Comment on: Haider DG, Schaller G, Kapiotis S, Maier C, Luger A, Wolzt M (2006) The release of the adipocytokine visfatin is regulated by glucose and insulin. *Diabetologia* 49:1909–1914

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To the Editor:

In a recent article published in *Diabetologia*, Haider and coworkers investigated the influence of glucose and insulin stimulation on visfatin concentrations in humans [1]. They concluded that visfatin secretion is increased during hyperglycaemia, and that this increase could be prevented by the co-infusion of insulin or somatostatin with glucose. Unfortunately, no insulin data are given in this paper, and the authors did not discuss how endogenous insulin secretion may have interfered with the experimental outcome. In addition, the authors' conclusions were based on reported visfatin levels ranging from 0.5 to 5 ng/ml. While we do not generally want to question the overall correlations observed in these experiments, it should be pointed out that these visfatin levels are about ten-fold lower than those reported by us and other groups using exactly the same visfatin assay method. It appears from the manuscript and the patient characteristics that the samples were derived from an experiment focusing on ghrelin, which was performed years ago and published for the first time in 2003 [2]. Therefore, the samples must have been stored for more than 3 years, and the storage conditions were not detailed in the paper. We recently performed measurements in non-diabetic patients at cardiovascular risk, where laboratory determinations occurred after immediate sample processing and storage at -80°C for not more than 4 months. After establishing the ELISA in accordance with the International Organization for Standardization

(ISO)- and College of American Pathologists (CAP)-accredited standard operating procedures of the IKFE laboratory, we measured values in the 25–50 ng/ml range [3]. Our results are in line with other recently published investigations in diabetic and non-diabetic patients, in whom visfatin levels between 15 and 40 ng/ml were reported, again using the same ELISA test method [4–6]. This discrepancy further highlights the need to exercise caution when using old sample cohorts to identify new markers without prior careful investigation of the stability of the markers under the storage conditions used.

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