Biomarkers of Atherosclerotic Plaque Instability and Rupture

Wolfgang Koenig, Natalie Khuseyinova

Abstract—Basic research over the last two decades has identified a large number of molecules pertinent to the atherosclerotic process, which have clearly improved our understanding of the underlying pathology. It is now well established that inflammation represents a major feature which is present in the vessel wall throughout all stages of the disease until the final pathophysiologic steps, representing plaque destabilization and eventually plaque rupture. Several cells typical for the atherosclerotic plaque, like monocyte-derived macrophages and T-lymphocytes are able to produce and secrete such mediator molecules, like cytokines, chemokines, growth-factors, enzymes, and disintegrins, which lead to activation of endothelial cells, proliferation of smooth muscle cells, lesion progression, and finally to the weakening of a vulnerable plaque by matrix degradation of its fibrous cap. Today, many of these molecules involved can be measured systemically by sensitive assays, and elevated concentrations in the circulation have been shown to be associated with future cardiovascular events. Determination of several of these molecules carries important prognostic information, independent of traditional risk factors, and may turn out to be useful in improving risk stratification. However, for most of these biomarkers the clinical utility has not yet been established. (Arterioscler Thromb Vasc Biol. 2007;27:000-000.)

Key Words: biomarkers ■ atherosclerosis ■ pathophysiology ■ risk prediction

Atherosclerosis is characterized by a complex multifactorial pathophysiology. Inflammation in the vessel wall is now considered to play an essential role in the initiation, progression and the final steps of atherosclerosis, namely plaque destabilization and eventually plaque rupture. Classical pathologic studies show the abundant presence of inflammatory cells, like monocyte-derived macrophages and T-lymphocytes at the site of rupture or superficial erosion preferable in the shoulder area of the plaque cap. These morphological characteristics are preceded by dysfunction of activated endothelial cells which produce adhesion molecules that interact with inflammatory cells. The ability of monocyte-derived macrophages to secrete various cytokines, chemokines, growth-factors, and disintegrins, then leads to activation and proliferation of smooth muscle cells, lesion progression, and finally to the weakening of a vulnerable plaque by matrix degradation of its fibrous cap (Figure). Yet atherosclerosis and its clinical complications are not only characterized by a local inflammatory response. Recent prospective studies have consistently shown that several molecular proinflammatory biomarkers, markers of plaque destabilization and plaque rupture may be used to predict future cardiovascular (CV) events not only in apparently healthy subjects, but also in patients with acute coronary syndrome (ACS). In particular, measurements of several of these markers carry important prognostic information, independent of traditional risk factors. This review aims at giving an overview on recent biomarker candidates that are related to destabilization and rupture of the atherosclerotic plaque.

C-Reactive Protein

C-reactive protein (CRP) is a member of the pentraxin family and represents the most extensively studied proinflammatory molecule. In healthy individuals, only trace levels of CRP can be detected in the circulation. Under acute conditions, concentrations of CRP increase during the first 6 to 8 hours and can reach peak levels approaching 300 mg/L after approximately 48 hours. CRP is a robust clinical marker because of its analytical stability, shows reproducible results, and high-sensitivity assays with good precision are commercially available.

CRP is synthesized by hepatocytes and its production is under transcriptional control of several cytokines, with interleukin (IL)-6 being a primary stimulus. However, recent evidence has suggested that CRP may be also produced locally in vascular smooth muscle cells (SMCs) and macrophages of atherosclerotic lesions. CRP has initially been considered as an innocent bystander in the atherosclerotic process. Recent evidence, however,
Markers of inflammation and plaque instability: from foam cell to plaque rupture (modified after reference 2) biomarkers, which are covered in this review. IL indicates interleukin, TNF-α, tumor necrosis factor-α; MCP-1, monocyte chemoattractant protein-1; sICAM, soluble intercellular adhesion molecule-1; sVCAM, soluble vascular cell adhesion molecule; oxLDL, oxidized low density lipoprotein; Lp-PLA2, lipoprotein-associated phospholipase A2; GPx-1, glutathione peroxidase; MPO, myeloperoxidase; MMPs, matrix metalloproteinases; PlGF, placental growth factor; PAPP-A, pregnancy-associated plasma protein-A; sCD40L, soluble CD40 ligand; CRP, C-reactive protein; sPLA2, secretory type II phospholipase A2; SAA, serum amyloid A; WBCC, white blood cell count.

sICAM, sVCAM, oxLDL, MMPs, matrix metalloproteinases; PlGF, placental growth factor; PAPP-A, pregnancy-associated plasma protein-A; sCD40L, soluble CD40 ligand; CRP, C-reactive protein; sPLA2, secretory type II phospholipase A2; SAA, serum amyloid A; WBCC, white blood cell count.

suggests that CRP may have direct proinflammatory effects, and contribute to the initiation, and progression of atherosclerotic lesions. Functionally, CRP has several effects that may influence progression of vascular disease, including activation and chemoattraction of circulating monocytes, mediation of endothelial dysfunction, induction of a prothrombotic state, increase of cytokine release, activation of the complement system, facilitation of extracellular matrix remodeling as well as lipid-related effects. However, several of the above mentioned potential proatherogenic properties of CRP should be interpreted with caution, because very recent findings indicated that several direct effects of CRP on the vasculature, observed in in vitro studies, might represent artifacts. Animal models, including transgenic mice, have also provided conflicting evidence regarding proatherogenic effects of CRP.

In contrast to the controversial results from in vitro and in vivo studies supporting a causal role for CRP in atherogenesis, epidemiological studies published during the past decade have provided strong evidence for CRP to predict future CV risk in a wide variety of clinical settings, including apparently healthy men and women, patients with stable angina pectoris (AP), or those with ACS, after myocardial infarction (MI), and with the metabolic syndrome.

So far, results from more than 25 different prospective studies have been reported, and the vast majority of these studies clearly demonstrated a significant and independent association between increased concentrations of CRP and future CV events (Table 1). An earlier meta-analysis summarizing the results of 14 prospective long-term studies with a total of 2557 cases and a mean follow up (FU) period of 8 years revealed a summary relative risk (RR) for CHD of 1.9 (95% confidence interval [CI], 1.5 to 2.3) for the top versus the bottom tertile (T) of the CRP distribution. More recently, however, the results from the Reykjavik study, raised some uncertainties regarding the predictive power of CRP by showing a more modest increased risk associated with elevated CRP concentrations with an odds ratio (OR) of 1.45 (95% CI, 1.25 to 1.68) for T3 versus T1 after multivariate adjustment. A subsequent meta-analysis of 22 population-based studies, including a total of 7068 patients with incident coronary events, showed a similar result. However, there are some issues concerning this study, which merit consideration. The Reykjavik study represents a prospective cohort of 18,569 participants, where CRP was measured in approximately 6500 middle-aged men and women without a history of MI at baseline, who were followed for 17.5 years. As compared with previously published studies, the Reykjavik participants had the highest cholesterol levels seen in any cohort or clinical trial, even higher than in the 4 S study, and lower CRP (upper tertile cut-off point of 2.0 mg/L, rather than 3.0 mg/L) as seen in almost all other studies. Thus, underestimation of the true risk associated with elevated CRP is very likely. In addition, the mean FU period of 17 years is extremely long and might also be responsible for the weakening of the association between the risk marker and the disease outcome. A phenomenon that is well known from classical risk factors. Indeed, if we look at the risk estimate at 10 years (“normal” FU time in most prospective studies) the risk estimate was 1.84 (95% CI, 1.49 to 2.28), that is similar to those from other studies, thereby reinforcing the status of CRP as a strong and independent predictor of future CV risk. In ROC analyses, CRP did not show an incremental predictive value once total cholesterol was in the model, but other classical risk factors, like smoking and hypertension did not either. More recently, the large EPIC-Norfolk study from the UK conducted between 1993 and 2003 found that CRP was among the strongest variables predicting risk of coronary heart disease (CHD); and it was the strongest if only fatal cases were analyzed; and in contrast to the Reykjavik study, the authors found that other risk factors had no incremental value. Additional data in support of a clinical utility of CRP as a predictor variable came from the MONICA Augsburg cohort studies and the Cardiovascular Health Study (CHS), an elderly population without a history of vascular disease at baseline. Thus, to date, of all biomarkers investigated in CV disease, the most extensive and robust database exists for CRP. Still, its incremental predictive value above and beyond traditional risk factors, based on any of the available scores has not been definitely proven. Eventually, this issue might be solved on the basis of individual subject data in a meta-analysis currently prepared by the Emerging Risk Factors Collaboration Group. Until then widespread screening for CRP in unselected populations cannot be recommended.

Cytokines

IL-6

IL-6 is a 26-kDa single chain glycoprotein, produced by many cell types including activated monocytes/macrophages and endothelial cells, as well as by adipose tissue. IL-6 is
TABLE 1. C-Reactive Protein and Cardiovascular Disease: Overview of Prospective Studies

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Study</th>
<th>Design</th>
<th>Population</th>
<th>Outcome Variable</th>
<th>FU</th>
<th>No.</th>
<th>Risk Estimate (RR/OR, 95% CI)</th>
<th>Reference</th>
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<tbody>
<tr>
<td>Kuller et al</td>
<td>MRMT</td>
<td>nested case-control</td>
<td>Healthy men</td>
<td>CHD</td>
<td>24</td>
<td>246/491</td>
<td>1.54 (0.96–2.50)**</td>
<td>Am J Epidemiol. 1996;144:537–547</td>
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<tr>
<td>Ridker et al</td>
<td>RHE</td>
<td>nested case-control</td>
<td>Healthy men</td>
<td>CHD</td>
<td>8</td>
<td>543/543</td>
<td>CHD: 2.9 (1.8–4.6)<strong>; Stroke: 1.9 (1.1–3.3)</strong></td>
<td>N Engl J Med. 1997; 336:973–979</td>
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<tr>
<td>Tracy et al</td>
<td>CHS</td>
<td>nested case-control</td>
<td>Elderly (65+)</td>
<td>CHD/Stroke</td>
<td>2.4</td>
<td>149/146</td>
<td>2.67 (1.04–6.8)**§</td>
<td>Arterioscler Thromb Vasc Biol. 1997; 17:1121–1127</td>
</tr>
<tr>
<td>Tracy et al</td>
<td>RAPP</td>
<td>nested case-control</td>
<td>Elderly (65+)</td>
<td>CHD</td>
<td>3</td>
<td>145/146</td>
<td>M: 2.0 (0.82–4.8)<strong>; F: 2.7 (1.1–6.9)</strong></td>
<td>Arterioscler Thromb Vasc Biol. 1997; 17:1121–1127</td>
</tr>
<tr>
<td>Hants et al</td>
<td>IOWA + RHE</td>
<td>case-control</td>
<td>Elderly (65+)</td>
<td>CV Mortality</td>
<td>2.4</td>
<td>178/469</td>
<td>1.89 (0.90–3.8)**</td>
<td>Am J Med. 1999;106:506–512</td>
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<tr>
<td>Jager et al</td>
<td>Hoxim</td>
<td>complete cohort</td>
<td>Nondiabetic M/F</td>
<td>CV Mortality</td>
<td>5</td>
<td>631</td>
<td>1.93 (0.81–4.2)**§</td>
<td>Arterioscler Thromb Vasc Biol. 1999; 19:3071–3078</td>
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<td>Grain et al</td>
<td>Glosup</td>
<td>nested case-control</td>
<td>Healthy M/F</td>
<td>CHD</td>
<td>12</td>
<td>133/258</td>
<td>RR not assessed; P = 0.3346</td>
<td>J Intern Med. 2000; 247:205–212</td>
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<td>Reaven et al</td>
<td>Helsinki Heart</td>
<td>nested case-control</td>
<td>Dyslipidemic men</td>
<td>CHD</td>
<td>8.5</td>
<td>241/241</td>
<td>3.56 (1.93–6.5)**§</td>
<td>Circulation. 2000; 101:252–257</td>
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<td>Strandberg et al</td>
<td>Helsinki Aging</td>
<td>complete cohort</td>
<td>Elderly (75+)</td>
<td>CV Mortality</td>
<td>10</td>
<td>455</td>
<td>2.22 (1.10–4.2)**§</td>
<td>Arterioscler Thromb Vasc Biol. 2000;20:1027–1060</td>
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<td>Mendall et al</td>
<td>Caerphilly</td>
<td>complete cohort</td>
<td>Healthy men</td>
<td>CHD</td>
<td>5</td>
<td>1,365</td>
<td>2.01 (1.14–3.5)**§</td>
<td>Eur Heart J. 2000;21:1584–1590</td>
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<td>Rost et al</td>
<td>Framingham</td>
<td>complete cohort</td>
<td>Healthy M/F</td>
<td>Stroke</td>
<td>12–14</td>
<td>1,462</td>
<td>M: 1.6 (0.87–3.1)<strong>§; F: 2.1 (1.19–3.8)</strong>§</td>
<td>Stroke. 2001; 32:2575–2579</td>
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<tr>
<td>Perø et al</td>
<td>Quebec CV</td>
<td>complete cohort</td>
<td>Healthy men</td>
<td>CHD</td>
<td>5</td>
<td>2,037</td>
<td>1.10 (0.70–1.6)**</td>
<td>Arch Intern Med. 2001;161:2474–2480</td>
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<td>Lovel et al</td>
<td>Speedwell</td>
<td>complete cohort</td>
<td>Healthy men</td>
<td>CHD</td>
<td>6.3</td>
<td>2,055</td>
<td>1.60 (0.90–2.9)**§</td>
<td>Arterioscler Thromb Vasc Biol. 2001;21:603–610</td>
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<td>Albert et al</td>
<td>RHE</td>
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<td>CHD</td>
<td>17</td>
<td>97/126</td>
<td>2.65 (0.87–8.3)**§</td>
<td>Circulation. 2002; 105:2959–2959</td>
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<td>Pradhan et al</td>
<td>WH</td>
<td>nested case-control</td>
<td>Healthy women</td>
<td>CHD</td>
<td>2.9</td>
<td>304/304</td>
<td>2.7 (1.1–6.6)**§</td>
<td>Am J Med. 2002: 102; 1989–207</td>
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<td>Rider et al</td>
<td>WHS</td>
<td>complete cohort</td>
<td>Healthy women</td>
<td>CHD</td>
<td>8</td>
<td>27/35</td>
<td>2.31 (1.6–3.9)** §</td>
<td>N Engl J Med. 2002;347:1557–1565</td>
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<td>Luc et al</td>
<td>PRIME</td>
<td>nested case-control</td>
<td>Healthy men</td>
<td>CHD</td>
<td>5</td>
<td>37/609</td>
<td>2.16 (2.6–3.7)**§</td>
<td>Arterioscler Thromb Vasc Biol. 2002;23:1250–1261</td>
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<td>Van der Meer et al</td>
<td>Rotterdam</td>
<td>nested case-control</td>
<td>Elderly (65+)</td>
<td>CHD</td>
<td>5</td>
<td>157/500</td>
<td>1.25 (0.6–2.5)**§</td>
<td>Arch Intern Med. 2003;163:1322–1328</td>
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<tr>
<td>Koenig et al</td>
<td>MONICA Augsburg</td>
<td>complete cohort</td>
<td>Healthy men</td>
<td>CHD</td>
<td>66</td>
<td>4,06</td>
<td>2.23 (1.49–3.3)**‡</td>
<td>Circulation. 2004:109:394–1393</td>
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<td>Babayanyan et al</td>
<td>ARC</td>
<td>nested case-control</td>
<td>Healthy M/F</td>
<td>CHD</td>
<td>6</td>
<td>6067/40</td>
<td>1.72 (1.04–2.8)**‡</td>
<td>Circulation 2004:109:837–842</td>
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<td>Pai et al</td>
<td>NHS</td>
<td>nested case-control</td>
<td>Healthy M/F</td>
<td>CHD</td>
<td>8</td>
<td>239/69</td>
<td>1.53 (0.89–2.6)**‡</td>
<td>New Engl J Med. 2004;103:2589–2610</td>
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<td>Cusman et al</td>
<td>CHS</td>
<td>complete cohort</td>
<td>Elderly (65+)</td>
<td>CHD</td>
<td>10</td>
<td>2,917</td>
<td>1.37 (0.76–2.4)**‡</td>
<td>Circulation. 2005;112:25–31</td>
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<td>Laaksonen et al</td>
<td>KND</td>
<td>complete cohort</td>
<td>Healthy men</td>
<td>CHD</td>
<td>8.8</td>
<td>1,438</td>
<td>2.16 (1.69–2.79)**‡</td>
<td>Eur Heart J. 2005; 26:1783–1789</td>
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<td>Wilson et al</td>
<td>RHE</td>
<td>complete cohort</td>
<td>Healthy M/F</td>
<td>CHD</td>
<td>6</td>
<td>4,446</td>
<td>1.16 (0.95–1.4)**‡</td>
<td>Arch Intern Med. 2005;165:2473–2478</td>
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<td>Beekholt et al</td>
<td>EPIC-Norfolk</td>
<td>nested case-control</td>
<td>Healthy M/F</td>
<td>CHD</td>
<td>6</td>
<td>1,108/2,164</td>
<td>1.60 (1.01–2.1)**‡</td>
<td>Arterioscler. 2006;145:415–422</td>
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<tr>
<td>Koenig et al</td>
<td>MONICA Augsburg</td>
<td>complete cohort</td>
<td>Healthy M/F</td>
<td>CHD</td>
<td>11</td>
<td>382/1,960</td>
<td>M: 1.38 (1.15–27.7)<strong>†; F: 1.25 (0.69–2.4)</strong>§</td>
<td>Arterioscler Thromb Vasc Biol. In press.</td>
</tr>
</tbody>
</table>

*Multivariable adjustment
§ Partially adjusted
† Increase per 1 Unit or standard deviation (SD)
$<vs <median
# Tertile analysis (T3 vs T1)
§ Quartile analysis (Q4 vs Q1)
‡ For CRP > 3 mg/L vs CRP  1 mg/L
FU indicates Follow-up; CI, Confidence Interval; RR, Relative Risk; OR, Odds Ratio; CHD, Coronary Heart Disease; CVD, Cardiovascular Disease; SCD, Sudden Cardiac Death; M, Male; F, Female; MRMT, Multiple Risk Factor Intervention Trial; PHS, Physicians’ Health Study; CHS, Cardiovascular Health Study; RAPP, Rural Health Promotion Project;Women’s Health Study; MONICA, Monitoring of Trends and Determinants in Cardiovascular Disease; Iowa 65 + RHE, Iowa 65 + Rural Health Study; BRHS, British Regional Heart Study; WOSCOPS, West of Scotland Coronary Prevention Study; WHI, Women’s Health Initiative; PRIME, Prospective Epidemiological Study of Myocardial Infarction; ARIC, Atherosclerosis Risk in Communities; NHS, Nurses’ Health Study; HPFS, Health Professionals Follow-Up Study; KIHID, Kuopio Ischaemic Heart Disease Risk Factor Study; FHS, Framingham Heart Study; KORA, Kooperative Gesundheitsforschung in der Region Augsburg.

able to stimulate macrophages to secrete MCP-1 and participates in the proliferation of SMCs. In a murine model of atherosclerosis, injection of excessive amounts of recombinant IL-6 resulted in enhanced fatty lesion development. Furthermore, IL-6 represents the principal procoagulant cytokine, but its most important function is the amplification of the inflammatory cascade through which IL-6 at least in part might exert its direct proatherogenic effects in the arterial wall. Indeed, large amounts of IL-6 have been found in human atherosclerotic plaque, in particular within the shoulder region of stable and unstable plaque, where it colocalized with the AT-1 receptor. Upregulation of the AT-1 receptor by IL-6 has led to increased ATII-mediated vasoconstriction, enhanced free oxygen radical production and the development of endothelial dysfunction. In addition, Maier et al have recently demonstrated in patients with ACS that IL-6 levels were...
TABLE 2. Interleukin-6 (IL-6) and cardiovascular disease: Overview of prospective studies

<table>
<thead>
<tr>
<th>Author et al</th>
<th>Study Design</th>
<th>Population</th>
<th>Outcome Variable</th>
<th>FU</th>
<th>No.</th>
<th>Risk Estimate (RR/OR, 95% CI)</th>
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<tbody>
<tr>
<td>Harris et al</td>
<td>Iowa 65+RHS case-cohort</td>
<td>Elderly (65+)</td>
<td>CV Mortality</td>
<td>4.6</td>
<td>176/499</td>
<td>2.20 (1.00–4.80)§</td>
</tr>
<tr>
<td>Ridker et al</td>
<td>PHS nested case-control</td>
<td>Healthy men</td>
<td>CHD</td>
<td>6</td>
<td>202/202</td>
<td>2.30 (1.1–4.6)§</td>
</tr>
<tr>
<td>Ridker et al</td>
<td>WHS nested case-control</td>
<td>Healthy women</td>
<td>CVD</td>
<td>3</td>
<td>122/244</td>
<td>2.20 (1.1–4.3)§</td>
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<tr>
<td>Volpato et al</td>
<td>WHAS complete cohort</td>
<td>Elderly (65+)</td>
<td>CV Mortality</td>
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<td>628</td>
<td>2.52 (1.21–4.9)§</td>
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<td>Pradhan et al</td>
<td>WHI nested case-control</td>
<td>Healthy women</td>
<td>CHD</td>
<td>2.9</td>
<td>304/304</td>
<td>2.10 (1.1–4.0)§</td>
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<td>Cesari et al</td>
<td>Health ABC complete cohort</td>
<td>Elderly (70+)</td>
<td>CHD Stroke</td>
<td>3.6</td>
<td>2225</td>
<td>CHD: 1.27 (1.01–1.54)¶ Stroke:1.45 (1.12–1.89)¶</td>
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<tr>
<td>Luc et al</td>
<td>PRIME nested case-control</td>
<td>Health men</td>
<td>CHD</td>
<td>5</td>
<td>317/609</td>
<td>2.16 (1.28–3.72)¶</td>
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<td>Lowe et al</td>
<td>WOSCOPS nested case-control</td>
<td>Dyslipidemic men</td>
<td>CHD</td>
<td>5</td>
<td>485/834</td>
<td>1.64 (1.11–2.40)¶</td>
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<tr>
<td>Koenig et al</td>
<td>MONICA/KORA case-cohort</td>
<td>Healthy MF</td>
<td>CHD</td>
<td>11</td>
<td>382/1,980</td>
<td>M: 1.42 (0.97–2.07)§ F: 2.99 (1.38–6.49)§</td>
</tr>
</tbody>
</table>

*Multivariable adjustment
¶Matched for age and smoking
§Tertile analysis (T3 vs T1)
¶Quartile analysis (Q4 vs Q1)
FU indicates Follow-up; CI, Confidence Interval; RR, Relative Risk; OR, Odds Ratio; CHD, Coronary Heart Disease; CVD, Cardiovascular Disease; M, Male; F, Female

Table 2: Interleukin-6 (IL-6) and cardiovascular disease: Overview of prospective studies.

IL-18

IL-18, a pleiotropic proinflammatory cytokine, is widely expressed in various cell types. Beyond induction of IFN-γ with subsequent promotion of Th1 immune response, IL-18 enhances the expression of matrix metalloproteases (MMPs) and these two abilities of IL-18 characterize it as a crucial and potent mediator of atherosclerotic plaque destabilization and vulnerability. Increased expression of IL-18 in human atherosclerotic plaque has been shown, especially in lesions prone to rupture, where it is localized mainly in plaque macrophages. In animal models, inhibition of IL-18 by IL-18 binding protein reduced atherosclerotic plaque development and progression in apoE-deficient mice and IL-18/apo-E double knockout mice exhibited reduced lesion size, thus further supporting a proatherogenic role of IL-18. In contrast, direct administration of IL-18 enhanced atherogenesis in an IFN-γ-dependent manner, even in the absence of T-cells and induced/promoted a switch to a vulnerable plaque phenotype by decreasing intimal collagen content and cap-to-core ratio.

Whereas experimental studies on the role of IL-18 in atherogenesis are relatively consistent and promising, the clinical evidence for this biomarker in cross-sectional studies in patients with CHD is controversial. However, results from one large prospective study, conducted in 1229 patients with angiographically confirmed CHD showed that increased IL-18 levels at baseline were independently associated with future CV death during a 3.9-year follow-up (FU), but at 5.9 years, IL-18 concentrations were no longer predictive of outcome, thereby questioning its value as a risk marker.

Today, only two studies assessed the prognostic value of elevated IL-18 for future coronary events in apparently healthy subjects. In the Prospective Epidemiological Study of Myocardial Infarction (PRIME) Study, a cohort from France and Northern Ireland, elevated IL-18 concentrations at baseline were associated with an increased risk for subsequent CHD events after multivariable adjustment. However, such an association was only seen when data from both populations were pooled for analysis. In a large case-cohort study in initially healthy middle-aged men and women from the MONICA/KORA Augsburg populations with a mean FU of 11 years, concentrations of IL-18 were measured in 382 case subjects with incident CHD and in 1980 non-case subjects. In multivariable analyses there was no statistically
significant association, neither in men nor in women. This large population-based case-cohort study therefore suggests that IL-18 might only serve as a marker of future CV events in men with manifest CHD and/or in areas of high absolute risk of CHD and thus, further studies are needed to evaluate its true clinical value.

**Oxidized LDL**

The oxidative modification hypothesis of atherogenesis suggests that the most significant event in early lesion formation is lipid oxidation, placing oxidized LDL (oxLDL) in a central role for the development of this disease. OxLDL has a large number of biological actions and consequences, including injuring ECs, expressing adhesion molecules, recruiting leukocytes and retaining them, as well as the formation of foam cells. Furthermore, elevated oxLDL could play a role in the transition from stable to vulnerable, unstable plaque, and this assumption is supported by recent studies showing that oxLDL stimulates matrix metalloproteinase (MMP)-1 and -9 expressions in human vascular EC and in monocyte-derived macrophages. It has also been shown that oxLDL up-regulates the expression of MMP-1 and -3 in human coronary ECs, an effect mediated through its endothelial receptor LOX-1. Furthermore, oxLDL triggers the CD40/CD40L signaling pathway, which might also lead to a proinflammatory reaction and induce endothelial injury.

Several cross-sectional studies have examined the involvement of oxidative modification of LDL in subjects with clinical evidence of CHD and demonstrated that oxLDL concentrations were significantly higher in patients with MI than in patients with unstable or stable angina or age-matched controls. Salonen et al were the first to conduct a prospective, population-based, nested case-control study in which the titer of autoantibodies to malondialdehyde-modified LDL and native LDL was associated with accelerated progression of carotid atherosclerosis. More recently, data of a first prospective nested case–control study from two population-based MONICA/KORA Augsburg surveys showed that plasma oxLDL was the strongest predictor of CHD events compared with a conventional lipoprotein profile, and other traditional risk factors for CHD. Further studies are warranted to establish the clinical relevance of oxLDL measurement in various stages of the atherosclerotic process and identify the specific pathophysiological mechanisms by which oxLDL exerts its deleterious effects.

**Glutathion Peroxidase**

Although results of several large antioxidant trials were disappointing, nonetheless, on the basis of experimental and epidemiological studies, it seems justified to assume that oxLDL may indeed play a key role in the generation of inflammatory processes in atherosclerotic lesions and that antioxidative mechanisms still may be important in the pathophysiology of the disease.

Glutathion peroxidase (GPx) is a selenium-containing enzyme with potent antioxidant properties, which uses glutathione to reduce hydrogen peroxide and lipid peroxides to water and lipid alcohols, respectively. To date, 4 isoforms of GPx have been identified, with GPx-1, as an intracellular molecule, being more intensively studied. Experimental studies in GPx-1 knockout mice have demonstrated an increased oxidation of LDL or have developed endothelial dysfunction attributable to deficiency in bioactive nitric oxide as compared with wild-type mice. This enzyme might also inhibit transcription of 5-lipoxygenase as well as leukotriene and prostanoid synthesis in mononuclear cells and macrophages, EC, platelets and leukocytes. In one prospective study, risk of future fatal and non-fatal CV events associated with baseline activity of erythrocyte GPx-1 and superoxide dismutase activity was investigated in 636 patients with angiographically confirmed CHD and was found to be inversely associated with increasing GPx-1 activity. Clearly, such data need replication in further studies, before any sound conclusions can be drawn on its potential value as an additional risk marker.

**Lipoprotein-Associated Phospholipase A2**

Lipoprotein-associated phospholipase A2 (Lp-PLA2) represents another emerging biomarker for atherosclerotic disease and is presently under intensive investigation. Lp-PLA2, a 45.4-kDa protein, is a calcium-independent member of the phospholipase A2 family. It is produced mainly by monocytes, macrophages, T-lymphocytes, and mast cells and has been found to be upregulated in atherosclerotic lesions, especially in complex plaque, as well as in thin cap coronary lesions prone to rupture. In the bloodstream, two-thirds of the Lp-PLA2 plasma isoform circulates primarily bound to low-density lipoproteins (LDL), the other third is distributed between HDL and very low-density lipoproteins (VLDL). Lp-PLA2 may promote oxidation of LDL, and recent investigations have stressed the proatherogenic properties of this enzyme. LDL provides a circulating reservoir, in which Lp-PLA2 remains inactive until LDL undergoes oxidative modification. After LDL oxidation within the arterial wall, a short acyl group at the sn-2 position of phospholipids becomes susceptible to the hydrolytic action of Lp-PLA2, that cleaves an oxidized phosphatidylcholine component of the lipoprotein particle generating two potent proinflammatory and proatherogenic mediators, namely lysophosphatidylcholine (LysoPC) and oxidized fatty acid (oxFA). LysoPC is a potent chemoattractant for T-cells and monocytes, promotes endothelial cell dysfunction, stimulates macrophage proliferation, and induces apoptosis in SMCs and macrophages. Thus, Lp-PLA2 may represent an important “missing link” between the oxidative modification of LDL in the intimal layer of the arterial wall and local inflammatory processes within the atherosclerotic plaque.

Several studies in initially healthy subjects but also in those with manifest atherosclerosis have found an association between increased concentrations of Lp-PLA2 and future coronary and cerebrovascular events, independent of a variety of potential confounders (Table 3). However, measurement of Lp-PLA2 in the early phase of the ACS was not associated with increased risk for recurrent events. Apart from an important role of Lp-PLA2 in the prediction of future CV disease, this enzyme could also represent an attractive novel therapeutic target, because initial studies have demonstrated a significant clinical benefit by inhibiting this enzyme.
Type II Secretory Phospholipase A₂

Type II secretory phospholipase A₂ (sPLA₂-II) is another well-established atherosclerotic risk factor.82 Elevated levels of sPLA₂-II were associated with an increased risk of future cardiovascular events in multivariable analyses.81 Elevated levels of sPLA₂-II were significant and independent predictors of future cardiovascular events in CHD patients,82 consistent with atherogenic and pro-inflammatory effects.83 MPO together with other enzymes such as lipoygenase and sPLA₂-II has been shown to promote the weakening of the fibrous cap and lead to the destabilization of atherosclerotic plaque.84

MPO is a leukocyte-derived enzyme, and is secreted by platelets and other inflammatory cells. It is involved in the production of isoprostanes, which are pro-inflammatory compounds such as IL-1β, IL-6, and tumor necrosis factor (TNF)-α, interferon (INF)-γ, and oxLDL. MPO is also expressed in hepatitis, macrophages, EDs, platelets, and vascular SMCs. sPLA₂-II is a Ca²⁺-dependent, 14-kDa enzyme which belongs to the group of acute phase reactants. sPLA₂-II production is upregulated in response to pro-inflammatory compounds such as IL-1β, IL-6, tumor necrosis factor (TNF)-α, interferon (INF)-γ, and oxLDL.85,86

Possible atherogenic mechanisms of sPLA₂-II include its effects on lipoproteins which results in the release of various lipid mediators at the site of lipoprotein retention in the arterial wall. MPO and its end product HOCl remains its ability to activate MMPs and deactivate inhibitors of MMPs,87,88 which promote the weakening of the fibrous cap and lead to the destabilized atherosclerotic plaque.

Myeloperoxidase

Myeloperoxidase (MPO), a member of the heme peroxidase superfamily, is a leukocyte-derived enzyme, and is secreted on leukocyte activation and degranulation. Its activity is regulated by a number of factors, including the concentration of hydrogen peroxide, the presence of thiocyanate, and the pH of the extracellular environment. Myeloperoxidase is involved in the production of isoprostanes, which are pro-inflammatory compounds such as IL-1β, IL-6, tumor necrosis factor (TNF)-α, interferon (INF)-γ, and oxLDL. MPO is also expressed in hepatitis, macrophages, EDs, platelets, and vascular SMCs. sPLA₂-II is a Ca²⁺-dependent, 14-kDa enzyme which belongs to the group of acute phase reactants. sPLA₂-II production is upregulated in response to pro-inflammatory compounds such as IL-1β, IL-6, tumor necrosis factor (TNF)-α, interferon (INF)-γ, and oxLDL.85,86

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Myeloperoxidase

Myeloperoxidase (MPO), a member of the heme peroxidase superfamily, is a leukocyte-derived enzyme, and is secreted on leukocyte activation and degranulation.85 There are several pathways through which MPO could exert its deleterious effects. MPO together with other enzymes such as lipoygenase and sPLA₂-II might initiate lipid oxidation in the subendothelial space of the vessel wall. MPO and its oxidation products have been found to be markedly enriched in human atherosclerotic lesions, compared with control vessels, where they colocalize with macrophages.85 MPO could be also involved in the development of endothelial dysfunction, because MPO uses the atheroprotective endothelial-derived NO as a substrate.86 Nonetheless, a most pivotal characteristic of MPO and its end product HOCI remains its ability to activate MMPs and deacivate inhibitors of MMPs, which promote the weakening of the fibrous cap and lead to the destabilized atherosclerotic plaque.
In line with these findings are the results of two prospective studies in patients with ACS. MPO mass concentrations have been measured in the c7E3 Anti-Platelet Therapy in Unstable Refractory angina (CAPTURE) trial in 1090 patients with ACS. Baseline MPO levels predicted an increased risk for adverse CV events, and this effect was even more pronounced in patients without myocardial necrosis (negative for cardiac troponin at baseline).69 In a large cohort of patients with chest pain, a single measurement of MPO on admission independently predicted acute MI.69 Thus, MPO might be a promising prognostic marker for CV events, especially in the ACS. However, further studies are needed to replicate these findings and to establish a potential role for MPO as a predictor of incident CHD in initially healthy subjects.

Matrix Metalloproteinases
Matrix metalloproteinases (MMPs) belong to a family of multidomain zinc-dependent endopeptidases that promote degradation of all protein and proteoglycan-core-protein components of the extracellular matrix (ECM).91 Based on domain organization and substrate specificities, MMPs are grouped into collagenases (MMP1, 8, 13), gelatinases (MMP2 and MMP9), stromelysins (MMP3, 10, and 11), matrilysins (MMP7), metalloelastases (MMP12), and membrane-type (MT)-MMPs.91 MMPs are widely expressed in monocytes/macrophages, ECs and SMCs, fibroblasts, and neoplastic cells.92 MMPs are involved in the embryonic development and morphogenesis, wound healing and tissue resorption. On the other hand, MMPs might be implicated in vascular and cardiac remodeling as a result of dysregulated expression of MMPs,103 thus suggesting its involvement in plaque destabilization of atherosclerotic lesions.

Several cross-sectional studies have demonstrated significantly increased concentrations of MMPs in patients with ACS compared with healthy controls or in patients with more advanced CHD.94–96 However, to date only one prospective study conducted in 1227 patients with angiographically confirmed CHD showed that increased concentrations of MMP-9 at baseline were associated with future CV death.97 Interestingly, high concentrations of the endogenous tissue inhibitors of metalloproteinase-1 (TIMP) were also predictive for future CV death in this study,28 which has been confirmed by others.99 Thus, undoubtedly, MMPs play an important role in plaque destabilization, but further studies are needed to prove or disprove their clinical usefulness for risk assessment.

Monocyte Chemoattractant Protein-1
Monocyte chemoattractant protein-1 (MCP-1) is the most important chemokine that regulates migration and infiltration of monocytes/macrophages. Its effects are mainly mediated through CC chemokine receptors 2 (CCR2), ECs, monocytes, and/or SMCs express MCP-1 in response to various cytokines, growth factors, oxLDL, and CD40 L.100 and thus MCP-1 expression is increased in atherosclerotic lesions,101 in particular in macrophage-rich areas. MCP-1 causes chronic vascular inflammation, induces proliferation and migration of SMCs, migration of ECs, neovascularization in plaque, oxidative stress, and thrombosis.102 Activation of the MCP-1/CCR2 pathway has also been shown to induce expression of MMPs,103 thus suggesting its involvement in plaque destabilization.

In animal models, the expression of MCP-1 was directly related to the extent of atherosclerosis and macrophage infiltration into the atherosclerotic lesion,104 and anti-monocyte MCP-1 gene therapy limited the progression and destabilization of established atherosclerosis in apolipoprotein E-knockout mice.105 Based on these findings, MCP-1 could present an interesting, novel target for intervention to reduce atherosclerotic complications.

Consistent with such experimental data, in the Orbofliban in Patients with Unstable coronary Syndromes (OPUS)-TIMI 16 trial, elevated levels of MCP-1 were associated with risk of death or MI after 10 months, independent of a variety of CV risk factors, clinical and ECG characteristics, renal function, and markers of necrosis and inflammation.106 However, although in a large case-cohort study from the MONICA/KORA Augsburg database, elevated levels of MCP-1 preceded CHD events, they were not independent predictors of risk, once traditional risk factors were also considered.107 Thus, further studies in various populations are needed to potentially establish MCP-1 as a clinically useful biomarker.

Placental Growth Factor
Placental growth factor (PIGF) represents another important candidate biomarker of plaque instability. PIGF, a member of the cysteine-knot family of growth factors, is a ~50-kDa angiogenic protein, demonstrating an ~40% amino acid sequence similarity to vascular endothelial growth factor (VEGF).108 PIGF was initially discovered in the placenta, which represents a primary source of its synthesis; further it is expressed in the heart, lungs, goiter, and thyroid tissue108 and was found to be upregulated within early and advanced atherosclerotic lesions.109 Besides its physiological functions during pregnancy, PIGF also possesses potent proatherogenic properties such as proliferation and migration of ECs and SMCs, chemotactic recruitment of circulating monocytes and macrophages into atherosclerotic lesions, and upregulation of several cytokines such as, eg, TNF-α.109,110 Moreover, PIGF might form a heterodimer with VEGF, thereby enhancing several deleterious effects of this growth factor.108 Experimental studies using apoE- and PIGF-deficient mice have confirmed a proatherogenic effect of PIGF, demonstrating a reduction of early atherosclerotic plaque development with decreased macrophage content.111 Furthermore, periadventitial PIGF adenoviral gene delivery to carotid arteries in hypercholesterolemic rabbits led to increased intimal thickening, neointimal macrophage accumulation, and adventitial neovascularization.111 Only two clinical studies have investigated the potential role of PIGF as a predictor of adverse outcome in the ACS.112,113 Circulating PIGF concentrations were measured in 547 patients of the placebo arm of the CAPTURE trial, as...
well as in 626 patients presenting to the emergency department with chest pain. Indeed, in these two populations, elevated concentrations of PIGF were significantly associated with an increased risk of adverse events (death or nonfatal MI) at 30 days, and this association was independent of several other biomarkers such as troponin, sCD40L, and CRP. Moreover, when the follow-up period in the CAPTURE study was extended from 1 to 48 months, increased PIGF concentrations remained a potent and independent predictor of the incidence of death or MI. Yet, the present database is still too limited for a recommendation regarding its clinical usefulness as a risk marker.

**Pregnancy-Associated Plasma Protein A**

Pregnancy-associated plasma protein A (PAPP-A) is a high-molecular mass, zinc binding metalloproteinase which may be produced by different activated cells in unstable plaques and released into the extracellular matrix. Using specific monoclonal antibodies, PAPP-A was found to be abundantly expressed in both eroded and ruptured coronary and carotid plaques, mainly in monocyte/macrophages present in the cap and shoulder region, but was only minimally expressed in stable plaque. PAPP-A is a specific activator of insulin-like growth factor-1 (IGF-1) and acts by degrading IGF binding proteins-4 and -5, thus allowing active IGF-1 to bind to cell-surface type 1 IGF receptors. IGF-1 induces cell proliferation, differentiation, migration, inflammatory cell activation, LDL-cholesterol uptake, and release of inflammatory cytokines, thus contributing to plaque progression and destabilization. Whether PAPP-A directly can degrade extracellular matrix remains unclear.

Several studies in patients with ACS, but also with stable CHD, have investigated PAPP-A as a potential marker of risk for clinical complications. In a small study, circulating PAPP-A levels were significantly higher in patients with unstable angina and MI compared with controls. In a larger cohort of 200 patients with troponin negative ACS, PAPP-A levels independently predicted ischemic cardiac events and need for revascularization during 6-month FU. Within the CAPTURE trial, PAPP-A levels indicated increased risk of death and MI in both troponin negative and troponin positive patients. In multivariable analysis, PAPP-A, sCD40L, IL-10, and VEGF were independent predictors of outcome. Similarly, in patients with STEMI, PAPP-A levels were increased and predicted 12-month risk of death and recurrent non-fatal MI. In addition, PAPP-A and its endogenous inhibitor, the proform of eosinophil major basic protein (proMBP), were related to complex angiographic stenosis morphology in patients with stable CHD, and PAPP-A was prospectively associated with future death and ACS in such patients.

Thus, in several studies increased circulating PAPP-A levels have been shown as a mediator of adverse inflammatory events, but it has also been suggested that PAPP-A may be a suppressor rather than a mediator of inflammation and tissue damage. Also, there is recent evidence for the presence of an ACS-related isoform of PAPP-A, which is not complexed with the proform of the eosinophilic major basic protein (proMBP), that should result in the development of more specific assays. Thus, further mechanistic and clinical studies are needed to assess the potential utility of PAPP-A for risk stratification in the ACS.

**Soluble CD40 Ligand**

CD40 and CD40L (CD 154), both members of the TNF superfamily, are coexpressed by all major cells implicated in atherosclerosis, namely activated T-lymphocytes, vascular ECs, SMCs, and monocytes/macrophages. Both, the receptor and the ligand are functional and CD40/CD40L interactions enhance the expression of various proatherogenic molecules like adhesion molecules, various chemokines (eg, MCP-1), cytokines, growth factors, and MMPs. In addition, CD40L-mediated functions include prothrombotic actions by enhancing the expression of tissue factor and diminishing the expression of thrombomodulin. OxLDL may play a role as an initial trigger of CD40/CD40L expression. The importance of CD40 signaling in atherosclerotic plaque development has been demonstrated using LDL receptor deficient mice. Interrupting CD40 signaling, drastically reduced de novo formation, and progression of established lesions. It also significantly enhanced the lesional content of collagen in mouse atheroma suggesting a change in plaque phenotype. Platelet activation induced by plaque rupture results in increased surface expression of CD40L, which is then cleaved. Circulating soluble (s) CD40L may activate ECs and CD40 expressed in other cells constitutive for the atherosclerotic plaque and induce a proinflammatory cascade in the vessel wall. Human studies indicated that sCD40L is associated with high intraplaque lipid content in patients with carotid atheroma, thus identifying high-risk lesions.

Elevated plasma concentrations of sCD40L have been observed in patients with ACS in the CAPTURE study, which was associated with increased risk for death or non-fatal MI. Patients with elevated sCD40L levels benefited from early antiplatelet therapy with abciximab in this study and also from early statin therapy in the Myocardial Ischemia Reduction with Aggressive Cholesterol Lowering (MIRACL) study. In another study, the predictive value of sCD40L was shown to be independent of troponin and CRP. Finally, data from the FRISC trial demonstrated that sCD40L levels are modified by a polymorphism in the CD40LG gene, were again related to outcome, and identified a subgroup particularly benefiting from antithrombotic and early invasive treatment. Thus, sCD40L could serve as a marker of increased thrombotic risk in ACS and may guide aggressive treatment. However, results have to be replicated in further large studies and a number of analytical issues need to be resolved before this biomarker can be used routinely.

**Summary and Conclusions**

Various molecules involved in the pathogenesis of atherosclerosis predict plaque destabilization and rupture and subsequent clinical complications. They are important research tools and probably useful surrogate markers of atherosclerosis in early clinical “proof of concept” studies. But does the measure of a substantial relative risk (usually in the order of 2- to 3-fold) for coronary events qualify these molecules as useful biomarkers for the clinical routine? Probably not, as suggested by the ongoing controversy regarding CRP. For...
none of the other molecules discussed here the evidence of a predictive value is so robust, and the database is as large as for CRP, yet the incremental value of CRP in clinical decision making has not been ultimately proven.

Recently it has been suggested136,137 that additional criteria need to be applied to a biomarker beyond the independence of its association with an end point, the reliability and accuracy of the test, documented by good sensitivity, specificity, predictive value, and cost-effective issues. Such further test characteristics include likelihood ratios, model calibration, C-statistics, and area under the curve (AUC) in receiver operating characteristic (ROC) analysis. Thus, we still have a long way to go until the most promising candidate molecules have been identified that might help us as clinicians in improving prediction of the deleterious clinical complications of atherosclerosis. To date, none of the biomarkers discussed here can be recommended to the physician for routine clinical use.

Disclosures

None.

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