Oral Contraceptives Highlight the Genotype-Specific Association Between Serum Phospholipids and Activated Factor VII


Abstract—The present analysis was undertaken to study the effect of oral contraceptive (OC) use on activated factor VII (FVIIa) in subjects characterized by FVII genotypes, with the further aim of evaluating the role of lipids in this pharmacological interaction. In OC users (n=42) and nonusers (n=130) of comparable age, we examined the FVII phenotypic variables (FVII coagulant activity [FVIIc], FVII antigen, and FVIIa), FVII genotypes (the 353R/Q and 5’F7 polymorphisms analyzed in combination; alleles M1/M2 and A1/A2, respectively), and a number of lipid and lipoprotein parameters: serum concentrations of total cholesterol (chol), low density lipoprotein and high density lipoprotein-chol, triglycerides, phospholipids (PhLs), apolipoprotein A1, and lipoprotein(a). PhLs, triglycerides, apolipoprotein A1, chol, FVII antigen, FVIIc, and high density lipoprotein-chol levels were shown to be statistically higher in users than nonusers. FVII levels, particularly those of FVIIa and FVIIc, were much higher in homozygotes for the A1 and M1 alleles (A11 M11), especially in OC users. A strong association was found between PhL and FVIIa: in the multiple regression analysis, women taking OCs who had elevated PhL concentrations also had very high levels of FVIIa, but only if their genotype was A11 M11. These results indicate that the increased FVII levels in OC users depend on the FVII genotype and that high PhL concentrations predict very high levels of FVIIa and FVIIc. (Arterioscler Thromb Vasc Biol. 1999;19:2024-2028.)

Key Words: factor VII ■ activated factor VII ■ phospholipids ■ factor VII genotype

Since the introduction of oral contraceptives (OCs) in the 1960s, epidemiological studies have revealed an association between their use and an increase in the risk of cardiovascular disease (CVD). The most important cardiovascular complications noted were venous thromboembolism, myocardial infarction, and thrombotic stroke, with higher risk and susceptibility in female smokers in the 35+ age range. The increased CVD risk has been attributed to the estrogenic component; in fact, it was found to be reduced after the introduction of OCs containing a lower estrogen dose, but recently venous thromboembolism was found to be higher in women using contraceptives containing third-generation progestogens. The effect of OCs on hemostasis is an increase in the levels of some coagulation factors (factors II, VII [FVII], IX, X, XI, and VIII; von Willebrand factor; and fibrinogen), of protein C, and of protein complexes and fragments related to the activation of coagulation (thrombin-antithrombin complexes and D-dimer); these enhance fibrinolysis and decrease the levels of antithrombin III, protein S, and C4b-binding protein.

Concerning FVII, a relationship between FVII levels, the dose of estrogen, and progestogen (norethisterone but not norgestrel) was consistently found. It is difficult, though, to pinpoint whether these changes are due to the estrogen or the progestative compound, and it is still a matter of debate whether the excess CVD risk after the use of OCs is related to the resulting dyslipidemia, the hemostasis changes, or both. Recently, a meta-analysis pointed out the absence of an association between the duration of OC administration and CVD risk; the same analysis showed that the increased risk was limited to the period of OC administration.

Because FVII has attracted attention owing to its association with lipids (namely triglycerides [TGs] and cholesterol...
Methods

Study Population

Of the 501 volunteer subjects enrolled in the “Clotart” study in 5 European countries (France, Italy, the Netherlands, Norway, and Spain), 219 (47.7%) were females; of these, 42 were taking OCs. All participants declared themselves to be in good health and free from CVD, diabetes, and cancer. General enrollment criteria were as previously reported.49,50 Women on OCs were compared with a control group of 130 women not taking OCs of comparable age range: 21.3 to 50.8 years (median, 32.5) for the women on the OC pill and 19.1 to 50.5 years (median, 33.8) for the controls (in the range: 21.3 to 50.8 years (median, 32.5) for the women on the OC pill). Values were expressed in the blasticin preparation with an international sensitivity index close to 1.0. Assays, the standard was a locally prepared, pooled plasma (20 males and 20 females). Prothrombin fragment 1 (F1a) and 2 (F1a2) were assayed by a choline oxidase determination of the amount of choline liberated by phospholipase D68 (Phospholipids, SGM Italia).

Assay Procedures

FVII coagulation activity (FVIIc) and FVII antigen (FVIIAg) assays were carried out as previously reported.48–50 In detail, FVIIc was evaluated by a choline oxidase determination of the amount of choline liberated by phospholipase D68 (Phospholipids, SGM Italia).

Results

General Description of the Subject Sample in the “Users” and “Nonusers” Subgroups

In Table 1, the levels of the variables and the statistical evaluation concerning the data for OC users and nonusers are set out. The following variables were significantly different between users and nonusers: PhLs, TGs, ApoA1, chol, FVIIAg, FVIIc, and HDL-chol.

Influence of FVII Genotypes on FVII Levels in Users and Nonusers

A highly significant difference in FVII levels was noted between the genotypes studied and between OC users and nonusers (Table 2): women with the All M11 genotype had significantly higher values than did those with other genotypes, more so for FVIIa and FVIIc than for FVIIAg. OC users had significantly higher levels of FVII than nonusers. This trend was more apparent with regard to FVIIc and FVIIAg assays than to FVIIa. F1a2 levels were significantly higher in the subjects with the All M11 genotype who were on OCs than in those not taking OCs (1.21 versus 1.10 mmol/L, F=7.4, P=0.008).

Multiple Regression Analysis of the Effect of High Lipid Concentrations on FVII Levels

High PhL concentrations were associated with very high and significant FVIIa and FVIIc levels in OC users (Table 3). The difference between users and nonusers was more significant for FVIIa and FVIIc than for FVIIAg. High concentrations of TGs and chol, on the other hand, were found to be consistently associated with insignificant changes of FVII in both users and nonusers.

Multiple Regression Analysis Regarding the Influence of FVII Genotypes on the Interaction Between FVII and PhL

In the All M11 genotype, high PhL levels were associated with markedly elevated FVIIa levels in OC users (Table 4). The differences between users and nonusers were highly significant. The statistical procedures used were from the BMDP software package. The distribution of variables was assessed for deviation from normality, and the appropriate normalizing (logarithmic) transformation was used to analyze the data by parametric methods. Tables were computed on the untransformed data. Parametric ANOVAs (1-way, 2-way) and ANCOVAs (with age as a covariate) were used, including the main effects and interactions in the models. Pearson’s linear correlation coefficients were used to detect any association between variables. A fixed multiple linear regression model was fitted to the data to estimate the effect (after adjustment for the effects of age, sex, and country) of high concentrations in each independent lipid variable on the dependent one (FVII parameters). Problems due to colinearity were checked and ruled out during the analysis. The appropriate Student’s t tests were performed to assess the significance of correlation and regression coefficients and of differences in coefficients between subgroups.
TABLE 1.  Comparison Between OC Users and Nonusers With Reference to Hemostatic and Lipid Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Unit of Measure</th>
<th>OC Use</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>FVIIc</td>
<td>%PNP</td>
<td>Yes</td>
<td>134.95 (37.56)</td>
<td>7.50</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
<td>118.28 (27.37)</td>
<td></td>
</tr>
<tr>
<td>FVIIAg</td>
<td>%PNP</td>
<td>Yes</td>
<td>111.07 (16.27)</td>
<td>7.95</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
<td>102.21 (18.29)</td>
<td></td>
</tr>
<tr>
<td>FVIIa</td>
<td>mU/ml</td>
<td>Yes</td>
<td>84.72 (41.0)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
<td>68.94 (26.05)</td>
<td></td>
</tr>
<tr>
<td>Chol</td>
<td>mmol/L</td>
<td>Yes</td>
<td>5.53 (1.02)</td>
<td>8.41</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
<td>5.03 (0.84)</td>
<td></td>
</tr>
<tr>
<td>HDL-chol</td>
<td>mmol/L</td>
<td>Yes</td>
<td>1.63 (0.37)</td>
<td>4.72</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
<td>1.47 (0.39)</td>
<td></td>
</tr>
<tr>
<td>LDL-chol</td>
<td>mmol/L</td>
<td>Yes</td>
<td>3.44 (1.04)</td>
<td>1.67</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
<td>3.21 (0.76)</td>
<td></td>
</tr>
<tr>
<td>TGS</td>
<td>mmol/L</td>
<td>Yes</td>
<td>0.99 (0.38)</td>
<td>19.62</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
<td>0.73 (0.42)</td>
<td></td>
</tr>
<tr>
<td>PhLs</td>
<td>mmol/L</td>
<td>Yes</td>
<td>3.25 (0.44)</td>
<td>27.02</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
<td>2.84 (0.39)</td>
<td></td>
</tr>
<tr>
<td>ApoA1</td>
<td>μmol/L</td>
<td>Yes</td>
<td>56.18 (11.11)</td>
<td>16.99</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
<td>48.54 (9.18)</td>
<td></td>
</tr>
<tr>
<td>Lp(a)</td>
<td>μmol/L</td>
<td>Yes</td>
<td>0.66 (0.70)</td>
<td>0.04</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
<td>0.61 (0.55)</td>
<td></td>
</tr>
</tbody>
</table>

Values are mean and (SD).

Discussion

This cross-sectional study was carried out using samples taken from healthy subjects enrolled through the use of a questionnaire focusing on the presence of risk factors for CVD. It is worth mentioning that this investigation did not take into account the details of OC use, such as the brand of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake. If this approach is seen as a bias for comparative evaluations concerning the effects of OC and the duration of OC intake.

Most of the studies and a recent review have described an increase in FVIIc and FVIIAg levels that was roughly related to the estrogen dose. In a recent report, we noted, however, great variation in the FVIIa levels, which could explain the lack of statistical difference between users and nonusers. This prompted us to evaluate the impact of FVII genotypes, the importance of which has been demonstrated in determining variation in the FVIIa levels. The genetic analysis demonstrated that FVIIc and FVIIa levels were much higher in the A11 M11 genotype than in the others. The use of OCs displayed only an additional effect on FVII levels, and the presence of an interaction between OC use and genotype was ruled out (Table 2).

In a recent report by our group, it was observed that high PhL concentrations were associated with high FVIIa levels. To test the strength of this association in the context of OC use, nonusers were compared to OC users.

TABLE 2.  FVII Levels in OC Users and Nonusers: Comparisons Between Genotype Groups

<table>
<thead>
<tr>
<th>Genotypes</th>
<th>OC Use</th>
<th>n</th>
<th>FVIIc (%)</th>
<th>FVIIAg (%)</th>
<th>FVIIa (ng/mL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A11 M11</td>
<td>Yes</td>
<td>30</td>
<td>145.9 (36.0)</td>
<td>113.8 (15.5)</td>
<td>96.9 (40.0)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>98</td>
<td>124.5 (24.7)</td>
<td>105.0 (18.0)</td>
<td>73.3 (25.1)</td>
</tr>
<tr>
<td>A12 M12†</td>
<td>Yes</td>
<td>8</td>
<td>111.5 (27.2)</td>
<td>106.9 (19.0)</td>
<td>57.4 (28.3)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>26</td>
<td>97.4 (25.7)</td>
<td>93.4 (16.5)</td>
<td>50.9 (19.2)</td>
</tr>
<tr>
<td>A22 M22</td>
<td>No</td>
<td>26</td>
<td>97.4 (25.7)</td>
<td>93.4 (16.5)</td>
<td>50.9 (19.2)</td>
</tr>
</tbody>
</table>

Comparisons

<table>
<thead>
<tr>
<th>Genotype</th>
<th>OC</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>FVIIc</td>
<td>F=27.78, P&lt;0.0001</td>
<td>F=8.23, P=0.0047</td>
<td></td>
</tr>
<tr>
<td>FVIIAg</td>
<td>F=5.80, P=0.0172</td>
<td>F=7.91, P=0.0055</td>
<td></td>
</tr>
<tr>
<td>FVIIa</td>
<td>F=31.91, P&lt;0.0001</td>
<td>F=1.74, P=NS</td>
<td></td>
</tr>
</tbody>
</table>

Slope was significantly different from 0 at *P<0.01; †P<0.05. Comparisons were made between OC users and nonusers. The values of the standardized regression coefficient are shown, together with the effect produced on FVII parameters by a hypothetical 50% increase of the lipid variables.

Difference between users and nonusers: a, t [3.36, P<0.01; b, t=3.10, P<0.01; c, t=2.22, P<0.05.
TABLE 4. Multiple Regression Analysis Concerning the Effect of PhLs on FVII Levels in Selected Genotypes

<table>
<thead>
<tr>
<th>Genotypes</th>
<th>OC</th>
<th>n</th>
<th>FVIIa</th>
<th>FVIIc</th>
<th>FVIIAg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>28</td>
<td></td>
<td>+0.36*</td>
<td>+0.89*</td>
<td>+0.65</td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>+221.2%†</td>
<td>+97.8%†</td>
<td>+31.0%</td>
</tr>
<tr>
<td>A11 M11</td>
<td>No</td>
<td>92</td>
<td>+0.32†</td>
<td>+0.43*</td>
<td>+0.22</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>+36.1*</td>
<td>+29.1%†</td>
<td>+12.1%</td>
</tr>
<tr>
<td>A12 M12+</td>
<td>Yes</td>
<td>6</td>
<td>NE</td>
<td>NE</td>
<td>NE</td>
</tr>
<tr>
<td>A22 M22</td>
<td>No</td>
<td>24</td>
<td>+0.71</td>
<td>+0.08</td>
<td>+0.10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>+11.4%</td>
<td>+6.4%</td>
<td>+5.4%</td>
</tr>
</tbody>
</table>

NE indicates not evaluated. FVII was the dependent variable; age, sex, and center were included in the regression model. Comparisons were made between OC users and nonusers. The values of the standardized regression coefficient are shown, together with the effect produced by a hypothetical 50% increase of the PhL concentration.

Slope was significantly different from 0 at *P<0.01, †P<0.001. Differences between values in OC users and nonusers: a, t=4.23, P<0.001; b, t=3.75, P<0.001; c, t=1.89, P=NS.

Acknowledgments

This work was carried out within the framework of the European Union Concerted Action BMH1-CT94-1202 "The Role of the FVII-Tissue Factor Pathway in Ischemic Heart Disease (Clotart)." The authors wish to thank Michael Briggs for his work in amending the text.

References


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for the European Union Concerted Action Clotart

doi: 10.1161/01.ATV.19.8.2024

Arteriosclerosis, Thrombosis, and Vascular Biology is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 1079-5642. Online ISSN: 1524-4636

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