Infections, Inflammation, and the Risk of Coronary Heart Disease

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Background—The role of infections and inflammation in the pathophysiology of coronary heart disease is emerging. We studied the independent and joint effects of these 2 components on coronary risk.

Methods and Results—We measured baseline levels of C-reactive protein (CRP) and antibodies to adenovirus, enterovirus, cytomegalovirus, and herpes simplex virus as well as to Chlamydia pneumoniae (Cpn) and Helicobacter pylori in 241 subjects who suffered either myocardial infarction or coronary death during the 8.5-year trial in the Helsinki Heart Study, a coronary primary prevention trial. The 241 controls in this nested case-control study were subjects who completed the study without coronary events. Antibody levels to herpes simplex type I (HSV-1) and to Cpn were higher in cases than in controls, whereas the distributions of antibodies to other infectious agents were similar. Mean CRP was higher in cases (4.4 versus 2.0 mg/L; \( P < 0.001 \)), and high CRP increased the risks associated with smoking and with high antimicrobial antibody levels. The odds ratios in subjects with high antibody and high CRP levels were 25.4 (95% CI 2.9–220.3) for HSV-1 and 5.4 (95% CI 2.4–12.4) for Cpn compared with subjects with low antibody levels and low CRP. High antibody levels to either HSV-1 or to Cpn increased the risk independently of the other, and their joint effect was close to additive.

Conclusions—Two chronic infections, HSV-1 and Cpn, increase the risk of coronary heart disease. The effect is emphasized in subjects with ongoing inflammation, denoted by increased CRP levels. (Circulation. 2000;101:252-257.)

Key Words: infection ■ inflammation ■ proteins ■ coronary disease
Methods

Study Population

The design, methodology, and results of the Helsinki Heart Study have been described previously. Briefly, this was a randomized, placebo-controlled, coronary primary prevention trial with gemfibrozil in dyslipidemic (non-HDL cholesterol >5.2 mmol/L) middle-aged men. Subjects with a history or ECG evidence of CHD or any other major illness were excluded from the study. During the 8.5-year follow-up, 241 out of 4081 study participants suffered either MI or coronary death. These are the CHD cases of the present nested case-control study; the controls were selected from participants who completed the follow-up without CHD. The controls were matched for treatment group (gemfibrozil/placebo) and place of residence. The matching for geography was considered essential because of regional exposure of some infectious agents studied.

Baseline serum samples stored at −20°C were used in the assessment of CHD risk. Baseline sera were available for the analysis in 239 case-control pairs. The samples were analyzed blinded, and the case and the control were always analyzed in the same assay set.

Laboratory Methods

The matched serum pairs were tested for viral IgG antibodies at a dilution of 1:1000 on microtiter plates, each of which also contained positive and negative controls. The results obtained with test sera were expressed as relative units in relation to the standard positive sample.

Enterovirus-group-specific antibodies were measured by a recently developed enzyme immunoassay (EIA) as previously described. This assay is based on a synthetic peptide derived from an immunodominant region of the capsid protein VP1, known to be a common antigenic determinant for several different enteroviruses. This peptide (KEVPALTAVETGATC with single-letter codes) has been used successfully as a group antigen in serological diagnosis of acute enterovirus infections.

Adenovirus-specific antibodies were measured by EIA with purified hexon of adenovirus type 5 as a group-specific antigen. Antibodies to HSV-1 and CMV were measured with commercially available assay kits (Labsystems, catalog No. 6110400 for HSV-1 and 6103201 for CMV). The principles of both assays are based on an indirect solid-phase EIA with horseradish peroxidase or alkaline phosphatase as conjugate enzymes.

Cpn-specific IgA serum antibodies and specific immune complex-bound IgG antibodies were measured by the microimmunofluorescence method with Cpn Kajaani 6 strain as antigen, as described in detail earlier. The diagnostic criteria for Cpn infection consisted of either IgA antibody titer >40 or immunocomplex-bound antibody titer >2, representing approximately the highest quartile and the median, respectively.

Hp-specific serum IgG antibodies were determined by EIA (Pyloiset, Orion Diagnostic) according to the manufacturer’s instructions.

Serum samples were analyzed in duplicate for CRP levels with a sandwich enzyme immunoassay (UC CRP ELISA, Eucardio Labor-
ations of high levels of HSV-1 antibodies and high CRP with CHD remained significant after adjustment for age and smoking.

The relative risks, adjusted for age, of high levels of antibodies to HSV-1 and Cpn in nonsmokers (Figure) were 2.05 (95% CI 1.15–3.67; 73 cases, 72 controls) and 1.44 (0.82–2.33; 49 cases, 40 controls), whereas smoking increased the risks to 3.74 (1.58–8.86; 47 cases, 14 controls) and 4.88 (2.42–9.81; 20 cases, 8 controls), respectively. When high HSV-1 antibody levels and smoking were considered, their joint effect seemed to be close to additive, whereas the risk associated with high Cpn antibody levels was mainly confined to smokers. High CRP level in nonsmokers increased the CHD risk significantly, OR 2.32 (95% CI 1.27–4.24; 40 cases, 21 controls), whereas the joint effect of high CRP and smoking was associated with a 9-fold increase in risk, OR 8.67 (3.52–21.4; 39 cases, 6 controls) compared with nonsmokers with low CRP (102 cases, 155 controls).

Simultaneous occurrence of high CRP and high HSV-1 antibody levels as well as high CRP and high Cpn antibody levels increased CHD risk substantially (Table 4). The simultaneous presence of high HSV-1 and high Cpn antibody levels increased the risk compared with the presence of either of these alone. When subjects with low levels of both antibodies were used as reference, ORs were 1.97 in subjects with high HSV-1 only, 1.74 in subjects with high Cpn only, and 4.10 in subjects with high levels of both antibodies.

Discussion

Our study demonstrated that high levels of antibodies and/or circulating immune complexes against HSV-1 and Cpn were risk factors for future coronary events in a prospective cohort of middle-aged dyslipidemic men. No associations were found, however, between CHD and high levels of antibodies against Hp, adenovirus, cytomegalovirus, or enterovirus. The risks associated with HSV-1 and Cpn were strongly modified by CRP, a serological marker of chronic inflammation, and by smoking.

In this study, we considered high IgG antibody levels as markers of previous infections. All microbes studied are common, however, and in addition to acute infections, most of them also cause chronic and/or latent infections. It may well be, as suggested by the data of Pesonen, that a process that eventually leads to CHD is initiated in early life after infections acquired in childhood. However, assessment of the

### Table 2. Distributions of CHD Cases and Controls by Antibody Titers and CRP Level at Study Baseline

<table>
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<th>Distribution</th>
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<tr>
<td>Adenovirus (IgG)</td>
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<td>Enterovirus (IgG)</td>
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<td>CMV (IgG)</td>
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<td>HSV (IgG)</td>
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<td>Cpn IgA</td>
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<td>Hp (IgG)</td>
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<td>CRP</td>
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IgA denotes immunoglobulin class, and IC, immunocomplexes.
chronicity of an infection is a complicated issue, and it is not clear whether increased levels of IgG antibodies reflect the duration of the infection, reactivation of a latent infection, reinfection, or some unknown immunological features of the host. There is evidence, however, for the association of increased HSV antibody levels and a history of frequent herpes recurrences. With regard to Cpn antibodies, conversely, the persistent presence of elevated IgA titers and specific immune complexes has been shown to reflect chronic Cpn infection.

Our results are in agreement with previous data demonstrating an association between Cpn and CHD. It should be noted that our previous report of this relation describes a subgroup of 103 cardiac events from a total of 241 reported in this paper. The seroepidemiological data relating Cpn and CHD are consistent in the majority of the studies, and the presence of the agent has been demonstrated in atherosclerotic lesions. The association between Hp and CHD is more controversial, and when it is adjusted for other risk factors, the contribution is minimal. Viral agents previously implicated in the pathogenesis of CHD include coxsackieviruses and representatives of the Herpesviridae. The problems in the studies of enteroviruses have been the large number of serotypes, the serotype-specific antibody assays, and the epidemic nature of enteroviral disease. Our present findings of no association between high enterovirus antibody levels and CHD are in contrast to the recent data derived from another Finnish cohort.

HSV-1 and HSV-2 have been found in human atherosclerotic lesions and CMV in restenotic lesions after angioplasty. CMV and HSV have both been found in tandem in early atherosclerotic lesions of young trauma victims. Previous seroepidemiological evidence both supports and is contradictory to the concept that CMV or HSV-1 is involved in the pathogenesis of atherosclerosis. We found no association between CMV and CHD, but antibody level in the highest quartile of distribution to HSV was a risk factor for future coronary events.

Our finding that a high serum level of CRP, an acute-phase protein used as a marker for inflammation, increases the risk for cardiac events is in accord with previous findings. The CRP level in our study cohort was related to the number of cigarettes smoked (data not presented), in agreement with previous studies. An interaction in our study cohort was found between high Cpn antibody level and smoking, with the risk almost totally confined to smokers, whereas the joint effect of smoking and high HSV antibody level on CHD risk indicated more of an additive effect.

The study of the joint effects between high microbial antibody levels and high CRP disclosed differences between the 2 agents. High HSV level increased the risk even in subjects with low CRP, but to increase the risk, high Cpn antibody levels required the presence of high CRP. The independent contribution of both high HSV and high Cpn
antibody levels in the joint effect analysis indicates that chronic infection with either of these 2 agents alone increases the risk and that coexistence of the other is close to additive with regard to the CHD risk.

The risk associated with high antibody levels alone were moderate in our study cohort. However, when the CRP level was simultaneously high, the risks were increased substantially. Our results thus support the hypothesis that inflammatory reaction can be one of the major factors in the pathophysiology of atherosclerosis and suggest that at least 2 different infections are capable of triggering this reaction.

Studies like the present one, based on selected populations, obviously have natural shortcomings and restrictions. All participants were dyslipidemic, white, middle-aged men, and the results may not be generalizable to other age groups, to other ethnic populations, to normolipidemics, or to women. Another shortcoming is the post hoc hypothesis, but the results in this kind of study should be considered more as hypothesis-generating. Conversely, the strengths of this study are the homogeneous population and very careful follow-up.

In conclusion, we have shown in this prospective study that high antibody levels to HSV-1 and to Cpn as markers of chronic, active, or recurrent infection were associated with an increased risk of CHD, whereas high antibody levels to adenovirus, cytomegalovirus, and enterovirus and to Hp were not. The risks associated with high antibody levels were strongly modified by smoking, and the simultaneous occurrence of elevated CRP level substantially increased the CHD risk. The high antibody levels to HSV-1 or to Cpn increased the risk independently of the other, indicating that at least 2 different infections are potential triggers of the inflammatory reaction, one of the key events in atherosclerosis.

Acknowledgments

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References


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