Gamma-Glutamyltransferase, Atherosclerosis, and Cardiovascular Disease

Triggering Oxidative Stress Within the Plaque

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This association is likely to occur within hepatocytes, before γ-GT releases in serum, through still-unknown mechanisms. Serum γ-GT activity is affected by genetic and environmental factors, with heritability estimated at 0.52. Within its normal range, it has many other determinants, even stronger than liver function or alcohol consumption. The findings of the Austrian Vorarlberg Health Monitoring and Promotion Program, a large unselected Norwegian population, and a prospective study of 7613 middle-age British men show a strong positive association between serum γ-GT level and body mass index, alcohol use, smoking, total lipoprotein and HDL, serum cholesterol, uric acid, serum triglycerides, heart rate, systolic and diastolic blood pressure, antihypertensive medication, preexisting ischemic heart disease, diabetes mellitus, and blood glucose use of oral contraceptives and menopause; pregnant women had lower values. γ-GT showed a negative association in men in regard to physical activity and lung function (forced expiratory volume in 1 second) and coffee consumption.

Prooxidant Effects of Glutathione Hydrolysis by γ-Glutamyltransferase

Catalytically active γ-GT has been found within atherosclerotic cerebral, carotid, and coronary plaques from autopic studies and surgical endoarterectomy, colocalized with oxidized density lipoproteins (LDL) and CD68 foam cells. As concerns the possible association between γ-GT and inflammatory process, it should also be considered that γ-GT has a key role in the interconversion of the glutathione-containing inflammatory mediator leukotriene C4 into leukotriene D4.

Although the exact mechanism leading to accumulation of γ-GT within the plaque is unknown, the association of γ-GT to lipoproteins suggests that LDL lipoproteins can carry γ-GT activity inside the plaque, where free iron is also present. In the extracellular milieu, γ-GT is the only enzyme responsible for GSH catabolism by hydrolysis of its γ-glutamyl bond between glutamate and cysteine. This reaction produces cysteinyl-glycine moieties, which are usually taken within intracellular milieu by the action of membrane dipeptidases, as precursors for GSH resynthesis.

Cysteinyl-glycine is a powerful reducer of Fe3+ in the extracellular milieu—and likely at the plaque level—that is able to simultaneously generate Fe2+ and a free thyl radical; subsequent reactions lead to the formation of superoxide anion radical and hydrogen peroxide. These γ-GT-mediated reactions have been shown to catalyze the oxidation of LDL lipoproteins, likely contributing to oxidative events influ-
normal values. The receiver operating characteristics analysis suggested γ-GT cutoff values of 15.5 U/L for men and 10.5 U/L for women, corresponding to 27.6 U/L and 18.7 U/L, respectively, for measurements made at 37°C. An increasing number of population studies have evaluated the relationship between serum γ-GT activity and mortality, since the observation of Conigrave et al in 1993 that indicated the predictive value of γ-GT for mortality, irrespective of hepatic disease or alcohol consumption.

Thereafter, Wannamethe confirmed the negative prognostic value of γ-GT: After adjustment for all confounders, elevated γ-GT (highest quintile ≥24 U/L versus the rest) was associated with a significant increase in mortality from all causes and from ischemic heart disease, namely in individuals with a history of ischemic heart disease. This suggested a link with underlying atherosclerotic coronary artery disease. Another more recent study aimed at evaluating the long-term prognosis among 714 patients with a small or unconfirmed acute myocardial infarction indicated γ-GT as an independent risk factor for death in association with age, previous myocardial infarction, smoking, and glucose.

The link with underlying atherosclerotic coronary artery disease has been demonstrated by a prospective study of our group. During a 6-year follow-up of 469 patients with ischemic syndrome and angiographically documented coronary artery disease, and after correcting for other cardiovascular risk factors (eg, age, smoking habit, serum cholesterol, left ventricular ejection fraction, body mass index, diabetes mellitus) or confounding factors, such as serum alanineaminotransferase level and self-reported alcohol consumption, the prognostic value of serum γ-GT activity for cardiac death and nonfatal infarction has been confirmed in a subset of patients corresponding to 36% of the whole population, characterized by the association of multivessel disease and history of myocardial infarction. The risk increased with different cutoff values of 25 and 40 U/L, however, within the normal range, and the event excess was concentrated within the first 3-year period. The prognostic significance of γ-GT seemed thus correlated not only with the extent of coronary artery disease but also with the instability of the plaque.

As concerns stroke mortality, the finding by Ruttmann’s group confirm earlier reports from a large Finnish study in unselected populations in both sexes, which demonstrated that γ-GT is associated with an independent prognostic value for ischemic stroke, independent of self-reported alcohol consumption, whereas another common marker of alcohol consumption, carbohydrate-deficient transferrin, was inversely associated with risk.

Ruttmann’s group does not report any information about the diagnosis of cardiovascular disease. This makes it impossible to understand whether the prognostic role of γ-GT is associated either with evolution or final complications of the atherosclerotic process. History of previous ischemic heart disease, in particular of previous myocardial infarction, regardless of ventricular function, strengthened γ-GT predictive value, indicating that considering coronary patients as a whole, those with higher γ-GT activity may constitute a subset at highest risk of repetitive events. The extent of coronary atherosclerotic disease enhances the γ-GT progno-

\[ γ-GT \text{ (enzymatic activity, red stain)} \]

\[ γ-GT \text{ (metabolism, GSH)} \]

\[ γ-GT \text{ (oxidative stress, LDL oxidation)} \]

\[ γ-GT \text{ (cell death, proliferation/apoptosis)} \]

\[ γ-GT \text{ (atherosclerosis, plaque erosion, aggregation)} \]

\[ γ-GT \text{ (atherosclerotic plaque, cell death, aggregation)} \]
tic significance, which may act on a larger substratum.8 Interestingly, both percutaneous and surgical revascularization were able to abolish the γ-GT prognostic value, confirming its intrinsic link with the evolution of the plaque.8

The pathogenetic mechanism proposed for the role of γ-GT in promoting the atherosclerotic process should be considered independent, complementary, and synergistic to conventional determinants. In fact, level of serum γ-GT is significantly genetically determined;4 serum γ-GT activity holds an independent prognostic value within reference level range in all epidemiological studies after adjustment for confounders such as indicators of hepatic function and alcohol consumption (the latter has often been found to exert a rather protective effect).5–8,13 γ-GT maintains its predictive value after adjustment for other established cardiovascular risk factors, which, however, affect at least in part its concentration, such as obesity, smoking, total serum cholesterol, arterial hypertension, diabetes, reduced physical activity, with particular emphasis in patients with history of preexisting ischemic heart disease.5–8,13

Do We Need Another Risk Factor?

In conclusion, the recent insights into the role of thiol metabolism in atherosclerosis not only increase our understanding of the disease but also have practical clinical applications in risk stratification and targeting of therapy for a clinical challenge of growing worldwide importance. Elevation in serum γ-GT activity predicts outcomes in unscreened populations and in patients with ascertained ischemic heart disease, independently of myocardial damage, thus adding to prognostic information provided by traditional risk factors.

As for ischemic cerebral and heart disease, γ-GT serum assay seems to have all of the main features of a true prognostic marker: the diagnostic assay has optimal sensitivity-specificity,1,2 epidemiological evidence of its presence before the event in apparently healthy people and patients with clinical overt disease increases our ability to predict it,5–9,13 it has additive and independent predictive value in comparison with established risk factors.5–9,13 Finally, as concerns ischemic heart disease, the prognostic impact of γ-GT can be abolished by therapeutic interventions, such as coronary revascularization.8

The physiological function of γ-GT enzyme activity as a source of peptide precursors for intracellular GSH resynthesis, as well as the current clinical concept of its serum activity as the consequence of a compensatory overexpression in response to hepatobiliary dysfunction or alcohol toxic effect, is challenged. The evidence is growing in favor of a detrimental role, triggering a prooxidant action within the atherosclerotic plaque. Additional investigation would permit the identification among subjects with higher γ-GT value those with a higher risk of developing clinical disease, allowing definition of the interrelationships with iron metabolism alterations, markers of inflammatory process, of glucose and metabolic disease, and with presence, features, and extent of atherosclerotic vessel disease, to better define the most risky combination for the vulnerable plaque and the best medical strategies for the stabilization of lesions, rather than percutaneous or surgical procedures.

References

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