The term biomarkers has become common in the conversation about cardiovascular disease from both an investigational and clinical perspective. Yet considerable confusion surrounds the definition, uses, validation, and the value of biomarkers. Fortunately, an NIH consensus statement published in 1998 provides a set of definitions in the biomarker arena that remain useful currently, albeit often not heeded (Table).1 A biological marker, or biomarker, is a characteristic that is objectively measured and evaluated as an indicator of a normal biological process, pathogenic process, or pharmacological response to a therapeutic intervention. Some biomarkers can be qualified as surrogate end points. A surrogate end point is a biomarker that can substitute for a clinical end point for clinical or regulatory use. A clinical end point is a characteristic or variable that reflects how a patient feels, functions, or survives. Note that our formal definitions of biomarker do not sanction the oft-heard term surrogate marker. To accompany a series of articles relating to cardiovascular biomarkers, this prefatory statement puts forth some of the common challenges to the use of biomarkers in investigation and the clinic. Although we draw our examples from the cardiovascular arena, the principles apply to many aspects of medicine. The NIH working group definition of biomarkers extends beyond in vitro diagnostics, usually measured in blood or other bodily fluids. Anthropomorphic measurements and commonly measured clinical variables, such as blood pressure, oxygen saturation, or heart rate, also fall under the definition of biomarkers. Examples of imaging biomarkers include carotid intima-media thickness, coronary calcium, ventricular dimensions, and the like. This review will focus primarily on blood biomarkers.

Analytic Considerations

The use of blood biomarkers requires attention to preanalytical concerns. The mode of blood drawing requires considerable care. For example, markers carried in platelets will vary in blood samples depending on how they are drawn and handled.2 Performing venipuncture without activating platelets or other cells with granular content, including many leukocytes, necessitates special precautions. The choice of anticoagulants also requires care. For example, the use of chelating agents, such as EDTA, precludes measurement of metalloenzymes, such as the matrix metalloproteinases, in an accurate manner. The separation of cellular elements from blood often requires centrifugation, the details of which require consideration to avoid spurious results. Emerging biomarkers, such as extracellular vesicles and exosomes, may furnish valuable diagnostic resources in the cardiovascular domain as currently explored in oncology.3 Sample preparation to harvest this potentially valuable...
source of relatively unexplored cardiovascular biomarkers requires ultracentrifugation.4

The stability of blood analytes can vary considerably. The 19th century French physiologist Claude Bernard discovered the glucogenic function of the liver because he noted a difference in the level of glucose assayed at different times after the conclusion of an experiment. The stability of analytes also varies based on storage considerations. Antibodies may remain stable at 4°C, whereas other biomarkers require storage below freezing or even at −70°C to maximize stability. To avoid degradation of analytes and improve consistency of results, protocols should minimize freeze/thaw cycles. In designing biobanks, preparing aliquots of frozen samples can forestall the need for repeated freeze/thaw cycles that may degrade analytes.

The timing of sampling blood biomarkers often requires particular consideration. For example, triglycerides will vary considerably depending on whether they are obtained in a fasted state at various times after meal, and fluctuate with the fat content of the diet. Other analytes, such as fibrinogen, have diurnal variations. Numbers and activation state of circulating immune cells may also vary during the diurnal cycle.5 The half-life of an analyte may also affect its utility as a biomarker. Those with short half-lives may prove less reliable in population studies than those with longer dwell times in the circulation.

Measurement of biomarkers requires care in the choice of assay. The standardization, specificity, and scalability of a biomarker and the dynamic range of an analyte require consideration. Many proteins pivotal in biological control require processing to obtain biological activity. Whether an assay measures the precursor, the active form, or both needs consideration. Many assays of analytes with active and inactive forms include angiotensin, interleukin-1β, and many proteinases, such as the matrix metalloproteinases and caspases. All assays require the requisite quality assurance and quality control.

Interpretation
The proper use of biomarkers requires consideration of the distinction between a causal factor that participates in the pathogenesis of disease and a biomarker that does not engage in a causal pathway. To have utility, a biomarker need not contribute directly to the disease mechanism. Yet, confusion about causality to a biomarker can confound the rigorous thinking. The classical schema of Fleming and DeMets6 highlights some of the slips twixt the cup and lip in the use of biomarkers (Figure 1). Many initial studies overestimate the magnitude of the utility of biomarkers.4 Therefore, the initial results of biomarker studies that do not use an independent validation cohort or population merit considerable skepticism.

Table. National Institutes of Health Biomarkers Definition Working Group (1998)

<table>
<thead>
<tr>
<th>Biological marker (biomarker)</th>
<th>A characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacological responses to a therapeutic intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surrogate end point</td>
<td>A biomarker intended to substitute for a clinical end point. A surrogate end point is expected to predict clinical benefit (or harm or lack of benefit or harm) based on epidemiological, therapeutic, pathophysiologic, or other scientific evidence</td>
</tr>
<tr>
<td>Clinical end point</td>
<td>A characteristic or variable that reflects how a patient feels, functions, or survives</td>
</tr>
</tbody>
</table>

Table information derived from Biomarkers Definitions Working Group.7
Use of Biomarkers in Clinical Practice

Diagnostic dilemmas often face the practitioner. Biomarkers can aid a physician to sort individuals into categories of disease or no disease.\(^\text{16}\) This use of biomarkers to discriminate requires validation and refinement. The use of highly sensitive troponin assays to discriminate individuals with acute coronary syndromes who require hospitalization versus those who do not require inpatient observation constitutes one example.\(^\text{17}\)

The use of biomarkers to determine the risk of an event or prognosis as a continuous variable demands careful consideration. Various risk scores in the cardiovascular arena have generated considerable controversy.\(^\text{18}\) Some risk scores use categorical biomarkers with arbitrary assignment of weighting (eg, the CHADS2 Score for Thrombotic Risk). Others use continuous variables and weighing of components of the score-based computational algorithms (eg, the Reynolds Risk Score for Women).\(^\text{19}\) Several recent reviews consider the statistical test that used to determine the ability of various biomarkers or risk scores to discriminate, calibrate, and prove clinically useful in practice.\(^\text{20}\)

As used in clinical trials, biomarkers can help to target interventions in clinical practice. For example, drug treatment of hypertension or diabetes mellitus depends on achieving certain cutpoints of biomarkers, such as systolic blood pressure or glucose or hemoglobin A1c. Although various guideline-mandated cutpoints can vary considerably, and some have engendered controversy, the concept that biomarkers can guide therapy governs a great deal of contemporary clinical practice. Yet, large-scale clinical trials have validated such clinical cutpoints surprisingly seldomly. In JUPITER, allocating statin therapy on the basis of the degree of inflammation as reflected by high sensitivity C-reactive protein not only yielded a primary prevention population with enhanced risk of a cardiovascular event, but also identified individuals who benefitted particularly from statin therapy.\(^\text{15}\) Widespread clinical adoption should await the validation of the ability of the biomarker to inform therapy that improves patient outcomes. In particular, imaging biomarkers, such as coronary calcium score, while indubitably enriching cardiovascular risk, lack clinical trial support as a guide to therapy.

When considering variables to include in the generation of an a priori (as opposed to an unbiased derivation) risk score, selecting biomarkers that report on orthogonal aspects of pathogenesis makes sense. For example, a biomarker of lipid risk, such as low-density lipoprotein, myocardial stress, such as a natriuretic peptide, myocardial injury, such as troponin, inflammation, such as high sensitivity C-reactive protein, and glycemia, such as hemoglobin A1c, each report on different biological pathways.\(^\text{20–21}\) Inclusion of biomarkers that lie in a common pathway (eg, low-density lipoprotein cholesterol, apolipoprotein B, and non–high-density lipoprotein cholesterol) would not be expected to add as much information to a risk assessment instrument as biomarkers that reflect independent, orthogonal pathogenic pathways (Figure 2).

Biomarkers can also inform regulatory decisions. For example, the US Federal Food and Drug Administration (FDA) has approved drugs for marketing based on their ability to affect such biomarkers as low-density lipoprotein cholesterol, hemoglobin A1c, or systolic blood pressure. The approval of proprotein convertase subtilisin/kexin

**Figure 1.** Failure modes of biomarkers. **A**, The situation that provides the greatest potential for a biomarker to serve as a surrogate endpoint. **B**, A case in which the surrogate does not lie in the causal pathway of the disease pathogenesis. **C**, A case in which several causal pathways of disease, the intervention affects only the pathway mediated through the biomarker. **D**, A case in which the biomarker does not report on the pathway of the intervention's effect or does not reflect its effect. **E**, A case in which the intervention has mechanisms of action not involved in the disease process. The dotted lines represent possible mechanisms of action. Reproduced from Libby et al\(^\text{7}\) with permission of the publisher. Copyright ©2014, Elsevier. Modified from Fleming and DeMets (Annals of Internal Medicine)\(^\text{6}\) with permission of the publisher. Copyright ©1996, American College of Physicians.

**Figure 2.** Orthogonality of biomarkers that report on distinct pathogenic pathways. BNP indicates brain natriuretic peptide; HDL, high-density lipoprotein; hsCRP, high-sensitivity C-reactive protein; LDL, low-density lipoprotein; and TG, triglyceride. Reproduced from Libby et al\(^\text{7}\) with permission of the publisher. Copyright ©2014, Elsevier.
type 9 inhibitors illustrates a regulatory action based on biomarker changes before completion of large-scale clinical outcome studies. Yet, counter examples have raised the regulatory bar for biomarker qualification as surrogate end points. Large-scale clinical trials have not always borne out that effects on biomarkers (eg, hemoglobin A1c lowering or high-density lipoprotein raising) correlate with an improvement in clinical outcome. Recent guidance from the US FDA mandates assessment of cardiovascular safety beyond affecting a biomarker, notably in the diabetes mellitus therapeutic area. Regulatory authorities have established criteria for the qualification of biomarkers and have variable levels of acceptance of biomarkers for registration of novel therapeutics.

**Future Perspectives About Cardiovascular Biomarkers**

Several trends may transform the use of biomarkers in cardiovascular research and practice. For example, enormous technological innovations in areas of miniaturization, platform integration, and usability are rendering point of care testing more feasible and reliable. Point of care testing in the home or in institutions spanning primary to quaternary care settings promise to render clinical decision making and delivery of care much more efficient and efficacious. Point of care testing in the field could enhance global health by expanding access to biomarker analyses in rural areas and developing regions. The adoption of point of care technologies could also democratize clinical trials by permitting more widespread inclusion of participants, reaching beyond traditional hospital-based research facilities.

The big data approach to biomarkers may also revolutionize medicine and provide new avenues for expanding medical knowledge beyond the traditional carefully conducted cohort studies or clinical trials. For example, the growing number of commercially available wearable devices that report longitudinally on variables such as motion or heart rate will furnish large data sets to enable correlation of derived biomarkers with clinical outcomes and reveal hidden relationships between cardiovascular outcomes and, for example, physical activity. Obvious confounding regarding access and assumptions regarding continuity of use of such wearable technologies pertain, yet the enormity of the data sets could counterbalance these concerns. Continuous monitoring of biomarkers in acute care and ambulatory settings enabled by microfluidics, wearable technologies, and associated analytic techniques may also transform research and practice in cardiovascular medicine.

Biomarkers may also serve increasingly as companion diagnostics. As we move toward greater personalization in an era of precision medicine, the use of biomarkers to indicate responsiveness to drugs and other interventions or to inform dosage decisions will likely assume increasing importance. The current use of genetic markers to choose dosing will likely assume increasing importance. The current use of genetic markers to choose dosing will likely assume increasing importance. The current use of genetic markers to choose dosing will likely assume increasing importance. The current use of genetic markers to choose dosing will likely assume increasing importance. The current use of genetic markers to choose dosing will likely assume increasing importance. The current use of genetic markers to choose dosing will likely assume increasing importance.

Conclusions: Biomarkers Friend and Foe

Although biomarkers have already proven their utility in cardiovascular medicine and afford great promise for future advances, their use requires considerable care in thinking and methodology. New biomarkers need validation. Studies reporting the use of biomarkers require rigorous and critical interpretation. Numerous confounding factors can cloud the clinical use of biomarkers, as well as their research applications. Yet, the thoughtful and critical use of biomarkers can certainly aid the discovery of new pathogenic pathways and therapeutic targets. Biomarker technology should speed the translation of advances in laboratory science to the clinic. Biomarkers can provide diagnostic and prognostic tools to the practitioner. The careful application of biomarkers can help design and guide clinical trials required to establish the efficacy of novel interventions to improve patient outcomes. Thus, the promise of harnessing biomarkers in cardiovascular applications by far outweighs their perils, if judiciously applied.
Cardiovascular biomarkers can risk stratify, allocate therapy, and define novel pathophysiologic pathways and therapeutic targets. The development of new serological biomarkers faces the challenge of providing additive value to existing well-validated markers. Fortunately, emerging technologies brighten the outlook by enabling novel methods for biomarker discovery and new biomarker categories. This article reviews the definition of biomarkers, examines their uses in investigation and the clinic, and highlights the need for rigorous evaluation and assessment of added value of novel biomarkers before qualification as surrogate end points or widespread adoption as either investigative or clinical tools.
Biomarkers: A Challenging Conundrum in Cardiovascular Disease

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