Apolipoprotein(a) Phenotypes Predict the Risk for Carotid Atherosclerosis in Patients With End-Stage Renal Disease

Florian Kronenberg, Hermann Kathrein, Paul König, Ulrich Neyer, Wolfgang Sturm, Karl Lhotta, Ernst Gröchenig, Gerd Utermann, Hans Dieplinger

Abstract Several studies have demonstrated that atherosclerotic complications are the major cause of morbidity and mortality in hemodialysis patients. High lipoprotein(a) [Lp(a)] plasma concentrations are an independent risk factor for atherosclerosis. Patients with end-stage renal disease (ESRD) have elevated plasma concentrations of Lp(a), which are not explained by size variation at the apolipoprotein(a) [apo(a)] gene locus. The aim of our study was to investigate whether Lp(a) concentrations and/or apo(a) phenotypes are predictive of the degree of atherosclerosis in the extracranial carotid arteries in ESRD patients. Of 167 patients, 108 showed atherosclerotic plaques (65%). Univariate analysis showed that the plaque-affected group was significantly older and had a higher frequency of angina pectoris, previous myocardial infarction, or cerebrovascular accident. Furthermore, this group included significantly more patients with low-molecular-weight apo(a) isoforms (26.9% versus 8.5%, P<.005) and had significantly higher mean Lp(a) plasma concentrations (29.3±31.0 versus 19.7±25.7 mg/dL, P<.05). Lp(a) plasma concentration increased significantly with the number of affected arterial sites, from 19.7 mg/dL in patients without plaques to 40.1 mg/dL in patients with seven or eight affected sites. In patients with low-molecular-weight phenotypes, significantly more arterial sites were affected (3.62 versus 2.08, P<.001). Multivariate regression analysis showed that age, angina pectoris, and the apo(a) phenotype were the only significant predictors of the degree of atherosclerosis. We conclude that, besides age, the apo(a) phenotype is the best predictor of carotid atherosclerosis in ESRD patients and may be used for assessment of general atherosclerosis risk in this patient group. (Arterioscler Thromb. 1994;14:1405-1411.)

Key Words • Lp(a) • apo(a) phenotype • carotid atherosclerosis • B-mode ultrasound • end-stage renal disease

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patients with terminal renal insufficiency suffer from an increased morbidity and mortality related to atherosclerotic diseases.1,2 Although there undoubtedly are many contributory factors, several lipoprotein abnormalities have been suggested as a major cause of these diseases (for review, see Reference 3).

Recently, increased plasma concentrations of lipoprotein(a) [Lp(a)] have been described in end-stage renal disease (ESRD) patients.6 The distribution of Lp(a) plasma concentrations in the Caucasian population is highly skewed and extremely broad (range, <0.1 to >100 mg/dL),13 with mean and median concentrations of approximately 15 and 8 mg/dL, respectively.14 The apolipoprotein(a) [apo(a)] gene locus on chromosome 6q2.6-2.7 has been described as the major gene controlling Lp(a) plasma concentrations.15-17 The alleles at this highly polymorphic locus determine a protein size polymorphism of apo(a)13 that is due to varying numbers of kringle IV repeats in the apo(a) gene.15,17-19 An inverse relation exists between Lp(a) plasma concentration and the molecular weight of apo(a). Large isoforms (S3 or S4 in the original nomenclature) are expressed at low concentrations and small isoforms (S1, S2, B, or F) at high concentrations. In healthy Caucasians, about half of the variability in Lp(a) levels can be explained by this polymorphism.15-18,20

Several retrospective21-24 and two prospective25,26 case-control studies have found an association between high Lp(a) plasma levels and coronary heart disease (CHD) or myocardial infarction. This association was not confirmed by the Helsinki Heart Study27 or the Physicians' Health Study.28 All studies relating Lp(a) levels to atherosclerotic risk may be biased by the nongenetic factors that affect Lp(a) concentrations. Recently, a multipopulation study demonstrated that the genetic apo(a) size polymorphism determines the risk for CHD through its effect on Lp(a) plasma concentrations in the general population.29,30 Several studies showed significantly elevated Lp(a) plasma concentrations in patients with symptomatic carotid atherosclerosis without ESRD31-33 and in hypercholesterolemic patients with carotid atherosclerotic plaques.34-36 Thickening of the arterial wall of the carotid arteries correlates with higher Lp(a) plasma concentrations.37,38 A recent study in hemodialysis patients described Lp(a) plasma concentrations as an independent factor contributing to the risk for atherosclerotic events.39 The aim of the present study was to investigate the predic-
Active power of the Lp(a) plasma concentration, apo(a) phenotype, and other atherosclerosis risk factors for the presence and degree of extracranial asymptomatic carotid atherosclerosis in ESRD patients.

**Methods**

**Patients**

All patients from two dialysis units (Innsbruck and Feldkirch) who were at least 25 years of age were invited to participate in the study of atherosclerosis risk factor evaluation and B-mode ultrasound examination of the carotid arteries. Only approximately 6% of the patients refused. The study comprised 167 patients (91 men and 76 women) with a mean age of 52.8±13.4 (range, 25 to 80) years. At the time of ultrasound examination they had been undergoing hemodialysis for an average of 36.9±40.3 (range, 1 to 181) months. Treatment was performed three times weekly for an average of 4 hours. The cause of chronic renal failure was chronic glomerulonephritis in 59 patients (35%), diabetic nephropathy in 25 (15%), chronic pyelonephritis in 21 (13%), polyneuropathy in 15 (9%), renovascular diseases in 12 (7%), analgesic nephropathy in 9 (5%), and other diseases in 7 (4%); the origin was unknown in 19 (12%) patients.

**Risk Factor Evaluation**

Evaluation of some risk factors (hypertension, diabetes mellitus) was based on multiple laboratory measurements at various times, as all examined patients were under observation for a long period because of chronic renal insufficiency. Patients were classified as hypertensive when the blood pressure was greater than 95 mm Hg diastolic and/or greater than 160 mm Hg systolic, and they were being treated with antihypertensive medication. Patients were considered diabetic when they were being treated for diabetes with oral hypoglycemic agents or insulin, and/or fasting glucose level was greater than 140 mg/dL. Because many of the patients had stopped smoking only recently, we decided to calculate in the univariate analysis only the rate of smokers and never-smokers. Risk factor evaluation was based on the degree of atherosclerosis on scanned images using a videoprinter.

**Assessment of Carotid Atherosclerosis**

Commercially available instrumentation (a Prisma [Diasonics] and Sonolayer SA A 270A [Toshiba] with a 7.5-MHz linear-array probe including a pulsed Doppler with 6.0-MHz frequency) for B-mode imaging and evaluation of vascular flow velocity was used. Two experienced physicians performed the examination and were unaware of patient history or laboratory findings. The carotid arteries were screened while the patient was in a supine position with the neck extended; vessels were examined using anterior oblique, lateral, posterior oblique, and transverse scans. Evaluation included eight different arterial sites: the common, internal, and external carotid arteries and the carotid bifurcation on each side. Each arterial site was carefully scanned for the occurrence of plaques. As previously described,25 we decided a priori to define plaque as a localized thickening of the vessel wall exceeding 2 mm with protrusion into the lumen. To minimize the variation introduced by introserver and interobserver differences, plaque at each site was defined as present or absent, independent of number, extension, and structure. All measurements were performed from “frozen” images at the end of diastole. Findings were documented as a hard copy of these images using a videoprinter.

**Laboratory Procedures**

Baseline values of all measured parameters were obtained from EDTA-plasma taken after a 12-hour overnight fast before dialysis. After low-speed centrifugation, samples were frozen and kept at −80°C pending analysis.40 Lp(a) quantification was performed with a double-antibody enzyme-linked immunosorbent assay (ELISA) using an affinity-purified polyclonal rabbit anti-apo(a) antibody for coating and the horseradish peroxidase–conjugated monoclonal antibody 1A2 for detection.41 This antibody does not cross-react with plasminogen. Lp(a)-positive serum with an intermediate size of apo(a) (S2S3) from Immuno served as a standard. Lp(a) concentrations were expressed as total Lp(a) lipoprotein mass, ignoring the presence of small amounts of “free” apo(a).42 When nonultracentrifugal methods are used, the percentage of “free” apo(a) in plasma has been determined as being less than 5%.43

Apo(a) phenotyping was performed with sodium dodecyl sulfate–polyacrylamide gel electrophoresis of plasma under reducing conditions followed by immunoblotting35 using the monoclonal antibody 1A2 for the detection of apo(a) phenotypes.44 Isomers that did not exactly comigrate with the standards were categorized with the closest respective isomer. Of the patients, 91% showed at least one isomer, and the frequency of null types did not differ between patients with and without plaques (8.3% versus 10.2%). There was no difference in the frequency of double-band apo(a) phenotypes between these two patient groups (25.9% versus 25.4%). ApoB plasma concentrations were measured with a double-antibody ELISA using the same affinity-purified polyclonal antibody against apoB for coating and in a peroxidase-labeled form for detection.2 ApoA-I concentrations were measured with a commercially available electroimmunodiffusion assay (Immuno). Plasma concentrations of total and high-density lipoprotein cholesterol and triglycerides were determined using commercially available kits from Boehringer Mannheim. Low-density lipoprotein was calculated with the Friedewald formula.45

**Statistical Analysis**

As in our previous works,29,30 we decided a priori to divide apo(a) phenotypes into two subgroups according to the molecular weight of isoforms. The low-molecular-weight (LMW) group included all subjects who had at least one of the isoforms F, B, S1, or S2. This corresponds to Kpn I alleles numbers 1 through 12 as determined by pulsed-field gel electrophoresis.17 The high-molecular-weight (HMW) group comprised all subjects with only S3 or S4 isoforms or with a null type (Kpn I alleles 13 through 29). Pearson’s $r^2$ test was used to compare the frequencies of LMW and HMW apo(a) phenotypes between patients with and without atherosclerotic plaques in the carotid arteries. The same statistical procedure was applied to test for differences in the frequencies of angina pectoris, previous myocardial infarction or cerebrovascular accident, diabetes mellitus, hypertension, smoking habit, and sex. Because of the highly skewed distribution of Lp(a) and triglyceride plasma concentrations, the nonparametric Wilcoxon rank sum test was performed to compare patients with and without plaques. The unpaired $t$ test was used to examine whether the plasma levels of cholesterol, high-density lipoprotein cholesterol, apoA-I, and apoB differed between the two patient groups.

Stepwise logistic regression analysis was used to test the relationship between plaque status and all variables with a value of $P<.1$ in the univariate analysis. Because of the widely accepted role in influencing atherosclerosis, sex was forced into the statistical model. Odds ratios as an approximation for the relative risk of having plaques were calculated from the regression coefficients.

The independence of the association between the number of plaque-affected arterial sites (degree of atherosclerosis) and the atherosclerosis risk factors was tested by a multivariate regression analysis. Because of the nonnormal distribution of apo(a) and triglyceride plasma concentrations, these two variables were
one of the eight arterial sites examined. When we divided patients into two groups according to the presence or absence of plaques and applied univariate statistical analysis, the group with plaques was significantly older (58.3 versus 42.0 years, \( P<.001 \)) and had a higher frequency of angina pectoris or history of previous myocardial infarction or cerebrovascular accident (Table 1). Moreover, this group had significantly higher Lp(a) plasma concentrations (29.3±31.0 versus 19.7±25.7 mg/dL, \( P<.05 \)). Patients were further dichotomized into two groups according to the presence (LMW group) or absence (HMW group) of LMW apo(a) isoforms (see "Methods"). The patient group with plaques included significantly more patients with LMW isoforms than the plaque-free group (26.9% versus 8.5%, \( P<.005 \)). This difference is mainly caused by a higher frequency of S2 isoforms (Fig 1). No other lipoprotein parameters differed significantly between the two patient groups. The prevalence of plaques was also independent of dialysis duration, sex, diabetes mellitus, hypertension, or smoking status.

The stepwise logistic regression analysis was applied to predict the plaque status (presence or absence of plaques in at least one of the eight arterial sites). The only significant predictors were age and the apo(a) phenotype (Table 2). In patients with LMW apo(a) phenotypes the estimated risk for plaques was 4.29 times higher (95% confidence interval, 1.26 to 14.56) than in those with HMW types (\( P<.02 \)).

**Results**

Risk Factors for the Presence of Atherosclerotic Carotid Plaques in ESRD Patients

In this study 167 patients with ESRD were evaluated by B-mode ultrasonography. Of these patients, 108 (65%) showed atherosclerotic plaques at a minimum of one of the eight arterial sites examined. When we divided patients into two groups according to the presence or absence of plaques and applied univariate statistical analysis, the group with plaques was significantly older (58.3 versus 42.0 years, \( P<.001 \)) and had a higher frequency of angina pectoris or history of previous myocardial infarction or cerebrovascular accident (Table 1). Moreover, this group had significantly higher Lp(a) plasma concentrations (29.3±31.0 versus 19.7±25.7 mg/dL, \( P<.05 \)). Patients were further dichotomized into two groups according to the presence (LMW group) or absence (HMW group) of LMW apo(a) isoforms (see "Methods"). The patient group with plaques included significantly more patients with LMW isoforms than the plaque-free group (26.9% versus 8.5%, \( P<.005 \)). This difference is mainly caused by a higher frequency of S2 isoforms (Fig 1). No other lipoprotein parameters differed significantly between the two patient groups. The prevalence of plaques was also independent of dialysis duration, sex, diabetes mellitus, hypertension, or smoking status.

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**Relation of Risk Factors to the Degree of Atherosclerosis**

Next we analyzed whether Lp(a) plasma concentrations, apo(a) type, or both correlate with the degree of atherosclerosis. Lp(a) plasma concentration increased

### Table 1. Plaque Prevalence and Univariate Comparison of Lipoprotein(a) Concentrations, Apolipoprotein(a) Phenotypes, Lipid and Apolipoprotein Levels, and Other Common Risk Factors in ESRD Patients

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Present (n=108)</th>
<th>Absent (n=59)</th>
<th>( P )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y</td>
<td>58.3±9.8</td>
<td>42.0±12.5</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Angina pectoris, %</td>
<td>33.7</td>
<td>9.1</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Previous myocardial infarction, %</td>
<td>13.9</td>
<td>0</td>
<td>&lt;.005</td>
</tr>
<tr>
<td>LMW apo(a) types, %</td>
<td>26.9</td>
<td>8.5</td>
<td>&lt;.005</td>
</tr>
<tr>
<td>Lp(a), mg/dL</td>
<td>29.3±31.0</td>
<td>19.7±25.7</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Previous cerebrovascular accident, %</td>
<td>16.0</td>
<td>3.4</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Body mass index, kg/m²</td>
<td>24.0±4.01</td>
<td>22.7±4.04</td>
<td>.058</td>
</tr>
<tr>
<td>ApoA-I, mg/dL</td>
<td>117.7±26.7</td>
<td>126.2±29.1</td>
<td>.071</td>
</tr>
<tr>
<td>Hypertension, %</td>
<td>80.2</td>
<td>69.6</td>
<td>.14</td>
</tr>
<tr>
<td>ApoB, mg/dL</td>
<td>107.8±37.0</td>
<td>100.6±35.3</td>
<td>NS</td>
</tr>
<tr>
<td>Total cholesterol, mmol/L</td>
<td>4.92±1.47</td>
<td>4.75±1.42</td>
<td>NS</td>
</tr>
<tr>
<td>HDL cholesterol, mmol/L</td>
<td>0.93±0.47</td>
<td>0.92±0.31</td>
<td>NS</td>
</tr>
<tr>
<td>Triglycerides, mmol/L</td>
<td>2.00±1.63</td>
<td>1.84±1.26</td>
<td>NS</td>
</tr>
<tr>
<td>LDL cholesterol, mmol/L</td>
<td>3.03±1.13</td>
<td>3.09±1.25</td>
<td>NS</td>
</tr>
<tr>
<td>Months of dialysis</td>
<td>36.5±40.7</td>
<td>37.7±39.9</td>
<td>NS</td>
</tr>
<tr>
<td>Male sex, %</td>
<td>52.8</td>
<td>57.6</td>
<td>NS</td>
</tr>
<tr>
<td>Diabetes mellitus, %</td>
<td>22.2</td>
<td>18.6</td>
<td>NS</td>
</tr>
<tr>
<td>Smokers/never-smokers*, %</td>
<td>42/58</td>
<td>39/61</td>
<td>NS</td>
</tr>
</tbody>
</table>

ESRD indicates end-stage renal disease; LMW, low-molecular-weight; apo, apolipoprotein; Lp, lipoprotein; HDL, high-density lipoprotein; and LDL, low-density lipoprotein.

*Patients who had stopped smoking were excluded from this analysis.

logarithmically transformed before the regression analysis. A value of \( P<.05 \) was considered significant. Statistical procedures were performed with spss/pc+ software (SPSS Inc).

### Table 2. Result of Stepwise Logistic Regression Analysis to Predict Plaque Status in Extracranial Carotid Arteries in ESRD Patients

<table>
<thead>
<tr>
<th>Coefficient</th>
<th>SEM</th>
<th>( \chi^2 )</th>
<th>OR (95% CI)</th>
<th>( P )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>-2.7808</td>
<td>1.5857</td>
<td>3.85</td>
<td></td>
</tr>
<tr>
<td>Male sex</td>
<td>0.0151</td>
<td>0.4467</td>
<td>0.01</td>
<td>1.02 (0.42-2.44)</td>
</tr>
<tr>
<td>Age</td>
<td>0.1190</td>
<td>0.0201</td>
<td>34.99</td>
<td>1.13 (1.08-1.17)</td>
</tr>
<tr>
<td>LMW apo(a) phenotype*</td>
<td>1.4559</td>
<td>0.6235</td>
<td>5.45</td>
<td>4.29 (1.26-14.56)</td>
</tr>
</tbody>
</table>

ESRD indicates end-stage renal disease; OR, odds ratio; CI, confidence interval; LMW, low-molecular-weight; and apo, apolipoprotein.

*LMW phenotype includes all subjects with either of the isoforms F, B, S1, or S2.
significantly with the number of affected arterial sites, from 19.7 mg/dL in patients without plaques to 40.1 mg/dL in patients with seven or eight affected sites \((P=.005)\) (Fig 2). Apo(a) type was also related to the severity of carotid atherosclerosis. In patients with LMW phenotypes, significantly more arterial sites were affected by atherosclerotic plaques than in patients with HMW phenotypes (mean, 3.62 versus 2.08, \(P<.001\)) (Fig 3). When patients were divided into two age groups (separated at the median value of 54 years), this difference was significant only in the younger group (2.21 versus 0.81, \(P<.005\)). In Fig 4 the number of affected arterial sites is plotted against age for LMW and HMW phenotypes separately. This demonstrated that patients with LMW phenotypes were on average 10 years younger than patients with HMW phenotypes with the same degree of atherosclerosis of the carotid vessels. As a corollary, patients with LMW phenotypes had on average more than one additional affected arterial site compared with patients of the same age with HMW phenotypes.

We then applied multivariate analysis to determine the independence of identified risk factors. In the total group, age, angina pectoris, and the apo(a) phenotype were the only significant predictors of the number of affected arterial sites. In the younger patient group the history of previous myocardial infarction was a predictor in addition to age and apo(a) phenotype. In the elderly patient group only the occurrence of angina pectoris was significantly predictive (Table 3).

**Discussion**

In recent years Lp(a) has been proposed as an independent risk factor for CHD in different ethnic groups, but this view has recently been challenged. Patients with ESRD have an increased risk for CHD. We and others recently demonstrated that Lp(a) is elevated in ESRD patients. This elevation in Lp(a) is not caused by differences in apo(a) isoform frequencies. Rather, we observed that only patients with HMW isoforms had significantly elevated plasma Lp(a) levels, whereas patients with LMW isoforms had levels nearly identical to those in isoform-matched control subjects. In keeping with this we observed a rapid decrease of Lp(a) plasma levels after renal transplantation only in patients with HMW apo(a) phenotypes. This suggests a strong nongenetic effect on Lp(a) levels in patients with LMW but not HMW isoforms. These findings may obscure the predictive value of Lp(a) levels in ESRD patients.

The present study investigated the atherosclerotic status of the extracranial carotid arteries in a large group of patients with ESRD and related it to Lp(a) concentrations and apo(a) type. To define carotid atherosclerosis we applied B-mode ultrasonography. Three relevant observations were made: (1) the plaque-affected group had significantly higher Lp(a) plasma concentrations and included significantly more patients with LMW apo(a) phenotypes; (2) patients with LMW apo(a) isoforms had a significantly higher degree of
atherosclerosis; and (3) multivariate regression analysis showed age, angina pectoris, and the apo(a) phenotype to be the only significant predictors of the number of arterial sites affected by plaques. Numerous studies have shown that atherosclerotic disease in the carotid system reflects to a high degree the atherosclerotic situation of the coronary arteries. In different patient groups a relation between elevated Lp(a) plasma concentrations and symptomatic or asymptomatic carotid atherosclerosis has been shown. Most studies were retrospective case-control studies, and none of them considered apo(a) phenotypes. The only study yet published that has related carotid atherosclerosis to Lp(a) concentrations and apo(a) type is the Atherosclerosis Risk in Communities (ARIC) Study. In the present study plaque-affected patients with ESRD showed significantly higher Lp(a) plasma concentrations and a higher frequency of LMW apo(a) isoforms than unaffected patients (29.3±31.0 versus 19.7±25.7 mg/dL, P<.001). Lp(a) concentrations increased with the number of affected arterial sites (Fig 2). This is in agreement with previous studies in non-ESRD patients. Affected patients also had a significantly higher frequency of LMW apo(a) isoforms compared with unaffected patients (26.9% versus 8.5%, P<.005). Patients with LMW phenotypes showed significantly more arterial sites affected by plaques. With regard to age, we observed a shift in the extent of atherosclerosis to younger age in the LMW phenotypes. The age difference between patients with LMW and HMW phenotypes with the same degree of atherosclerosis was on average 10 years (Fig 4).

Several studies have reported associations between carotid atherosclerosis and risk factors such as hypertension or smoking, which were not confirmed for hypertension or duration of hypertension in two other studies. We were also unable to observe an association of disease with hypertension and smoking. Similar to another study, our patient group had a very high prevalence (>75%) of hypertension, which makes evaluation of its influence on carotid atherosclerosis difficult.

Generally, it is difficult to estimate the duration of exposure to risk factors in patients with chronic diseases such as atherosclerosis. This is especially true for ESRD patients. Such patients already differ in risk profile before renal disease develops. During the progression of renal failure the exposure to risk factors may change: in the predialysis phase many patients are hypercholesterolemic and/or hypertriglyceridemic, but during dialysis treatment the most common lipid abnormality is hypertriglyceridemia. Several patients, who were hypertensive during predialysis, became normotensive under dialysis treatment and vice versa. Consequently, in this patient population, laboratory measurement performed during ESRD provides a single static view of exposure to risk factors. Cross-sectional studies and even prospective studies starting after the onset of renal disease may be biased in such a situation. This also applies to Lp(a) levels. From this point of view it is not surprising that the traditional atherosclerosis risk factors were not predictive in our patient group or yielded controversial results. This situation calls for predictive markers not influenced by the disease state. As shown here, this requirement is met by the genetically determined apo(a) phenotype. In the stepwise and multivariate regression analyses, besides age apo(a) type was an independent predictor of plaque status and degree of atherosclerosis in the carotid arteries. Inclusion or exclusion of Lp(a) plasma concentrations in the statistical model had no influence on the predictive power of the apo(a) phenotype. Even when phenotype was omitted from the model, Lp(a) level reached no significance. This is in contrast to the ARIC Study, which is investigating preclinical extracranial carotid atherosclerosis (defined as arterial wall thickness) by B-mode ultrasonography. Lp(a) plasma concentration was found to be an independent predictor of plaque status and degree of atherosclerosis in the carotid arteries. Ultrasound studies. We were also unable to observe an association of disease with hypertension and smoking. Similar to another study, our patient group had a very high prevalence (>75%) of hypertension, which makes evaluation of its influence on carotid atherosclerosis difficult.

### Table 3. Multivariate Regression Analysis of Risk Factors Influencing the Number of Affected Arterial Sites in ESRD Patients

<table>
<thead>
<tr>
<th>Group and Variable</th>
<th>Coefficient</th>
<th>SEM</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>0.098</td>
<td>0.015</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Angina pectoris</td>
<td>-1.213</td>
<td>0.479</td>
<td>&lt;.02</td>
</tr>
<tr>
<td>Apo(a) type</td>
<td>1.007</td>
<td>0.498</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Variables not in equation*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ApoB</td>
<td></td>
<td></td>
<td>.11</td>
</tr>
<tr>
<td>Previous myocardial infarction</td>
<td></td>
<td></td>
<td>.15</td>
</tr>
<tr>
<td>Age &lt;55 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>0.067</td>
<td>0.019</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Previous myocardial infarction</td>
<td>-5.375</td>
<td>1.490</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Apo(a) type</td>
<td>1.287</td>
<td>0.435</td>
<td>&lt;.005</td>
</tr>
<tr>
<td>Variables not in equation*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td></td>
<td>.18</td>
</tr>
<tr>
<td>Age ≥55 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angina pectoris</td>
<td>-1.795</td>
<td>0.733</td>
<td>&lt;.02</td>
</tr>
<tr>
<td>Variables not in equation*</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ESRD indicates end-stage renal disease; Apo, apolipoprotein.

*Only variables with .05<P<.2 are shown.
our study that, besides age, variation in the apo(a) gene is related to the risk for atherosclerotic vascular disease in these patients. Studies that fail to find such a relation when Lp(a) levels are analyzed therefore should be considered with caution. It must be emphasized that Lp(a) level in contrast to apo(a) type is not an unchangeable genetic trait. In the present study Lp(a) levels were less predictive than was apo(a) type because of the confounding effect of renal disease on Lp(a) plasma concentrations. Such effects may also partly explain the negative results obtained in studies that related Lp(a) level and not apo(a) type to atherosclerotic vascular disease.

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