Protein C, Antithrombin, and Venous Thromboembolism Incidence
A Prospective Population-Based Study

Aaron R. Folsom, Nena Aleksic, Lu Wang, Mary Cushman, Kenneth K. Wu, Richard H. White

Abstract—Although deficiencies of protein C and antithrombin, 2 natural plasma anticoagulants, are known risk factors for venous thrombosis, population-based prospective incidence data on these associations are lacking. Venous thromboembolic events have been identified in adults in 2 longitudinal cohort studies, the Atherosclerosis Risk in Communities (ARIC) Study and the Cardiovascular Health Study (CHS). Incidence was examined in relation to prediagnostic plasma levels of protein C (ARIC Study only) and antithrombin. Over a mean of 8.1 years of follow-up, there were 130 incident venous thromboembolic events that were not due to cancer in the ARIC Study. The age-adjusted incidence was elevated 3.36-fold (95% CI 1.24 to 9.11) in the 1.1% of subjects with protein C values <2.0 mg/L compared with subjects with higher values. In contrast, in the ARIC Study and the CHS, there was no association between low plasma antithrombin and venous thromboembolism. In conclusion, in this population-based study, a low protein C, but not antithrombin, level has been determined to be associated with an increased incidence of venous thromboembolism. Attributable risk estimates suggest that low protein C levels account for ~2.5% of venous thromboembolic events in the ARIC population. (Arterioscler Thromb Vasc Biol. 2002;22:1018-1022.)

Key Words: antithrombin ■ protein C ■ prospective study ■ venous thrombosis ■ pulmonary embolus

D eficiencies of protein C and antithrombin, 2 natural plasma anticoagulants, are known contributors to familial venous thrombosis. Type I deficiency is defined by the reduction of the functional activity and plasma antigen levels of the anticoagulant; type II deficiency is defined by reduced activity but normal antigen levels. Deficient protein C or antithrombin is typically present in 4% to 9% of the patients with familial thrombophilia.1 In unselected patients with venous thrombosis, deficiencies of protein C and antithrombin are less common (~3% and 1%, respectively).2–4 In contrast, the prevalence of protein C deficiency in the general population has been estimated to be between 0.2% and 0.4%,5,6 and the prevalence of type I antithrombin deficiency has been estimated to be 0.02%.7 A number of mutations of the protein C and antithrombin genes contribute to deficiencies of these anticoagulant proteins.1 In middle-aged carriers of such mutations, the incidence of venous thrombosis is ~1% per year and is somewhat higher for antithrombin than for protein C deficiency.8–11 Lifestyle and other physiological factors contribute modestly to variations in protein C and antithrombin levels in the population.12,13

Rosendaal14 has estimated the population attributable risk (ie, the proportion of venous thrombosis caused by a risk factor) to be 2% for protein C deficiency and <1% for antithrombin deficiency and much less for activated protein C resistance or elevated factor VIII. To our knowledge, there has been no longitudinal study of the general population relating levels of protein C or antithrombin to incidence of venous thromboembolism (VTE). We undertook the present study to test the hypothesis that low levels of these natural anticoagulants are associated with increased VTE incidence in the general population.

Methods

Study Population and Baseline Assessments

The Longitudinal Investigation of Thromboembolism Etiology (LITE) Study is a prospective study of VTE occurrence in 2 pooled, multicenter, longitudinal, population-based cohort studies: the Atherosclerosis Risk in Communities (ARIC) Study and the Cardiovascular Health Study (CHS). The LITE Study design, methods, and VTE incidence rates have been described in detail elsewhere.15,17 In brief, 15 792 ARIC participants aged 45 to 64 years at baseline in 1987 to 1989 and 5201 CHS participants aged ≥65 years at baseline in 1989 to 1990 underwent assessments of cardiovascular risk factors. An additional 687 African Americans were recruited to CHS in 1992 to 1993. Baseline cardiovascular risk factors included in the present study were measured comparably in the ARIC Study and the CHS, as described elsewhere.15

After informed consent was obtained, blood was drawn from fasting participants in the morning in both studies. The blood
samples were stored briefly on ice (ARIC Study) and at room 
temperature (CHS), then centrifuged for 3000 g for 10 minutes, 
and stored in −70°C freezers. Up to 3 follow-up examinations 
were performed every 3 years in the ARIC Study, and up to 9 follow-up 
examinations were performed annually in the CHS. Blood samples 
from the subsequent examinations were stored at −70°C.

VTE Case Identification
Potential cases of VTE were identified from baseline through September 1998. Hospital records were obtained, and VTE events 
were validated by 2 physicians as “definite deep vein thrombosis 
(DVT)” (nearly always having a positive duplex ultrasonogram or a 
positive venogram), “probable DVT” (having a positive Doppler 
ultrasound or a positive impedance plethysmography), and “definite 
PE” (having ventilation-perfusion scans with multiple segmental or 
subsegmental mismatched defects, a positive pulmonary angiogram, 
or CT or autopsy documentation of pulmonary embolism [PE]).

Definite and probable DVT and definite PE were pooled as VTE for 
this analysis. Cases were also classified as incident (no self-reported 
VTE history before baseline) or recurrent (self-reported VTE history 
before baseline) and as idiopathic (no obvious cause) or secondary 
(associated with cancer, major trauma, surgery, or marked immobil-
ity). In the ARIC Study, 185 individuals developed VTE; 150 
developed VTE in the CHS. Of the 335 events, 237 had venous 
(associated with cancer, major trauma, surgery, or marked immobil-
ity) before baseline) and as idiopathic (no obvious cause) or secondary 
/events due to cancer, 87 who reported baseline anticoagulant 
use. There were 219 cases (the ARIC Study plus the CHS) and 529 controls remaining for analyses. We used 
unconditional logistic regression to calculate odds ratios and 95%
percentile. The hazard ratio was plotted 

Study Designs
Two study designs were used to accomplish our aims. In the ARIC 
Study, but not in the CHS, plasma protein C and antithrombin were 
measured for all participants,22-23 thus allowing a traditional cohort 
analysis. Because the CHS had not measured these factors, we 
decided to measure antithrombin, the rarer of the 2 deficiencies, on 
cases and controls from the LITE Study (ie, remeasured in the ARIC 
Study, but not in the CHS, plasma protein C and antithrombin were 
measured for all participants,12,13 thus allowing a traditional cohort 
study).15 Adjustment was made in the ARIC and LITE analyses for 
baseline anticoagulant use. There were 219 cases (the ARIC Study 
plus the CHS) and 529 controls remaining for analyses. We used 
unconditional logistic regression to calculate odds ratios and 95%
percentile (2.3 mg/L for protein C and 

Laboratory Methods
Protein C antigen was measured at the ARIC baseline by using a 
commercial ELISA kit (Asserachrom Protein C, Diagnostica Stago). 
Low protein C values were repeated and confirmed. The coefficient of 
variation for protein C was 12%; the reliability coefficient 
(between-subject variance divided by total variance) obtained from 
repeated testing of individuals over several weeks was 0.56.18 
Antithrombin was assayed at the ARIC baseline with an amidolytic 
assay using a synthetic chromogenic substrate for thrombin (CBS 
34.47, Diagnostica Stago) and bovine thrombin (Kabi). The test may 
be influenced by heparin cofactor II. The antithrombin values 
(percentages) were obtained by relating the optical density of the 
unknown samples to a calibration curve that was constructed with 
each run by use of a hollinized plasma pool (University Coagulation 
Reference Plasma ThromboScreen, Pacific Hemostasis) as the stan-
dard. Low antithrombin values (values <50%) were repeated and 
confirmed. The coefficient of variation for antithrombin was 12%; 
the reliability coefficient assessed by repeat visits over several weeks was 0.42.18 
Antithrombin was measured in the LITE Study (remeasured in the 
ARIC Study and first-measured in the CHS) by use of an automated 
chromogenic assay (IL Test Antithrombin) based on bovine factor 
Xa; an ACL Futura Coagulation System (Instrumentation Labora-
tory) was used. The method is specific and is not influenced by 
heparin cofactor II. Within-run coefficients of variation were 3% for 
normal values and 4% for low values of antithrombin. Low values of 
antithrombin were repeated and confirmed. The reliability coeffi-
cient based on 15 split specimens, which were stored for a long time 
and then analyzed, was r = 0.38. Because the ARIC Study had stored 
samples briefly on ice and the CHS had stored samples at room 
temperature, we conducted a pilot study (n = 10) processing split 
normal plasma samples both ways. The mean ± SD antithrombin 
values were 106 ± 9 for room temperature and 110 ± 12 for cold 
processing (r = 0.72).

We detected the presence or absence of the factor V Leiden 
(1691G→A, R506Q) mutation and the prothrombin 20210G→A 
polyorphism on LITE cases and controls by using standard 
methods.20,21 Factor VIII coagulant activity (VIIIc) was measured by 
a Coag-a-Mate X2 (Organon-Teknika) with the use of factor immu-
nodicientificic plasma (Organon-Teknika).

Statistical Analyses
A traditional longitudinal analysis was used to analyze protein C and 
antithrombin measured at baseline in the ARIC Study. Because the 
focus was on incident VTE–unrelated cancer, we first excluded 276 
participants who reported at baseline a history of VTE, 874 who 
reported a history of cancer, 87 who reported baseline anticoagulant 
use, and 273 who had missing blood measurements (a total of 1434 
were excluded; some had >1 exclusion). This left 14 358 subjects at 
risk to be followed longitudinally. Rates of VTE not due to cancer 
were calculated for 2 definitions of low protein C and antithrombin, 
namely, <1 percentile (2.0 mg/L for protein C and <65% for 
antithrombin) and <5 percentile (2.3 mg/L for protein C and <80% 
for antithrombin). Relative risks (RRs [hazard ratios]) and 95% CI 
were calculated by using Cox proportional hazards models. The 
dose-response relation for protein C was examined graphically by 
using a restricted cubic spline model.22 The hazard ratio was plotted 
relative to a value of 3.7 mg/L, which was approximately the 80th 
percentile.

For antithrombin in the LITE nested case-control sample, we also 
revisited analyses to incident events and excluded 51 participants 
with a history of VTE, 130 with a history of cancer, and 19 with 
baseline anticoagulant use. There were 219 cases (the ARIC Study 
plus the CHS) and 529 controls remaining for analyses. We used 
unconditional logistic regression to calculate odds ratios and 95%
CIs of VTE in relation to antithrombin <1 percentile (55%) and <5 
percentile (65%).

A number of lifestyle, physiological, and hemostatic factors have 
already been evaluated for their association with VTE in the LITE 
cohort.15 Adjustment was made in the ARIC and LITE analyses for 
factors previously associated with VTE, including age (continuous) 
in all models and race, sex, body mass index (continuous), and factor 
VIIIc (continuous) in multivariate models.

Results
The ARIC cohort at baseline was aged 45 to 64 years (mean 
54 years); 72% were white, and 28% were black. The LITE 
cases of VTE and controls at baseline were aged 45 to 94 
years (mean 64 years); 74% were white, and 26% were black. 
Approximately 14% of cases and 4% of controls carried 
factor V Leiden,17 and 4% of cases and 2% of controls carried 
the prothrombin 20210A polymorphism.

In the ARIC baseline cohort in 1987 to 1989, the mean ± SD for protein C was 3.17 ± 0.62 mg/L; for antithrom-
bin, it was $111 \pm 22\%$. By use of a different assay and stored samples, the baseline mean antithrombin was $90 \pm 16\%$ in LITE VTE cases and controls. By the different assays, the 2 antithrombin values for the ARIC participants were correlated ($r=0.36$).

Over a mean of 8.1 years of follow-up, there were 130 incident VTE events unrelated to cancer in the ARIC Study (incidence rate 1.10 per 1000 person-years). The prevalence of protein C values $<2.3$ mg/L was 4.4% ($n=4$) among the VTE cases versus 1.1% ($n=156$) in all of the ARIC Study. Compared with higher values, the age-adjusted incidence of VTE was elevated 3.36-fold in subjects with protein C values $<2.0$ mg/L (Table). With adjustment for age, sex, body mass index, and factor VIIIc, this RR was unchanged (3.38, 95% CI 1.24 to 9.20). VTE incidence was elevated only 1.19-fold for protein C values $\geq 2.3$ mg/L (Table).

By use of a cubic spline method (Figure), it appeared that the RR of VTE began rising at protein C values $<2.5$ mg/L and that it might rise to an RR of 4 at protein C levels $\leq 1.5$ mg/L. (A total of 33 ARIC subjects had protein C values $\leq 1.5$ mg/L.) VTE risk was fairly constant at protein C values $>2.5$ mg/L.

Low antithrombin, in contrast, did not seem to be associated with the incidence of VTE in the ARIC Study or with the odds of incident VTE in the LITE sample involving the ARIC Study and the CHS (Table). This conclusion was unchanged after the restricted cubic spline method was used in the ARIC Study or deciles of the distribution were used in the LITE Study. There also was no association with multivariate adjustment for age, race, sex, body mass index, or factor VIIIc.

Combinations of deficiencies have been reported to greatly increase VTE risk. However, these combinations in relation to protein C and antithrombin are relatively rare in the general population. In the ARIC Study, only 3 people at baseline had both protein C $<2.0$ mg/L and antithrombin $\leq 65\%$; none of them had VTE events during follow-up. In the LITE Study, no one had this combination of low protein

### Table: Prevalences of Low Levels of Protein C and Antithrombin III and Associations With Incident VTE Not Due to Cancer

<table>
<thead>
<tr>
<th>Study</th>
<th>Definition of Low Values</th>
<th>Prevalence</th>
<th>VTE Incidence Rate per 10^3</th>
<th>Relative Risk*</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARIC (n=14,358, 130 VTE events)</td>
<td>Protein C, mg/L</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$&lt;2.3$</td>
<td>4.4%</td>
<td>1.23</td>
<td>1.19</td>
<td>0.52–2.70</td>
</tr>
<tr>
<td></td>
<td>$&lt;2.0$</td>
<td>1.1%</td>
<td>3.47</td>
<td>3.36</td>
<td>1.24–9.11</td>
</tr>
<tr>
<td></td>
<td>$&lt;0.80$</td>
<td>4.9%</td>
<td>1.04</td>
<td>0.93</td>
<td>0.41–2.11</td>
</tr>
<tr>
<td></td>
<td>$&lt;0.65$</td>
<td>0.5%</td>
<td>No events</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td></td>
<td>Antithrombin, %</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$&lt;0.80$</td>
<td>4.9%</td>
<td>1.04</td>
<td>0.93</td>
<td>0.41–2.11</td>
</tr>
<tr>
<td></td>
<td>$&lt;0.65$</td>
<td>0.5%</td>
<td>No events</td>
<td>...</td>
<td>...</td>
</tr>
</tbody>
</table>

*L* Age-adjusted relative risk (or odds ratio in LITE) for subjects with low levels versus the remainder.

The distribution of protein C is represented by the bell-shaped curve (and the right scale). The other solid dark line (and the left scale) represents the RRs for various values of protein C based on a cubic spline model. The dotted lines are the 95% CIs for the RRs.
C and low antithrombin, nor did anyone have 1 of these in combination with factor V Leiden.

Discussion

In the prospective population-based ARIC Study of adults (mean age 54 years), the incidence of VTE not due to cancer was increased in participants with low levels of protein C. The risk of VTE was not reduced further by high levels of protein C, consistent with a threshold. For a protein C value <2.0 mg/L, present in 1.1% of the population, VTE incidence was 3.5 per 1000 person-years; in other words, it was 3.36 times (95% CI 1.2 to 9.1) the VTE rate of those with higher protein C values. This incidence rate of 3.5 per 1000 person-years is approximately the same as the incidence rates reported by some studies of presumed or known carriers of mutations for protein C deficiency. Our RR estimate is similar to RR estimates from population-based case-control studies with similar ages: RR 3.1 (95% CI 1.4 to 7.0) in the Leiden Thrombophilia Study, which had a mean age of 47, and RR 2.9 (95% CI 1.1 to 8.1) in an Oxford study of 45- to 64-year-old women. Thus, population-based studies suggest a 3-fold increased risk of VTE that is based on a single measurement of low protein C. This is half the RR of VTE for DNA-confirmed protein C deficiency. On the basis of an observed prevalence of low protein C of 1.1% and an RR of 3.36, ~2.5% of VTE in this ARIC sample might be due to low protein C. This figure is similar to Rosendaal’s estimate of the population attributable risk of 2% for protein C deficiency.

We found no association between low levels of antithrombin and VTE incidence in these subjects aged >45 years. In contrast, the 2 previous population-based case-control studies found low levels of antithrombin to increase VTE risk. RR estimates were 2.2 (95% CI 1.0 to 4.7) in the Leiden Thrombophilia Study and 3.3 (95% CI 1.2 to 9.7) in the Oxford study. One possible reason for this discrepancy is that we undoubtedly had few participants with true antithrombin deficiency in the lowest 1% of the antithrombin distribution, given an estimated prevalence of deficiency of 0.02% and the fact that we excluded those with a past history of VTE. Previous case-control studies also have used liberal definitions of antithrombin deficiency that yielded prevalences of 1.9% among controls in the Leiden study and 6% among controls in the Oxford study. Varying the cut point for our definition of deficiency did not change our null result. Another possibility for the lack of association is that our antithrombin assay may have been insufficiently accurate to identify the few truly antithrombin-deficient subjects. A final possibility is that the older age of the LITE sample led to a null finding, but the analysis based on middle-aged ARIC subjects was also null.

It has been pointed out that inherited anticoagulant defects, including factor V Leiden, may cluster together in many hereditary venous thrombosis cases. Many of these cases manifest VTE early in life. However, our data suggest that the clustering of low protein C and low antithrombin, or these in combination with factor V Leiden, is relatively rare in the general population and among patients with VTE onset after the age of 45 years.

Although this is the first prospective study of VTE incidence in relation to low levels of protein C and antithrombin, it has some limitations. First, low levels were defined arbitrarily as the lowest ~1% of participants. Deficiency was not confirmed by a repeat measurement from a separate blood draw or by DNA analysis, as might be done in clinical practice. Thus, our sample with deficiency or not suffers from some miscategorization. Second, protein C and antithrombin had low reliability (ie, high method variance plus intra-individual variance), which would attenuate regression coefficients by ~50%. Thus, because of miscategorization, the true RR estimates are undoubtedly higher than reported, and the dose-response relation depicted in the Figure may be underestimated. Third, because deficiencies are relatively rare, few participants had low values, even with our large sample size. Because VTE due to protein C or antithrombin deficiency often occurs early in life, some people with known deficiencies might have chosen at baseline not to take part in the ARIC Study. Finally, our antigen-based protein C assay would have detected only the more common type I, and not type II, deficiency.

We excluded from analysis participants with a baseline history of VTE or anticoagulant therapy, as is appropriate for an incidence cohort. We also excluded participants with cancer. Compared with those not excluded, those excluded had an ~1% higher prevalence of low protein C but a similar prevalence of low antithrombin. To determine whether these exclusions affected our findings, we repeated the analyses without exclusions. The RRs for low protein C were only slightly different from those in the Table: RR 1.43 (95% CI 0.73 to 2.80) for protein C <2.3 mg/L and RR 3.27 (95% CI 1.34 to 7.98) for protein C <2.0 mg/L. The RRs for antithrombin, without exclusions, were virtually identical to those in the Table.

In conclusion, we provide prospective evidence that low protein C levels in adults more than 45 years old is associated with a >3-fold increase in VTE incidence. The rarity of protein C deficiency meant that it accounted for ~2.5% of the VTE events in this cohort. In contrast, we found no relationship between low antithrombin levels and VTE incidence.

Acknowledgments

This research was supported by National Heart, Lung, and Blood Institute grant R01-HL59367 (LITE), contracts N01-HC-55015, N01-HC-55016, N01-HC-55018, N01-HC-55019, N01-HC-55020, N01-HC-55021, and N01-HC-55022 for the ARIC Study and contracts N01-HC-85079 to N01-HC-85086 for the CHS. The authors thank the staff and participants of the ARIC and CHS projects for their long-term contributions and Wayne Rosamond, Susan Heckbert, David Yanez, and Laura Kemmis for technical assistance.

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Arterioscler Thromb Vasc Biol. 2002;22:1018-1022; originally published online April 4, 2002;
doi: 10.1161/01.ATV.0000017470.08363.AB
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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