control group of seventeen persons was selected. All of them were free from hepatic...

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>Number of patients</th>
<th>$\Sigma_1$</th>
<th>$\Sigma_2$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Min</td>
<td>Max</td>
</tr>
<tr>
<td>Obstructive jaundice</td>
<td>24</td>
<td>95</td>
<td>185</td>
</tr>
<tr>
<td>Acute infective hepatitis</td>
<td>21</td>
<td>0</td>
<td>110</td>
</tr>
<tr>
<td>Hepatocirrhosis</td>
<td>20</td>
<td>0</td>
<td>123</td>
</tr>
<tr>
<td>Liver congestion due to heart failure</td>
<td>12</td>
<td>43</td>
<td>180</td>
</tr>
<tr>
<td>Cholelithiasis</td>
<td>9</td>
<td>98</td>
<td>182</td>
</tr>
<tr>
<td>Liver metastases</td>
<td>8</td>
<td>45</td>
<td>112</td>
</tr>
<tr>
<td>Adult diabetes</td>
<td>6</td>
<td>92</td>
<td>160</td>
</tr>
<tr>
<td>Control group</td>
<td>17</td>
<td>96</td>
<td>200</td>
</tr>
</tbody>
</table>

* One case: $\Sigma_1 = \Sigma_2$. 
disease and had normal serum flocculation tests, bromsulphalein and serum transaminases.

Method
The tests were performed in the morning after a 14-hr fasting period. Two intravenous doses of 1 mg of glucagon were given at an interval of 1 hr. Capillary blood samples were taken, by finger prick, 5 min and immediately before the first injection, and 20, 25 and 30 min after the first and second injection. The capillary blood glucose (mg/ml) at the six post-glucagon determinations was compared, for each subject, with the control level (average of the two pre-glucagon samples). The sum of the increases after each injection indicated the 'total hyperglycaemia' in the first (Σ₁) and second (Σ₂) hour. Blood glucose was determined by the Nelson–Somogyi method (Nelson, 1944).

Results
The results for the various diagnostic categories and the control group are presented in the accompanying table.

In the control group, the mean average increase in glycaemia was 136 mg (range 96–200) in the first hour and 160 mg (110–240) in the second hour. In sixteen subjects Σ₂ was higher than Σ₁ and in one subject Σ₂ was equal to Σ₁.

A normal response to glucagon was observed in the patients with obstructive jaundice even when the disease had been present for several weeks.

In patients suffering from infective hepatitis, Σ₁ was lower than in the control group and the overlap was very slight. Σ₂ was always lower than in the control population and usually lower than Σ₁ (Fig 1A).

Similar results were achieved in patients with cirrhosis; the overlap was somewhat larger than in the patients suffering from hepatitis and two patients displayed a normal double-glucagon test (Fig. 1B).

The difference was statistically highly significant (P<0.0001) for Σ₁, Σ₂ and Σ₂ – Σ₁ between the control group and the patients with hepatitis, and for Σ₁ and Σ₂ between the controls and the patients with cirrhosis.

Patients with hepatic congestion due to heart failure showed low Σ₁, and Σ₂ was lower than Σ₁ in all instances. Patients with liver metastases had similar low values in the two tests and Σ₂ was lower than Σ₁ in six of eight cases. As several patients were rather cachetic at the time of the test, malnutrition may have interfered with the results.

![Fig. 1. Individual results of the double glucagon test. Summed increase in glycaemia after the first (Σ₁) and second (Σ₂) injection of 1 mg glucagon.](http://pmj.bmj.com/)
Neither cholelithiasis nor stable diabetes had any influence on either $\Sigma_1$ or $\Sigma_2$, the results of the tests being very similar to those in the control group.

Discussion and conclusion

In the control group, the response to intravenous glucagon is higher after the second than after the first dose. This is probably due to the double action of glucagon on the production of glucose: a glyco- genolytic action of rapid onset and a gluconeogenic effect starting after about one hour (Exton et al., 1966). Thus the increase in blood glucose, in the second hour, is the sum of the glyco- genolytic effect of the second injection and the gluconeogenic effect of the first. This hypothesis will be further investigated.

Recently we performed a double glucagon test before and after phenformin, since phenformin was reported to inhibit gluconeogenesis (Altschuld & Kruger, 1968). As expected, the total hyperglycaemia in the second hour ($\Sigma_2$) was lower after phenformin than before phenformin (Verhaegen et al., 1970).

Ghannem et al. (1962) and Linke (1959) examined liver function by the single glucagon test and found a significant difference between patients suffering from liver diseases and normal persons. However, the great overlapping invalidated the value of the test. As the double glucagon test offers a larger spreading of the values with a different course according to various diagnostic categories it seems to possess a higher absolute and differential diagnostic value.

The test does not appear to be sufficiently informative for assessing the severity of cirrhosis as patients with well compensated cirrhosis generally presented abnormal values and the one patient with advanced alcoholic cirrhosis had a normal response.

Figure 1C shows that the results are widely divergent in cases of obstructive jaundice and hepatitis.

In the patients with obstructive jaundice and in those with cholelithiasis the pattern was very similar to that of the control population. Furthermore, the three patients with long-standing obstructive jaundice displayed clearly pathological serum flocculation tests and transaminases although the double glucagon test was unaffected.

All the patients with infective hepatitis displayed considerably divergent results from those of the control group. In many of these patients, the double glucagon test was repeated after a few weeks. The pattern remained abnormal until 6 weeks after the onset of the disease, although by this time all other biochemical parameters had returned to normal.

The follow-up studies are of too short a duration to establish whether the double glucagon test is effective for differentiating between patients in whom hepatitis develops into chronic hepatitis and those in whom the disease develops into cirrhosis.

Our results offer strong evidence for the value of the double glucagon test in the differential diagnosis of liver cell impairment and obstruction.

Acknowledgments

We are most grateful for the valuable help by Miss V. Schuermans. We thank Mr H. Pauwels for the technical assistance and Novo Industries, A/V, Copenhagen for supplying the glucagon.

References


