Systemic Low-Grade Inflammation and Risk of Coronary Heart Disease: Results from the MONICA/KORA Augsburg Cohort Studies

Abstract

Atherosclerosis is characterised by a non-specific local inflammatory process accompanied by a systemic response. A number of prospective studies in initially healthy subjects and in patients with manifest atherosclerosis have now convincingly demonstrated a strong and independent association between even slightly elevated concentrations of various systemic markers of inflammation (plasma viscosity, C-reactive protein [CRP], and other acute phase reactants) and a number of cardiovascular endpoints. Presently, CRP, the classical acute phase protein, seems to be the marker of choice for the clinical situation. Initial evidence suggests that measurement of CRP adds to global risk assessment based on the Framingham risk score. The recent AHA/CDC consensus report recommends the measurement of CRP in asymptomatic subjects at intermediate risk for future coronary events (10-year risk of 10–20%) and in selected patients after an acute coronary syndrome. Whether CRP shall alter treatment strategies in subjects without clinically manifest atherosclerosis is presently being tested in a large randomised clinical trial. In addition, recent research has suggested that CRP may not only be a risk marker, but may be directly involved in the pathogenesis of atherothrombosis. However, there are other emerging biomarkers. Lipoprotein-associated phospholipase A₂ (Lp-PLA₂), an enzyme produced by monocytes/macrophages, T-cells and mast cells was found to generate proinflammatory and proatherogenic molecules from oxidised LDL. We tested the association of these new biomarkers with traditional risk factors.
Plasma viscosity

Plasma viscosity is determined by various macromolecules, e.g., fibrinogen, immunoglobulins, and lipoproteins. It may therefore reflect several aspects involved in cardiovascular diseases, including the effects of classical risk factors, hemostatic disturbances, and inflammation. We examined the association of plasma viscosity with the incidence of a first major CHD event (fatal and non-fatal myocardial infarction, MI, and sudden cardiac death, n = 50) in 933 men aged 45–64 years participating in the first MONICA survey in 1984/85 (S1). The incidence rate was 7.23 per 1000 person-years (95% confidence interval, CI, 5.37–9.53) and the subjects were followed for 8 years. All suspected cases of incident CHD were classified according the MONICA protocol. There was a positive and statistically significant association between baseline levels of plasma viscosity and incident CHD even after controlling for a variety of potential confounders. A 1 standard deviation (SD) increase in plasma viscosity (0.070 mPa·s) was associated with a 42% increase in the relative risk (RR 1.42, 95%CI, 1.09–1.86). Comparison of the RR for a CHD event in the top quintile to the risk in the bottom quintile yielded a more than 3-fold increased risk (RR 3.31, 95% CI 1.19–9.25) [6].

There is a well-known north-south gradient in CHD incidence in Europe which cannot be explained on the basis of traditional risk factors. We therefore looked into the geographical variations of plasma viscosity in relation to coronary event rates in two regions with different absolute CHD risk, Glasgow in Scotland and Augsburg in Southern Germany. We analyzed plasma viscosity data from the S1 and compared them to values form Glasgow MONICA, collected in the same year. In multivariable adjusted analyses, we found a striking difference of a 1 SD of the population mean (0.066, 95% CI, 0.058–0.073) in men and a similar difference in women, with lower values in Augsburg compared to Glasgow. This large geographical difference may explain in part the differences in CHD event rates between these two populations [7].

In several publications using the data from S1, we reported positive associations between plasma viscosity and various lipoproteins [8], smoking [9], blood pressure [10], and a negative association with leisure-time physical activity [11]. Also, in postmenopausal women from the S1 we found decreased plasma viscosity values during hormonal replacement therapy [12].

In addition, we prospectively analyzed the association between plasma viscosity and total mortality in the same cohort and found a RR to die of 2.68 (95% CI, 1.63–4.42) in subjects being in the top quintile of the plasma viscosity distribution compared to the bottom quintile [13].

In summary, plasma viscosity was strongly associated with CHD events and with total mortality in initially healthy middle-aged men from the general population.

C-reactive protein (CRP)

CRP, the classical acute phase protein, is a sensitive marker of inflammation, tissue damage and infection [14]. In contrast to virtually all other major acute phase reactants, its plasma half life (~19 h) is rapid but is identical under all conditions, so that the synthesis rate of CRP is the sole determinant of its plasma concentration [15]. Excellent anti-CRP antibodies and a well estab-
In long-term observational epidemiologic studies, risk variables are usually measured once at “baseline” and then related to outcome. Most physiological variables however, are not stable over time, but rather show a more or less pronounced diurnal, seasonal, and long-term variability. The potential for long-term variability is of great importance since such variation may have considerable impact on the accuracy of risk prediction by particular analytes. Surprisingly little information is available about this aspect of even the conventional risk factors in adequately sized analytes. Surprisingly little information is available about this aspect of even the conventional risk factors in adequately sized analytes. In order to investigate the association between CRP levels and CHD risk in large, unselected population, we have measured serum CRP by a high-sensitivity (hs) immunoradiometric assay [20] in 936 initially healthy men aged 45–64 years, who took part in S1. Based on an 8-year follow-up, we found an almost threefold increase in risk of a first major coronary event in these men, if individuals in the top quintile of the CRP distribution were compared to the bottom quintile [21]. This study further showed that CRP, although an acute phase reactant with a relatively short half-life turned out to be a reliable long-term marker of risk.

In particular, for CRP, which is extremely sensitive and shows a dynamic range of up to 10,000 fold in response to a variety of stimuli, this information is needed to reliably assess the risk prediction associated with elevated values. We measured CRP by a hs-assay in 936 men aged 45–64 years in 1984/85 (S1), and re-measured it 3 years later in 696 men from the same cohort (response rate 74%). All 936 men were subjected to an 8-year follow-up of their cardiovascular status. The analytical variation of the assay was small, with the analytical variance component (VC) at one percent of the within-subject VC, a repeatability coefficient of 25 percent, and a reliability coefficient of 1.00, indicating extremely little analytical measurement error. In contrast, the within-subject variability of CRP corresponded to a repeatability coefficient of 740 percent and a reliability coefficient of 0.54, indicating considerable within-subject variation. Based on our estimates, three serial determinations of CRP should be done to achieve a reliability of 0.75, the value we found for total cholesterol. Correcting the hazard rate ratios in our original analysis of the association of CHD and hs-CRP for the measurement error in CRP and covariables, leads to a considerably larger estimate. Our results suggest that the true association between CRP and cardiovascular risk is underestimated by a single CRP determination, and that several serial CRP measurements should be made [22].

An important issue in risk assessment relates to the potentially clinical relevant additional information conveyed by a new risk marker; in other words, does the addition of a new marker to the conventional risk profile enable improved risk prediction from a clinical standpoint? The Framingham Risk Score (FRS) is recommended for global risk assessment in subjects prone to CHD, and we investigated the potential of CRP measurements to modify risk prediction based on the FRS in a large CHD-event free cohort of middle-aged white men of German nationality sampled from the general population (the population-based MONICA Augsburg studies (S1–S3), conducted between 1984/85 and 1994/95).
We compared the proportions of incident coronary events within 10 years estimated by the Cox model for the five categories of the FRS alone (Fig. 1, left panel) and for different CRP categories in each category of FRS, adjusted for survey and components of the FRS (Fig. 1, right panel). Probability values of the stratified analyses are given in Fig. 1 (right panel, above each FRS category). Cox regression revealed a considerable modification in coronary event incidence based on CRP concentrations and, more importantly, in categories of FRS associated with a 10% to 20% risk per 10 years, elevated concentrations of CRP were consistently and statistically significantly associated with a further increased risk (P = 0.03 and P = 0.02). In contrast, in men with a risk < 6% and 6% to 10% per 10 years, CRP had no statistically significant additional effect on the prediction of a first coronary event. In ROC analyses, regarding the different areas under the curve (AUC), a remarkable increase was found for the intermediate FRS categories of 11% to 14% and 15% to 19% (increase in the AUC from 0.725 to 0.776 and from 0.695 to 0.751).

In this prospective population-based study, increased CRP concentrations and an elevated total cholesterol/HDL-cholesterol (TC/HDL-C) ratio were both independently related to incident coronary events. However, even if the strongest lipid/lipoprotein variable was chosen for risk assessment, these data clearly show that the measurement of CRP contributes significantly to the prediction of a first coronary event and adds clinically relevant information to the TC/HDL-C ratio. Finally, and most importantly, these prospective data from a large European cohort of middle-aged men clearly suggest that CRP modulates the risk conveyed by the FRS as the hazard ratios (HRs) from the top to the bottom category decreased remarkably after inclusion of CRP in the various models. This was observed in particular in those with an FRS between 10% and 20% over a period of 10 years. These men may benefit from additional noninvasive tests such as determination of CRP by a hs assay.

Thus, our data suggest the inclusion of CRP as an additional variable to further improve risk prediction in asymptomatic subjects at intermediate risk of CHD. This would be in line with recent American Heart Association/Centers for Disease Control guidelines.

Lipoprotein-associated phospholipase A2 (Lp-PLA2)

Lipoprotein-associated phospholipase A2 (Lp-PLA2) is an enzyme that may directly promote atherogenesis by generating potent pro-inflammatory and pro-atherogenic products, like lysophosphatidylcholine (lysoPC) and oxidized free fatty acids (oxFFA) from oxidation of LDL [24–26], an important step in atherogenesis. Lp-PLA2 is produced mainly by the characteristic cells of the atherosclerotic plaque, namely monocytes/macrophages, T-lymphocytes, and mast cells [27,28]. Furthermore, Lp-PLA2 has been detected in both human and rabbit atherosclerotic lesions [29]. Experimental studies in Watanabe heritable hyperlipidemic rabbits have demonstrated that inhibition of Lp-PLA2 leads to the reduction of atherosclerotic lesion formation [30]. In the bloodstream, two-thirds of the Lp-PLA2 plasma isoform circulates primarily bound to LDL, the other third is distributed between high-density lipoproteins (HDL) and very-low-density lipoproteins (VLDL) [31]. On the other hand, this enzyme is also known as the platelet activating factor acetylhydrolase (PAF-AH) which may reflect its antiatherogenic activity: to catalyze the degradation of PAF and oxidized phospholipids; in HDL cholesterol in particular, Lp-PLA2 has been suggested as a protective factor against the accumulation of oxidation products [32], thereby protecting LDL from further oxidation [33–35].

Indeed, data from three prospective epidemiologic studies assessing the association of Lp-PLA2 with cardiovascular endpoints yielded varying results [36–38]. We sought to investigate simultaneously the association between plasma concentrations of Lp-PLA2, C-reactive protein (CRP), and long-term risk of CHD in initially healthy middle-aged men from the general population in Augsburg, Southern Germany.

Plasma concentrations of Lp-PLA2 were determined by ELISA in 934 apparently healthy men aged 45–64 years sampled from S1 in 1984/85 and followed until 1998. During this period 97 men suffered from a coronary event diagnosed according to the MONICA protocol. Baseline levels of Lp-PLA2 were higher in subjects who experienced an event compared to event-free subjects (295 ± 113 vs. 263 ± 79 ng/mL, p < 0.01). Lp-PLA2 was positively correlated with total cholesterol (R = 0.30, p < 0.001) and age (R = 0.12, p = 0.001), and only slightly with HDL cholesterol (R = 0.09, p = 0.005) and CRP (R = 0.06, p = 0.06), but not with body mass index and blood pressure. In a Cox model, a 1 SD increase in Lp-PLA2 was associated with risk of future coronary events (hazard ratio, HR 1.37, 95% confidence interval, CI 1.16–1.62). After controlling for potential confounders, the HR was attenuated, but still remained statistically significant (HR 1.23, 95% CI, 1.02–1.47). Further inclusion of C-reactive protein (CRP) in the model did not appreciably affect its predictive ability (HR 1.21; 95% CI, 1.01–1.45). Elevated levels of Lp-PLA2 appeared to be predictive of future coronary events in apparently healthy middle-aged men with moderately elevated total cholesterol, independent of CRP. This suggests that Lp-PLA2 and CRP may be additive in their ability to predict risk of coronary heart disease [39].

Summary and outlook

These data from the MONICA/KORA cohort studies, involving all three population-based surveys (S1–S3) between 1984/85 and 1994/95 clearly show that various systemic markers of inflammation are able to predict future CHD events. For overview of published topics in the area of inflammation see Table 1. Thus, the role of a low-grade systemic inflammatory response is strongly supported by these results. Large cohorts like MONICA/KORA represent valuable databases for the evaluation of new risk markers that potentially will find their way into the clinical situation and contribute to an improved understanding of the pathophysiology of CHD and to improved risk prediction. As basic research progresses, new candidate markers in serum but also genetic markers related to the inflammatory response will be identified in the future and can be tested in these populations.
Table 1  Systemic inflammation and risk of coronary heart disease: Overview of publications based on the MONICA/KORA studies

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**C-reactive protein**

| Circulation 1999; 99: 237 – 242 | CRP and future risk of coronary heart disease | CRP and oral contraceptive use | CRP and all-cause mortality |
| Am J Epidemiol 2003; 158: 357 – 364 | CRP within-subject variation and risk of CHD | CRP and particulate air pollution | CRP distribution in various MONICA populations |
| Arch Intern Med 2003; 163: 93 – 99 | CRP and incident diabetes mellitus | Seasonal variation in CRP | CRP and incident diabetes mellitus |
| Brain Behav Immun 2003; 17: 268 – 275 | CRP, obesity and depressive mood | Various smoking characteristics and CRP | CRP and incident diabetes mellitus |
| Circulation 2004; 109: 1349 – 1353 | CRP adds to the Framingham score | CRP in women on different HRT | CRP and female sex hormone levels |

**Lipoprotein-associated phospholipase A2**

| Circulation 2004; 10: 1100 – 1108 | Lp-PLA2, CRP and incident coronary events | Lp-PLA2, CRP and incident coronary events | Lp-PLA2, CRP and incident coronary events |

**References**

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