Role of Advanced Glycation End Products and Its Receptors in the Pathogenesis of Cigarette Smoke-Induced Cardiovascular Disease

Kailash Prasad, MBBS (Hons.), MD, PhD, FRCP, FACC, FICA, FIACS1  Indu Dhar, PhD2
Gudrun Caspar-Bell, MD, FRCP3

1 Department of Physiology, College of Medicine, University of Saskatchewan, Saskatoon, Canada
2 Department of Pharmacology, College of Medicine, University of Saskatchewan, Saskatoon, Canada
3 Department of Medicine, Royal University Hospital, College of Medicine, University of Saskatchewan, Saskatoon, Canada

Address for correspondence Kailash Prasad, MBBS (Hons.), MD, PhD, FRCP, FACC, FICA, FIACS, Department of Physiology, College of Medicine, University of Saskatchewan, 107 Wiggins Road, Saskatoon, SK, S7N 5E5, Canada (e-mail: k.prasad@usask.ca).


Abstract
The interaction of advanced glycation end products (AGEs) with its cell-bound receptor RAGE increases gene expression and release of proinflammatory cytokines and increase generation of reactive oxygen species (ROS). Circulating receptors, soluble RAGE (sRAGE), and endoscretory RAGE (esRAGE) by binding with RAGE ligands have protective effects against AGE–RAGE interaction. Cigarette smoking is a risk factor for coronary artery disease, stroke, and peripheral vascular disease. This article reviews; if the AGE–RAGE axis is involved in the cigarette smoke-induced cardiovascular diseases. There are various sources of AGEs in smokers including, gas/tar of cigarette, activation of macrophages and polymorphonuclear leukocytes, uncoupling of endothelial isoform of nitric oxide synthase (eNOS) and xanthine oxidase. The levels of AGEs are elevated in smokers. Serum levels of sRAGE have been reported to be reduced, elevated, or unchanged in smokers. Mostly the levels are reduced. There is one article which shows an elevation of levels of sRAGE in smokers. Serum levels of esRAGE are unaltered in smokers. Mechanism of AGE–RAGE-induced atherosclerosis has been discussed. Atherosclerosis leads to the cardiovascular diseases. It has been suggested that ratio of AGE/sRAGE or AGE/esRAGE is useful in determining the deleterious effects of AGE–RAGE interaction in smokers. sRAGE alone is not a good marker for smoke-induced cardiovascular disease. In conclusion cigarette smoke induces formation of AGEs and reduces sRAGE resulting in the development of atherosclerosis and related coronary heart disease, stroke, and peripheral vascular disease. Ratio of AGEs/sRAGE is a better marker for cardiovascular disease than AGEs or sRAGE alone in smokers.

Keywords
► cigarette smokers
► advanced glycation end products
► soluble receptors for AGEs
► receptor for AGE
► cardiovascular disease

Cigarette smoking is a major risk factor for coronary artery disease (CAD), stroke, and peripheral vascular disease.1,2 Smoking predisposes to aortic and peripheral atherosclerosis resulting in abdominal aortic aneurysm and intermittent claudication.3 Epidemiological studies show that cigarette smokers have greater risk of developing CAD than nonsmokers.3–7

Coronary angiography in severe cigarette smokers has shown that the coronary arteries are atherosclerased.8 Cigarette smoking is an independent predictor of new coronary
Cigarette Smoke and AGEs-RAGE Axis

Prasad et al.

lesion. The mechanisms of cigarette-induced cardiovascular diseases are numerous including, atherosclerosis, thrombosis, and coronary spasm. Oxidative stress has been implicated in the development of atherosclerosis. Cigarette smoking may induce atherosclerosis through reactive oxygen species (ROS). Cigarette smoking could generate ROS through gas/tar of cigarette, activation of macrophage and polymorphonuclear leukocytes, uncoupling endothelial isoform of NOS, and xanthine oxidase.

Advanced glycation end products (AGEs) and its receptor, soluble receptors for AGEs (sRAGE) have been implicated in the cardiovascular diseases. It has been reported that the serum levels of sRAGE are low while the levels of AGEs are high in patients with nondiabetic CAD. In animal studies it has been shown that AGE–RAGE axis is implicated in the development of atherosclerosis.

Interaction of AGEs with its cellular receptor, receptor for AGEs (RAGE) produces ROS. The sRAGE, the other receptors for AGEs acts as a decoy for RAGE ligands (AGEs) and compete with membrane-bound RAGE for ligand binding and thus reduce the generation of ROS.

It is possible that low serum levels of sRAGE and high levels of AGEs are involved in the cigarette smoke-induced cardiovascular diseases.

The present review deals with the AGES–RAGE axis, sources of AGEs in smokers, serum levels of AGES, sRAGE and esRAGE in smokers, and mechanism of atherosclerosis.

**AGES–RAGE Axis**

AGES are heterogeneous group of irreversible adducts resulting from the nonenzymatic glycation and glycoxidation of proteins, nucleic acid, and lipids. Glucose interacts with free amino group of lysine or arginine, producing Schiff bases, which are rapidly transformed into Amadori products. A series of complex reactions results in the formation of AGEs including Nε-carboxymethyl-lysine, Nε-carboxyethyl-lysine, pentosidine, furoseine, and pyraline. There are four receptors for AGES: full length RAGE, a member of the immunoglobulin super family and is multiligand receptor; N-truncated RAGE, C-terminal RAGE having two isoforms, cRAGE (cleaved RAGE) and esRAGE. cRAGE is proteolytically cleaved from cell surface while esRAGE is alternative splicing to remove the transmembrane region. Both esRAGE and cRAGE are extracellular and functionally equivalent and interact with the same RAGE ligands. Measurement of total sRAGE includes both cRAGE and esRAGE (sRAGE enzyme-linked immuno sorbent assay kit) while measurement of esRAGE measures only esRAGE which is about 20% of the total sRAGE.

Interaction of AGES with full length RAGE activates nuclear factor κappa-B (NF-kB), increases gene expression and release of inflammatory cytokines, and increases production of ROS.

Both sRAGE and esRAGE act as a decoy for RAGE by binding with RAGE ligands and prevents them from binding with membrane-bound full length RAGE. sRAGE and esRAGE have protective effects against AGE–RAGE interaction.

**Sources of AGEs in Smokers**

The information related to the sources of AGEs in smokers is very few. Cerami et al did an extensive study on the formation of AGEs from tobacco leaves and cigarette smoke. They reported that reactive glycation products (glycotoxins) are present in the water extracts of tobacco leaves and tobacco smoke promote formation of AGEs in vivo and in vitro. The generation of AGES by cigarette smoke was concentration and time dependent. They also showed that cigarette smoke condensate was approximately 10-fold less active in production of AGES than aqueous tobacco leaf extracts. The high levels of AGES in smokers have been implicated in the development of atherosclerosis.

**Serum Levels of AGES**

Serum levels of AGES are elevated in cigarette smokers. Radoi et al reported that during smoking, the combustion of pre-AGE compounds present in tobacco produces a series of reactive and toxic AGE. AGE or LDL-linked AGE levels in serum are elevated in cigarette smokers. In another study, Berg et al have shown that current or past smokers have increased serum levels of AGEs compared with those who never smoked, median levels of AGEs were 10.7 U/mL (range, 7.8–16.5 U/mL) and 9.5 U/mL (range, 7.1–13.8 U/mL) (smokers vs. nonsmokers).

AGES levels are not only elevated in the serum but also in the tissue. Nicholl et al have shown that the levels of AGEs or immunologically related molecules are higher in the lenses and blood vessels of cigarette smokers. These data suggest that serum and tissue levels of AGEs are elevated in cigarette smokers.

**Serum Levels of sRAGE and esRAGE in Smokers**

The serum levels of sRAGE in smokers are variable. There are various reports which show a decrease in serum levels of sRAGE in smokers. Gopal et al reported that plasma levels of sRAGE were lower in ex-smokers as compared with the never smokers. In patients with chronic obstructive pulmonary disease (COPD) the sRAGE levels were not significantly different between ex-smokers and current smokers. However, lwamoto et al reported that the plasma levels of sRAGE are lower in smokers with COPD (969.1 ± 406.0 pg/mL) and smokers without COPD (973.4 ± 426.5 pg/mL) as compared with nonsmokers (1,201.1 ± 483.6 pg/mL). Reduction of
Mechanism of AGEs–RAGE Axis-Induced Atherosclerosis

Interaction of AGEs with full length RAGE increases production of ROS, activates NF-κB and increases the expression of adhesion molecules and cytokines.31,32,37 Cytokines are known to stimulate granulocytes to generate ROS.48–51

ROS have been implicated in the development of atherosclerosis.13,52 Oxidative hypothesis of atherosclerosis has been detailed elsewhere.53 In short low-density lipoprotein (LDL) cholesterol is mildly oxidized to minimally modified LDL (MM-LDL) which stimulates smooth muscle cells and endothelial cells to produce monocyte chemoattractant protein-1 (MCP-1). ROS increases the expression of cell adhesion molecules, intercellular adhesion molecule-1, vascular cell adhesion molecule-1, and endothelial leukocyte adhesion molecules on the endothelial cells.54–57 Cell adhesion molecules help monocytes to adhere to the endothelial cell surface. MM-LDL is further oxidized to oxidized-LDL (OX-LDL). MCP-1 and OX-LDL facilitate the migration of monocyte to migrate to the subendothelial area. MM-LDL induces release of monocyte colony stimulating factor from endothelial cells that help in differentiation of monocyte/macrophage. Differentiated macrophage develops receptor for OX-LDL which is taken up by macrophage to form foam cells. Macrophage increases the expression of numerous growth factors which leads to the formation of collagen, elastic fiber, and protein and transcription of smooth muscle cells. Proliferation and migration of smooth muscle cells, synthesis of connective tissue and matrix, migration of monocyte and formation of foam cells, culminate in the initiation and progression of atherosclerosis. The role of AGEs–RAGE interaction in the development of atherosclerosis and the protective effects of sRAGE and esRAGE are depicted in Fig. 1.

Interaction of AGE and RAGE will produce atherosclerosis. sRAGE and esRAGE interacts with AGEs and hence fewer AGEs are available to interact with RAGE resulting in the reduced production of ROS, cytokines, and cell adhesion molecules. This will result in attenuation of the formation of atherosclerosis.

Comments

Most of the published data show that there is a reduction in the serum levels of sRAGE in cigarette smokers43–45 except one report which shows an increase in the serum levels of sRAGE in smokers.46 It is very difficult to reconcile these differences in the serum levels of RAGE in smokers. There are numerous data which suggest a protective role of sRAGE against deleterious effects of AGE–RAGE interaction22–26 in patients with nondiabetic CAD. AGE–RAGE axis has been implicated in the development of atherosclerosis in animals and sRAGE has been reported to have protective effects against atherosclerosis.28–30 As mentioned in the AGE–RAGE axis section of this review, interaction of AGE with RAGE increases the production of inflammatory cytokines, ROS and NF-κB which in turn induces proinflammatory cytokines.31,32,37 Low levels of sRAGE would increase the proinflammatory cytokines while high levels of sRAGE would reduce the proinflammatory cytokines. Biswas et al.46 however reports that serum levels of sRAGE are elevated in smokers. They suggest that elevated levels of sRAGE would increase proinflammatory biomarkers and are responsible for cardiovascular disease in smokers.

Other investigators38,39 besides Biswas et al.46 have suggested sRAGE a proinflammatory biomarker. Nakamura et al.28 have shown that there is significant positive correlation between sRAGE and inflammatory markers in patients with type 2 diabetes. Pullerits et al.39 have reported that sRAGE may be a proinflammatory and chemotactic molecule through its interaction with α 2 integrin Mac-1. However, these increases in the sRAGE may not be the culprit and proinflammatory biomarkers. These investigators did not measure the serum levels of AGEs in the studies.

Four players including, AGEs, cellular receptor RAGE, and circulating receptors sRAGE and esRAGE are involved in the AGE–RAGE axis. In humans it is not feasible to measure cell-bound receptor RAGE.
AGEs, sRAGE, and esRAGE can be measured in the serum of humans. Other players such as AGEs besides sRAGE and esRAGE should be considered in the equation of biomarker related to the AGE–RAGE axis. Increases in serum sRAGE may be associated with increase in serum AGEs. If this occurs then increases in sRAGE may not be proinflammatory. If the increase in AGEs is more than sRAGE, more RAGE is available to interact with cell-bound RAGE to produce inflammatory mediators and ROS. For example, the levels of sRAGE are elevated in diabetes60–62 and end-stage renal disease.63,64 The levels of AGEs are also elevated in diabetes65–67 and end-stage renal disease.68,69 In this context, the authors would like to point out that the serum levels of AGEs are elevated in smokers.39–41 It is possible that elevated levels of serum sRAGE are not enough to handle large amount of AGEs. It would be scientifically sound to use the ratio of AGEs/sRAGE or AGEs/esRAGE as a biomarker of the disease. The statement of Biswas et al,46 that sRAGE is proinflammatory, does not seem scientifically sound. In this respect Prasad et al70 has reported that AGEs/sRAGE or AGEs/esRAGE would be a better biomarker than sRAGE or esRAGE for disease associated with AGE–RAGE axis.

In conclusion serum levels of sRAGE are low and the levels of AGE are elevated in cigarette smokers. The decrease in the serum levels of sRAGE and increase in the levels of AGE may be involved in the cigarette smoke-induced cardiovascular disease in cigarette smokers. AGEs/sRAGE would be better proinflammatory marker than sRAGE or AGEs alone.

Acknowledgment

The authors acknowledge the assistance of Mr. Muhammad A. Shoker in preparation of the article.

References

26. McNair ED, Wells CR, Mabood Qureshi A, et al. Soluble receptors for advanced glycation end products (sRAGE) as a predictor of...
31 Prasad K. Soluble receptor for advanced glycation end products (sRAGE) and cardiovascular disease. Int J Angiol 2006;15:57–68
41 Berg TJ, Snorgaard O, Faber J, et al. Serum levels of advanced glycation end products are associated with left ventricular diastolic function in patients with type 1 diabetes. Diabetes Care 1999;22(7):1186–1190
44 Biswas SK, Mudi SR, Mollah FH, Bierhaus A, Arslan MI. Serum soluble receptor for advanced glycation end products (sRAGE) is independently associated with cigarette smoking in non-diabetic healthy subjects. Diab Vasc Dis Res 2013;10(4):380–382
48 Ellis TN, Beaman BL. Interferon-gamma activation of polymorphonuclear neutrophil function. Immunology 2004;112(1-2):2–12
56 Nakamura K, Yamagishi S, Adachi H, et al. Serum levels of sRAGE, the soluble form of receptor for advanced glycation end products, are associated with inflammatory markers in patients with type 2 diabetes. Mol Med 2007;13(3-4):185–189
57 Pullerits R, Brisslert M, Jonsson IM, Tarkowski A. Soluble receptor for advanced glycation end products triggers a proinflammatory cytokine cascade via beta2 integrin Mac-1. Arthritis Rheum 2006;54(12):3898–3907
59 Tan KCB, Shiu SWM, Chow WS, Leng L, Bucala R, Betteridge DJ. Association between serum levels of soluble receptor for advanced glycation end products and circulating advanced glycation end products in type 2 diabetes. Diabetologia 2006;49(11):2756–2762

Berg TJ, Dahl-Jørgensen K, Torjesen PA, Hanssen KF. Increased serum levels of advanced glycation end products (AGEs) in children and adolescents with IDDM. Diabetes Care 1997;20(6):1006–1008

Kilhovd BK, Berg TJ, Birkeland KI, Thorsby P, Hanssen KF. Serum levels of advanced glycation end products are increased in patients with type 2 diabetes and coronary heart disease. Diabetes Care 1999;22(9):1543–1548


Prasad K. Low levels of serum soluble receptors for advanced glycation end products, biomarkers for disease states: Myth or reality. Int J Angiol 2014;23:11–16