Cyclooxygenase-1 and -2–Dependent Prostacyclin Formation in Patients With Atherosclerosis

Orina Belton, PhD; Dara Byrne, MB; Dermot Kearney, MB; Austin Leahy, MB, MCh; Desmond J. Fitzgerald, MD

**Background**—The formation of prostacyclin (PGI₂), thromboxane (TX) A₂, and isoprostanes is markedly enhanced in atherosclerosis. We examined the relative contribution of cyclooxygenase (COX)-1 and -2 to the generation of these eicosanoids in patients with atherosclerosis.

**Methods and Results**—The study population consisted of 42 patients with atherosclerosis who were undergoing surgical revascularization. COX-2 mRNA was detected in areas of atherosclerosis but not in normal blood vessel walls, and there was evidence of COX-1 induction. The use of immunohistochemical studies localized the COX-2 to proliferating vascular smooth muscle cells and macrophages. Twenty-four patients who did not previously receive aspirin were randomized to receive either no treatment or nimesulide at 24 hours before surgery and then for 3 days. Eighteen patients who were receiving aspirin were continued on a protocol of either aspirin alone or a combination of aspirin and nimesulide. Urinary levels of 11-dehydro-TXB₂ and 2,3-dinor-6-keto-PGF₁α, metabolites of TXA₂ and PGI₂, respectively, were elevated in patients with atherosclerosis compared with normal subjects (3211±533 versus 679±63 pg/mg creatinine, P<0.001; 594±156 versus 130±22 pg/mg creatinine, P<0.05, respectively), as was the level of the isoprostane 8-iso-PGF₂α. Nimesulide reduced 2,3-dinor-6-keto-PGF₁α excretion by 46±5% (373±103 to 167±37 pg/mg creatinine, P<0.01) preoperatively and blunted the increase after surgery. Nimesulide had no significant effect on 11-dehydro-TXB₂ before (2678±694 to 2110±282 pg/mg creatinine) or after surgery. The levels of both products were lower in patients who were taking aspirin, and no further reduction was seen with the addition of nimesulide. None of the treatments influenced urinary 8-iso-PGF₂α excretion.

**Conclusions**—Both COX-1 and -2 are expressed and contribute to the increase in PGI₂ in patients with atherosclerosis, whereas TXA₂ is generated by COX-1. (Circulation. 2000;102:840-845.)

**Key Words:** atherosclerosis • cyclooxygenase • prostaglandins

Atherosclerosis is an inflammatory lesion that is characterized by mononuclear infiltration and smooth muscle cell proliferation.¹–⁴ As with inflammation at other sites, atherosclerosis is associated with an increase in prostaglandin biosynthesis.⁵ The products include thromboxane (TX)A₂, a potent platelet activator, vasoconstrictor, and smooth muscle mitogen,⁶ and prostacyclin (PGI₂), a platelet inhibitor and vasodilator.⁷ TXA₂ is in large part generated by platelets in normal subjects, but it may also be formed by nucleated cells such as monocytes.⁸–¹⁰ PGI₂ is generated by large vessel endothelium and vascular smooth muscle cells (VSMCs).¹¹ In addition to prostaglandins, there is an increased formation of isoprostanes, which are isomers of prostaglandins formed by free radical oxidation of arachidonic acid.¹²,¹³ Some isoprostanes, such as 8-iso-PGF₂α, can also be formed by cyclooxygenase (COX).¹⁴,¹⁵ Isoprostanes are of interest not only as markers of oxidant injury but also as physiological mimics of prostaglandins.¹⁶,¹⁷ For example, 8-iso-PGF₂α activates platelets and VSMCs in a manner similar to TXA₂. Thus, several products are generated in atherosclerosis that may influence the development of the disease or the risk of thrombosis.

Prostaglandins and TXA₂ are synthesized from arachidonic acid by the enzyme COX. There are 2 isozymes of this enzyme that are the products of distinct genes.¹⁸,¹⁹ COX-1 is constitutively expressed in most tissues and is the only functioning COX in platelets. COX-2 is an inducible form of the enzyme and is barely detectable in most tissues under normal physiological conditions.²⁰ However, recent studies demonstrate that COX-2 is a major source of PGI₂ in normal subjects.²¹–²³ COX-2 expression is increased by free radicals,²⁴ cytokines,²⁵ growth factors,²⁶ hormones,²⁷ and hypoxia,²⁸ stimuli that are implicated in the development of atherosclerosis.¹ Consequently, COX-2 may be responsible for the increase in prostaglandin formation seen in this condition. There is evidence that cytokines also induce the expression of COX-1, which has been implicated as a source of prostaglandins at sites of inflammation.²⁹,³⁰ We examined the expression of COX isozymes in human atherosclerotic plaque and the effect of nimesulide, a selective COX-2 inhibitor,³¹ on prostaglandin formation in patients with atherosclerosis.
Methods

Subjects
The study was approved by the Irish Medicines Board and the Ethics Committee of Beaumont Hospital Dublin. All patients gave written informed consent. Forty-two patients (mean age 70 ± 2 years, 36 men and 6 women) with clinical and angiographic evidence of atherosclerosis were studied. Eighteen patients were smokers, 19 were ex-smokers, and 5 were nonsmokers. Twenty-one patients were hypertensive, and 10 had a history of ischemic heart disease. Four patients had diabetes mellitus, and 3 patients were being treated for hypercholesterolemia. All patients were undergoing surgical revascularization for peripheral vascular disease or carotid endarterectomy. The study was open label and nonblinded. Patients (n = 24) who were not previously taking aspirin or any other nonsteroidal anti-inflammatory drug were randomized to receive either no treatment or 100 mg nimesulide BID beginning 24 hours before surgery and continuing for 3 days. Patients already taking aspirin (n = 18) were randomized to continue to take 300 mg/d aspirin alone or a combination of 300 mg/d aspirin and 100 mg nimesulide BID. This relatively high dose of aspirin was selected because the study was conducted for only 3 days and because optimal inhibition of platelet COX may be delayed with low-dose aspirin regimens.8 Patients with a history of active peptic ulcer disease or with renal or hepatic impairment were excluded from the study. Blood for serum TXB2 and endotoxin-induced PGE2 (COX-1 and -2 bioactivity, respectively) levels was collected at baseline and 1 hour after the first dose of drug. Urine was collected during each 24-hour period for the determination of prostaglandin metabolite and isoprostane excretion. Samples of femoral or aortic tissue were obtained at the time of surgery for COX expression analysis. Samples were either fixed immediately in formaldehyde for immunohistochemistry or treated with Tri-Reagent (Sigma) for RNA extraction.

Reverse Transcription-Polymerase Chain Reaction for COX Isoforms in Atherosclerotic Tissue
COX-1, COX-2, and GAPDH mRNA were extracted and detected with reverse transcription-polymerase chain reaction as described previously.24,31 Each primer pair was designed to span at least 1 intron of the gene. The primers used were COX-2, 5'-TCAAATGAGATGCTGTCGCTCTCTCC-3' (sense), 5'-TCAACCTGGGAGGATGTTTAC-3' (antisense); COX-1, 5'-TGGCCCGCCGCTGGAAGATG-3' (sense), 5'-GAGCTGTAGAGACATGCTGG-3' (antisense); and GAPDH 5'-AAAATTGTC-3' (sense), 5'-AGGGCGGACGCTT-3' (antisense).

Immunohistochemical Analysis
Segments of atherosclerotic plaque were collected during surgery in formal saline (0.9% NaCl, 10% formaldehyde) and fixed for 24 hours. The tissues were paraffin embedded (Shandon Citadel 200; Lipshaw USA), and 5- to 8-μm sections were cut (Leitz 1512 microtome; Weltzarm GmbH). The sections were incubated in primary antibody against COX-1 (Cayman Chemical), COX-2 (Cayman Chemical), anti-smooth muscle cell α-actin (Sigma Chemical), or HAM56 (DAKO) for 1 hour at room temperature. The COX-1 monoclonal antibody cross-reacts with both human and ovine COX-1 but does not cross-react with COX-2 from any species. The COX-2 polyclonal antibody was generated against amino acids 567 to 599 in the C terminus of human COX-2, a sequence that is unique to COX-2. This antibody does not cross-react with COX-1 from any species. After washing in PBS, the slides were incubated in the secondary biotinylated antibody, and the immunocomplex was visualized with use of the diaminobenzidine chromogen (ABC Complex, Vectastain Elite kit; Vector Laboratories). The presence of COX-2 in VSMCs was confirmed with immunofluorescence confocal microscopy. The sections were incubated with the COX-2 primary mouse antibody and an α-actin rabbit antibody. These sections were incubated with a Texas Red-labeled anti-rabbit IgG (Vector Laboratories) and with a fluorescein isothiocyanate (FITC-)labeled anti-mouse IgG (Vector Laboratories). Imaging was performed with an Axioplan LSM510 confocal microscope (Karl Zeiss).

COX-1 Activity in Whole Blood
Serum TXB2 was assayed by allowing whole blood to clot in nonsiliconized glass tubes at 37°C for 1 hour.32 Serum was separated through centrifugation at 1000g for 10 minutes. TXB2 levels were measured with enzyme immunoassay (R and D Systems Europe).

COX-2 Activity in Whole Blood
Blood was drawn into tubes containing 200 μmol/L aspirin and 10 IU/mL sodium heparin (final concentrations) 2 hours after drug administration. Aliquots (1 mL) of whole blood were incubated in the presence and absence of 10 μg/μL lipopolysaccharide (LPS; bacterial endotoxin derived from Escherichia coli O26:B6; Sigma Chemical) for 24 hours at 37°C. Plasma was separated by centrifugation at 1000g for 10 minutes and assayed for PGE2 by enzyme immunoassay (R and D Systems Europe). The induced PGE2 is due to expression of COX-2 in monocytes in the whole blood.

Urinary Eicosanoid Excretion
Urinary metabolites of PGI2 (2,3-dinor-6-keto-PGF1α) and TXA2 (11-dehydro-TXB2) and urinary 8-iso-PGF2α were measured with gas chromatography/mass spectrometry as previously described.33,34

Statistical Analysis
The numbers of patients were selected on the basis of the detection of a ≥50% reduction in 2,3-dinor-6-keto-PGF1α formation, as seen with nimesulide in normal subjects.24 The data are expressed as mean ± SEM. For the comparison of normal subjects with atherosclerotic patients, the data were analyzed with an unpaired Student’s t test. For samples for the same subjects over time, the data were analyzed with Friedman’s nonparametric 2-way ANOVA with subsequent paired analysis where appropriate. For comparisons between treatments, the data were analyzed with Kruskal-Wallis 1-way ANOVA with subsequent nonpaired analysis between groups.

Results

COX Isoform Expression in Atherosclerotic Plaque
COX-2 mRNA expression was not detected in 5 normal arterial sections that were obtained postmortem from young individuals who had no gross or microscopic evidence of atherosclerosis. However, all 10 samples analyzed from patients with atherosclerosis showed COX-2 mRNA expression. COX-1 mRNA was expressed in both normal and atherosclerotic sections but appeared to be induced in atherosclerotic tissue (data not shown).

Sections of atherosclerotic plaque were analyzed for COX-1 and -2 protein through immunohistochemistry (n = 10). The areas of atherosclerotic plaque were distinguishable with light microscopy by the presence of fatty streaks, foam cells, calcification, and cellular proliferation. This was confirmed with staining for proliferating VSMCs with anti–α-actin35 and for macrophages with HAM56.36 In the normal vessel, there was constitutive and diffuse expression of COX-1 protein in the adventitia and media but no detectable COX-2. In contrast, both COX-1 and -2 were expressed in atherosclerotic plaque.

Immunofluorescent Microscopic COX-2 Expression in Infiltrating Macrophages and VSMCs
The labeling of COX-2 with Texas Red demonstrated COX-2 expression that corresponded to regions that also stained
green for smooth muscle cells (with FITC-labeled anti–α-actin). It is worth noting that not all of the VSMCs stained for COX-2 (Figure 1).

Inhibition of COX-1 and COX-2 Ex Vivo
Blood was obtained for prostaglandin determinations at 1 to 2 hours after dosing to confirm the selectivity of nimesulide for COX-2. Serum TXB₂, an assay of COX-1 activity, was markedly suppressed with aspirin (239.8±22.5 to 24.2±2.2 ng/mL, P<0.001) and with aspirin plus nimesulide (to 18.0±1.04 ng/mL, P<0.001). In contrast, serum TXB₂ was little affected by nimesulide when administered alone (217.0±18.79 ng/mL). The induction of PGE₂ after the incubation of whole blood with LPS ex vivo was used as an assay of COX-2 activity. Aspirin had no effect on this assay (as expected, because it is rapidly hydrolyzed) (from 25.4±3.28 to 27.35±4.19 ng/mL). In contrast, nimesulide markedly suppressed LPS-induced PGE₂ formation (from 25.4±3.28 to 5.01±1.04 ng/mL).

Urinary Eicosanoid Excretion in Atherosclerosis:
The Effect of Aspirin and Nimesulide
Urinary metabolite levels were measured in 18 patients with cardiovascular disease before they were given any drug. We also studied normal healthy volunteers (mean age 35±5 years, 6 men and 6 women), all of whom were nonsmokers and had no history of cardiovascular disease. Compared with normal healthy volunteers (n=12), urinary excretion of 2,3-dinor-6-keto-PGF₁α was markedly elevated in these patients (594±156 versus 130±22 pg/mg creatinine, P<0.05). There also were significant increases in urinary 11-dehydro-TXB₂ (3211±533 versus 679±63 pg/mg creatinine, P<0.001) and 8-iso-PGF₂α (536±63 versus 250±21 pg/mg creatinine, P<0.01).

The excretion of urinary metabolites before and after nimesulide but before surgery is shown in the Table. Nimesulide reduced urinary 2,3-dinor-6-keto-PGF₁α by 46±5% (n=8, P<0.01) but had no significant effect on 11-dehydro-TXB₂ excretion or 8-iso-PGF₂α. Also shown in the Table are the data for patients who were taking aspirin and for patients who were given the combination of aspirin and nimesulide. As expected, urinary 2,3-dinor-6-keto-PGF₁α and 11-dehydro-TXB₂ were reduced in patients who were taking aspirin. The addition of nimesulide had little further effect and in particular did not reduce 11-dehydro-TXB₂ compared with aspirin alone. Although there was a modest reduction in 8-iso-PGF₂α excretion with nimesulide, this was not statistically significant.

Effect of Nimesulide and Aspirin After Surgery
After surgery, there was a marked increase in the urinary excretion of 11-dehydro-TXB₂ and 2,3-dinor-6-keto-PGF₁α but not in the urinary excretion of 8-iso-PGF₂α (Figure 2). Nimesulide had no effect on the rise in urinary 11-dehydro-TXB₂ levels after surgery (Figure 2A), whereas aspirin blunted this increase. It is worth noting, however, that there still was an increase in urinary 11-dehydro-TXB₂ despite prior treatment with aspirin and that this was unaffected by the addition of nimesulide.
COX isoform is less sensitive to aspirin. 39 inflammation.29,30 may be responsible for prostaglandin formation at sites of rosis. Recent data suggest that COX-1 may also be induced and markedly reduces the excretion of PGI2 metabolites in normal COX in tissues.37 Indeed, TXA2 may be generated by several selective for platelet COX, all regular doses of aspirin inhibit activity.21–23 The results of similar studies with regular- and vascular COX maximally suppress TXA2 formation, 8 whereas the selective inhibition of COX-2 has very little effect.21–23 The results of studies in normal subjects suggest that platelet COX-1 is the major source of TXA2 in humans. Thus, platelet-specific preparations of aspirin with no effect on COX, there still was an increase in urinary 11-dehydro-TXB2 in patients taking aspirin. These findings suggest that both COX isoforms to prostaglandin generation was studied through an examination of the effects of nimesulide on eicosanoid formation. We have shown previously that nimesulide is selective for COX-2 at the dose used in this study.21,41 Nimesulide had no effect on gastric COX activity or systemic TXA2 formation while it suppressed LPS-induced PGE2 formation.41 Selectivity was confirmed in the present study in that nimesulide had little effect on serum TXB2, an assay of COX-1 activity, whereas it markedly suppressed LPS-induced PGE2, an assay of COX-2 activity.32

Nimesulide reduced the urinary excretion of 2,3-dinor-6-keto-PGF1α in patients with atherosclerosis by nearly 50% before surgery and to a similar extent after surgery. This finding suggests that the increased PGI2 formation in part reflects COX-2 expression. However, urinary 2,3-dinor-6-keto-PGF1α was not reduced to the low levels seen in normal subjects taking aspirin8,37 either before or after surgery. Aspirin had a very profound effect, but despite >95% inhibition of platelet COX, there still was an increase in urinary 11-dehydro-TXB2 in the patients taking aspirin. These findings suggest that both platelet and tissue COX-1 contribute to the increase in TXA2 biosynthesis in patients with atherosclerosis.

An important question that concerns COX-2 inhibitors is whether the selective reduction of PGI2 increases the risk of atherosclerosis. The role of PGI2 in vivo is not clear. Although PGI2 is a potent inhibitor of platelets,7 the endogenous plasma levels are well below the threshold for a systemic antiallele effect.11 However, disruption of the PGI2 receptor in mice increases the risk of thrombosis.42 Moreover, a recent study that showed greater efficacy in stroke prevention with a lower dose of aspirin suggests a role for endogenous PGI2.43 Thus, the reduction in PGI2 formation seen with a COX-2 inhibitor in the presence of normal TXA2 formation may place patients at an increased risk of thrombosis. However, it should be emphasized that the findings for the present study group of severely diseased patients may not be applicable to patients with more modest

### Discussion

The results of studies in normal subjects suggest that platelet COX-1 is the major source of TXA2 biosynthesis, possibly reflecting enhanced platelet activity.5 However, although low-dose aspirin is relatively selective for platelet COX, all regular doses of aspirin inhibit COX in tissues.37 Indeed, TXA2 may be generated by several cell types in vascular tissue, including monocytes, where either COX-1 or -2 may be responsible.9 Thus, it has been suggested that tissue COX-2 may be the source of the persistent TXA2 generation seen in patients with unstable angina who were taking aspirin,8 in particular because this COX isoform is less sensitive to aspirin.9

Although COX-1 may be the primary source of TXA2 in normal subjects, data from several studies show that COX-2 is the major source of endogenous PGI2. Thus, COX-2 inhibition markedly reduces the excretion of PGI2 metabolites in normal volunteers.21–23 However, it is not known whether COX-2 is responsible for the increased PGI2 formation seen in atherosclerosis. Recent data suggest that COX-1 may also be induced and may be responsible for prostaglandin formation at sites of inflammation.29,30

We showed through several approaches that COX-2 was induced in atherosclerotic plaque and that this was in part responsible for the increase in PGI2 biosynthesis seen in patients with atherosclerosis. Thus, COX-2 mRNA was found in the atherosclerotic but not the normal blood vessels. Immunohistochemical studies localized the COX-2 expression to VSMCs and inflammatory cells, as reported previously.40 Perhaps as a result of the surgery, there was no endothelium evident in the sections, so it was not possible to evaluate COX isoform expression in endothelial cells. In addition to COX-2, product formation, mRNA expression, and immunohistochemical studies (not shown) provided evidence that COX-1 was also induced in atherosclerotic tissue.

### Table: Urinary Excretion of Prostaglandin Metabolites and 8-isoPGF2α in Patients With Atherosclerosis Before Surgery

<table>
<thead>
<tr>
<th></th>
<th>Nimesulide (n=9)</th>
<th>Nimesulide (n=9)</th>
<th>Aspirin (n=14)</th>
<th>Aspirin + Nimesulide (n=6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11-Dehydro-TXB2</td>
<td>2678±694</td>
<td>2110±282</td>
<td>1004±266†</td>
<td>1195±591*</td>
</tr>
<tr>
<td>2,3-dinor-6-keto-PGF1α</td>
<td>378±182</td>
<td>182±45†</td>
<td>241±53</td>
<td>100±34†</td>
</tr>
<tr>
<td>8-iso-PGF2α</td>
<td>429±77</td>
<td>324±34</td>
<td>484±57</td>
<td>349±14</td>
</tr>
</tbody>
</table>

Patients taking aspirin either continued to take aspirin (n=8) or nimesulide was added to their treatment.

*P<0.05, †P<0.01 vs patients on no treatment (before nimesulide).
Moreover, it is worth noting that in the present study, there was no further increase in TXA2 formation while the patients were taking nimesulide even after the stimulus of surgery. TXA2 is in large part derived from platelets, and increased TXA2 formation is a marker of platelet activity. Therefore, we saw no evidence that the reduction in PGI2 enhanced platelet activity in vivo.

Indeed, given its expression in proliferating VSMCs, it is possible that the COX-2 activity contributes to the progression of atherosclerosis. COX-2 limits cell death in several tissues, including cardiomyocytes and epithelial cancers, and so may promote VSMC growth. COX-2 expression has also been shown to induce metalloproteinases, which are enzymes involved in cell migration and destabilization of the atherosclerotic plaque. Thus, COX-2 expression may contribute to the VSMC proliferation and migration that are hallmarks of early atherosclerosis. Moreover, there is evidence that COX-2 expression occurs early in the development of atherosclerosis in apoE-deficient mice.

We also found a marked increase in isoprostane generation in patients with atherosclerosis, which is consistent with previous studies. Both COX isoforms, and in particular COX-2, have been shown to generate 8-iso-PGF2α in vitro. However, none of the treatments significantly modified isoprostane formation, demonstrating that isoprostanes are not generated enzymatically in atherosclerosis. These data are consistent with studies of antioxidants that demonstrate isoprostane formation in atherosclerosis reflects oxidant injury.

Our results are in agreement with recent evidence of COX-2 expression in atherosclerosis. However, our results suggest that both isoforms are expressed and, moreover, that both contribute to the increase in PGI2 biosynthesis seen in patients with atherosclerosis. In contrast, the increase in TXA2 formation reflects COX-1 activity, probably as a consequence of enhanced platelet activation.

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References


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