A Prospective Study of Trans Fatty Acids in Erythrocytes and Risk of Coronary Heart Disease

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Background—High consumption of trans fat has been linked to the risk of coronary heart disease (CHD). We assessed the hypothesis that higher trans fatty acid contents in erythrocytes were associated with an elevated risk of CHD in a nested case-control study among US women.

Methods and Results—Blood samples were collected from 32 826 participants of the Nurses’ Health Study from 1989 to 1990. During 6 years of follow-up, 166 incident cases of CHD were ascertained and matched with 327 controls. Total trans fatty acid content in erythrocytes was significantly correlated with dietary intake of trans fat (correlation coefficient = 0.44, P < 0.01) and was associated with increased plasma low-density lipoprotein cholesterol (P for trend = 0.06), decreased plasma high-density lipoprotein cholesterol concentrations (P for trend < 0.01), and increased plasma low-density lipoprotein to high-density lipoprotein ratio (P for trend < 0.01). After adjustment for age, smoking status, and other dietary and lifestyle cardiovascular risk factors, higher total trans fatty acid content in erythrocytes was associated with an elevated risk of CHD. The multivariable relative risks (95% confidence intervals) of CHD from the lowest to highest quartiles of total trans fatty acid content in erythrocytes were 1.0 (reference), 1.6 (0.7 to 3.6), 1.6 (0.7 to 3.4), and 3.3 (1.5 to 7.2) (P for trend < 0.01). The corresponding relative risks were 1.0, 1.1, 1.3, and 3.1 (P for trend < 0.01) for a total of 18:1 trans isomers and 1.0, 1.5, 2.5, and 2.8 (P for trend < 0.01) for a total of 18:2 trans isomers.

Conclusions—These biomarker data provide further evidence that high trans fat consumption remains a significant risk factor for CHD after adjustment for covariates. (Circulation. 2007;115:1858-1865.)

Key Words: blood cells □ coronary disease □ fatty acids □ women

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Several prospective cohort studies have found a positive association between trans fat intake and the risk of CHD.10–14 With data combined from 4 such studies,11–14 Mozaffarian et al estimated a pooled relative risk of 1.23 (95% CI, 1.11 to 1.37) for every 2% energy from trans fat intake at baseline.7 However, the effect size may be underestimated or overestimated because of measurement errors associated with dietary assessment. Biomarkers of trans fat intake have the advantages of freedom from reporting errors and the ability to assess different isomers of trans fatty acids; we therefore performed a nested case-control study to investigate the associations between trans fatty acid content in erythrocytes and risk of CHD.

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Methods

Study Population
The Nurses' Health Study was initiated in 1976 and enrolled 121,700 female registered nurses aged 30 to 55 years who lived in 11 US states. In 1989 and 1990, blood samples were collected from 32,826 women, among whom 167 cases of nonfatal myocardial infarction (MI) or CHD death were newly diagnosed between the time of blood drawing and June 1996. For each case, 2 controls matched for age (± 1 year), smoking status (never, past, and current), fasting status at blood drawing (fasting for 10 hours or not), and date of blood drawing were randomly selected with risk-set sampling (ie, controls were selected from the rest of the nondiseased participants at the time of diagnosis of the cases). All cases and controls were free of diagnosed cancers and cardiovascular diseases at the time of blood drawing. After exclusion of 1 case and 7 controls that had missing data on blood fatty acid contents (as a result of contamination, dilution, or loss of blood samples), 166 cases and 327 controls were available for analysis.

Assessment of Coronary Heart Disease
Medical records obtained from women who reported nonfatal MI in the biennial follow-up questionnaires were reviewed by study physicians who were blinded to the exposure status of participants. Nonfatal MI was confirmed if the World Health Organization criteria were met, which require typical symptoms plus either diagnostic electrocardiographic findings or elevated cardiac enzyme levels. Deaths were identified by reports from next of kin, postal authorities, or by a search of the National Death Index. At least 98% of deaths among the Nurses' Health Study participants were identified. CHD deaths were identified by examination of autopsy reports, hospital records, or death certificates, if CHD was listed as the cause of death. CHD deaths were then confirmed by a previous report of CHD and records, or death certificates, if CHD was listed as the cause of death. Unconfirmed CHD deaths were excluded from the present study. Total CHD was defined as nonfatal MI plus fatal CHD.

Assessment of Other Factors
Information on the occurrence of diseases, medical history, and major lifestyle risk factors for CHD was collected at baseline by follow-up questionnaires. Information about history of hypertension, hypercholesterolemia, and diabetes was based on self-report. Diet has been assessed and updated every 4 years by validated semiquantitative food frequency questionnaires since 1980. A detailed description of the reproducibility and validity of the food frequency questionnaires has been published elsewhere. Intake of nutrients and other lifestyle covariates were derived from the 1990 food frequency questionnaires and follow-up questionnaires, respectively. To minimize missing data, we carried forward the values obtained in previous questionnaires for values that were missing in the 1990 questionnaires.

Blood Sample Collection and Fatty Acid Analysis
Within 24 hours of blood drawing, 97% of the samples arrived for analysis. Immediately upon arrival, the samples were centrifuged and divided into aliquots of plasma, erythrocytes, and buffy-coat fractions. These aliquots were stored in liquid nitrogen freezers at -130°C. Fatty acids in erythrocytes and whole plasma were analyzed by gas-liquid chromatography. A detailed description of laboratory process has been reported elsewhere. In gas-liquid chromatography analysis, the content of each fatty acid was expressed as a percentage of total fatty acids. Both technicians and laboratory personnel were blinded as to case-control status. Each case-control triplet was shipped in the same batch and analyzed in the same run. Within each triplet, samples were assayed by the same technicians in a random sequence under identical conditions. Laboratory control samples were run along with the case-control samples. We quantified 7 trans isomers in erythrocytes and plasma. The average intra-assay coefficient of variation % of 18:1 trans isomers was 7.6% for erythrocytes and 8.0% for plasma. For 18:2 trans isomers, the values were 10.0% for erythrocytes and 6.9% for plasma.

Plasma total and HDL cholesterol was measured enzymatically. Low-density lipoprotein (LDL) cholesterol was determined by a homogenous direct method. The detailed description of laboratory methods and procedures has been published elsewhere. The study protocol was approved by the institutional review board of the Brigham and Women's Hospital and the Human Subjects Committee Review Board of Harvard School of Public Health.

Statistical Methods
Means and standard deviations were calculated for normally distributed continuous variables; medians and interquartile ranges were used otherwise. Proportions were calculated for categorical variables. Student t tests were used to evaluate the significance of associations between normally distributed continuous variables and CHD. Wilcoxon rank sum tests were used otherwise. \( \chi^2 \) tests of significance were used for categorical variables.

Conditional logistic regressions were used to estimate the relative risks of CHD associated with trans fatty acid contents. In nested case-control studies, odds ratios derived from conditional logistic regression models are unbiased estimates of hazard ratios or relative risks. In the present study we focused primarily on erythrocyte trans fatty acid content because erythrocytes were more strongly correlated with long-term trans fat intake than plasma in our analysis (see Results). Cut points for quartiles of trans fatty acid contents were determined from the distribution of trans fatty acids among control participants. In addition to conditioning on the matching factors (by conditioning on the stratum indicator of matching), we further adjusted for established and potential risk factors for CHD, such as body mass index, physical activity, alcohol intake, parental history of MI before age 65 years, and other covariates. To examine potential confounding by fatty acids of other classes in the same blood fraction, we entered them into the multivariable models separately. Long-chain n-3 fatty acids, ie, eicosapentaenoic acid (20:5n-3) and docosahexaenoic acid (22:6n-3), and total n-6 fatty acids, which primarily consisted of linoleic acid (18:2n-6) and arachidonic acid (20:4n-6), changed the relative risks of at least 1 category of total trans fatty acid content in erythrocytes by >15%. We therefore further adjusted for these fatty acids. Probability values for linear trend were calculated with an ordinal score based on the median value in each quartile of trans fatty acids entered into the models.

A secondary analysis examined the extent to which the association between trans fatty acids and the risk of CHD is explained by blood lipoprotein profiles by further controlling for the LDL to HDL ratio in the multivariable models. Potential confounding by other dietary risk factors (eg, folate, vitamin E supplement use, dietary fiber, and fruit and vegetable intake) was also assessed. Multivariable linear regression was used to examine the linear trend of plasma lipoprotein parameters across quintiles of total trans fatty acid content in erythrocytes. Plasma lipoprotein parameters (such as plasma LDL and HDL cholesterol concentrations, and the LDL to HDL ratio) were entered into the model as dependent variables; quintiles of total trans fatty acid content, as well as age, smoking status, body mass index, and other covariates were entered as independent variables. Least-square means of biomarkers were calculated for each quintile. Robust estimators of variance for these means were calculated to allow for deviance from the assumption of normally distributed dependent variables. Probability values for linear trend were estimated with the median value of each quintile of total trans fatty acid content entered into the model as an ordinal variable.

All probability values were 2-sided, and 95% CIs were calculated for relative risks and least-square means. Data were analyzed with the Statistical Analysis Systems software package, version 9.1 (SAS Institute, Inc., Cary, N.C.). The authors had full access to and take responsibility for the integrity of the data. All authors have read and agree to the manuscript as written.
Results

Table 1 shows the baseline characteristics of study participants. Women diagnosed with CHD events had a higher body mass index, drank less alcohol, were less physically active, were more likely to have a parental history of MI, and had less favorable plasma lipoprotein parameters than did controls.

Baseline erythrocyte contents of trans isomers are shown in Table 2. On average, trans isomers in erythrocytes accounted for only a small proportion of total fatty acids (total content for cases was 1.78% and for controls was 1.66%). The 18:1 isomers accounted for most of the total fatty acids found in erythrocytes (70% in both cases and controls); trans 18:1 was the most abundant 18:1 isomer in erythrocytes. For 18:1 trans isomers, CHD cases had significantly higher contents of 18:1n-9 and 18:1n-12 trans isomers than did controls. With respect to the 18:2 trans isomers, significant differences were found only for 9c,12t trans isomers, for which the contents are low in erythrocytes (mean < 0.01).

The distribution of covariates across quartiles of total trans isomers in erythrocytes among controls is shown in Table 3. Erythrocyte trans fatty acid contents were inversely correlated with alcohol and folate intake. Weak inverse correlations were found between erythrocyte trans fatty acid content and fiber, fruit, and vegetable intake.

Trans fatty acids in erythrocytes reflected dietary trans fat intake as measured by the 1990 food frequency questionnaires; a Spearman partial correlation coefficient (\( r_s \)) of 0.44, which was adjusted for age, fasting status, and other covariates (\( P < 0.01 \)), was observed between them. The correlation between trans fat intake and plasma total trans fatty acid contents was weaker (\( r_s = 0.30, P < 0.01 \)).

Higher total trans fatty acid content in erythrocytes were associated with nonsignificantly increased plasma LDL cholesterol (\( P \) for trend = 0.06), significantly decreased plasma HDL cholesterol concentrations (\( P \) for trend < 0.01), and significantly increased plasma LDL to HDL ratio (\( P \) for trend < 0.01) (Figure 1).

Table 4 shows the relationship between baseline trans fatty acid contents in erythrocytes and the risk of total CHD. Total trans fatty acid content was significantly associated with the risk of CHD after conditioning on the...
matching factors (model 1). In comparison to the women whose erythrocyte total trans fatty acid contents were in the lowest quartile, women in the highest quartile had a relative risk of total CHD of 2.7 (95% CI, 1.5 to 5.0; \( P \) for trend <0.01). After adjustment for established risk factors for CHD (model 2), the association was unchanged. After further adjustment for long-chain n-3 and total n-6 fatty acids (model 3), the association was strengthened (relative risk between extreme quartiles, 3.3; 95% CI, 1.5 to 7.2; \( P \) for trend <0.01). Similarly, in all 3 models, total 18:1 trans isomers and total 18:2 trans isomers were both significantly associated with an elevated risk of CHD (\( P \) for trend <0.01 in model 3). Adjustment for other fatty acids, such as \( \alpha \)-linolenic acid and saturated and monounsaturated fatty acids, did not change these associations. Further adjustment for intake of fiber, folate, vitamin E supplement, fruits, and vegetables did not alter these associations. To examine whether these findings might be caused by changes in diet subsequent to the diagnosis of diabetes, we excluded participants who were diagnosed with diabetes at baseline. Results were basically unchanged (data not shown). Associations for individual 18:1 and 18:2 trans isomers were similar to the associations for total 18:1 and 18:2 trans isomers, respectively.

Because 18:2 trans isomers are present at lower content and narrower variation than 18:1 trans isomers, to make a fair comparison we also estimated the relative risks for the same unit of increment in each class of trans isomer. For each 0.25% increment of content in erythrocytes, total 18:1 trans isomers were associated with an adjusted relative risk of 1.3 (95% CI, 1.1 to 1.6; \( P <0.01 \)); total 18:2 isomers were associated with an adjusted relative risk of 2.2 (95% CI, 1.2 to 4.2; \( P =0.01 \)).

To examine whether associations could be entirely explained by blood lipoproteins that may be in the causal pathway between trans fat intake and the risk of CHD, we

### TABLE 3. Distribution of Cardiovascular Risk Factors According to Quartile of Erythrocyte Total Trans Fatty Acid Contents Among Controls at Baseline*

<table>
<thead>
<tr>
<th>Quartile of Total Trans Fatty Acids in Erythrocytes</th>
<th>1 (n=81)</th>
<th>2 (n=82)</th>
<th>3 (n=82)</th>
<th>4 (n=82)</th>
<th>( P ) for Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total trans fatty acids, mean, %†</td>
<td>1.17</td>
<td>1.50</td>
<td>1.72</td>
<td>2.23</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Fatty acids, mean, %</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total 18:1 trans isomers†</td>
<td>0.78</td>
<td>1.02</td>
<td>1.21</td>
<td>1.61</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Total 18:2 trans isomers†</td>
<td>0.26</td>
<td>0.33</td>
<td>0.37</td>
<td>0.47</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Body mass index, mean, kg/m²</td>
<td>25.1</td>
<td>25.6</td>
<td>25.6</td>
<td>25.3</td>
<td>0.81</td>
</tr>
<tr>
<td>Physical activity, median, MET-hr</td>
<td>16.0</td>
<td>14.4</td>
<td>10.6</td>
<td>12.2</td>
<td>0.59</td>
</tr>
<tr>
<td>Diet</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trans fat intake, mean, g/d</td>
<td>2.5</td>
<td>2.7</td>
<td>3.1</td>
<td>3.6</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Dietary fiber intake, mean, g/d</td>
<td>21.1</td>
<td>20.5</td>
<td>20.1</td>
<td>18.5</td>
<td>0.05</td>
</tr>
<tr>
<td>Alcohol drinkers, %</td>
<td>74.1</td>
<td>62.2</td>
<td>57.3</td>
<td>48.8</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Alcohol intake among drinkers, median, g/d</td>
<td>9.3</td>
<td>4.7</td>
<td>3.7</td>
<td>2.1</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Folate intake, median, μg/d</td>
<td>426</td>
<td>440</td>
<td>418</td>
<td>334</td>
<td>0.02</td>
</tr>
<tr>
<td>Fruit and vegetable intake, median, serving/d</td>
<td>6</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>0.03</td>
</tr>
<tr>
<td>Medical history, %</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>7.4</td>
<td>4.9</td>
<td>8.5</td>
<td>6.1</td>
<td>0.98</td>
</tr>
<tr>
<td>Hypertension</td>
<td>35.8</td>
<td>22.0</td>
<td>37.8</td>
<td>22.0</td>
<td>0.26</td>
</tr>
<tr>
<td>Hypercholesterolemia</td>
<td>34.6</td>
<td>35.4</td>
<td>39.0</td>
<td>39.0</td>
<td>0.48</td>
</tr>
<tr>
<td>Parental MI before age 65 years</td>
<td>17.3</td>
<td>18.3</td>
<td>18.3</td>
<td>20.7</td>
<td>0.59</td>
</tr>
<tr>
<td>Postmenopausal</td>
<td>90.1</td>
<td>87.8</td>
<td>92.7</td>
<td>90.2</td>
<td>0.72</td>
</tr>
<tr>
<td>Postmenopausal hormone use‡</td>
<td>57.5</td>
<td>61.1</td>
<td>57.9</td>
<td>58.1</td>
<td>0.95</td>
</tr>
<tr>
<td>Cholesterol, mean, mmol/L§</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LDL</td>
<td>3.24</td>
<td>3.37</td>
<td>3.38</td>
<td>3.38</td>
<td>0.40</td>
</tr>
<tr>
<td>HDL</td>
<td>1.77</td>
<td>1.57</td>
<td>1.55</td>
<td>1.49</td>
<td>( P &lt;0.001 )</td>
</tr>
<tr>
<td>LDL to HDL ratio (mean)</td>
<td>2.1</td>
<td>2.4</td>
<td>2.4</td>
<td>2.5</td>
<td>0.02</td>
</tr>
</tbody>
</table>

*Percentages are based on nonmissing data.

†Total 18:1 trans isomers include 18:1n-12, 18:1n-9, and 18:1n-7 trans isomers. Total 18:2 trans isomers include 9t,12t 18:2n-6, 9t,12c 18:2n-6, and 9c,12t 18:2n-6 trans isomers. Total trans fatty acids include 16:1n-7, 18:1, and 18:2 trans isomers, as well as 14:1n-5, 20:1n-9, and 20:2n-6 trans isomers, for which the contents are low in erythrocytes (mean<0.01).

‡Proportions are based on the number of postmenopausal women.

§Data of HDL were missing for 5 women; data of LDL were missing for 17 women. To covert values from mmol/L to mg/dL, multiply by 38.6698.
In this nested case-control study, we observed significant positive associations between erythrocyte trans fatty acid content and the risk of CHD. The risk among women in the highest quartile of erythrocyte trans fatty acid content was 3 times that of women in the lowest quartile after adjustment for established cardiovascular risk factors and other classes of fatty acids in erythrocytes. The plasma LDL to HDL ratio, which was significantly correlated with erythrocyte trans fatty acid contents, only partially explained these associations.

Substantial evidence from prospective cohort studies supports a positive association between dietary intake of trans fat and risk of CHD. In a pooled analysis of 4 cohort studies, Mozaffarian et al estimated a pooled relative risk of 1.33 (95% CI, 1.11 to 1.37) for every 2% energy from trans fat intake at baseline. The association was stronger in the Nurses’ Health Study when repeated measures of diet were analyzed: multivariable relative risk of CHD was 1.23 (95% CI, 1.11 to 1.37) for every 2% energy from trans fat intake. Hu et al demonstrated that the use of repeated measures of diet strengthened the observed association as compared with the analysis that used baseline measures only, probably as a result of reduction in measurement error by use of the cumulative average of diet.

Biomarkers of dietary intake are often believed to be more reliable than traditional dietary measurements because they are not subject to reporting errors. Several retrospective case-control studies have examined the relationship between trans fatty acid contents in human blood or tissues and CHD risk, but results have been inconsistent. Small sample size, inadequate biomarkers, and uncontrolled confounding by dietary factors may explain the discrepancy among these studies. Our study is consistent, however, with 4 more recent and well-designed case-control studies. Le-maitre et al observed moderate associations between erythrocyte or plasma phospholipid trans fatty acid content and increased risks of sudden death and fatal CHD. Similarly, in a Costa Rican population Baylin et al detected a positive association between adipose tissue trans fatty acid contents and an elevated risk of non-fatal MI. Clifton et al showed that, after trans fat was eliminated from margarines sold in Australia, the positive associations observed between trans...

**Discussion**

Relationship between erythrocyte trans fatty acid content and plasma lipid parameters among controls at baseline. Least-square means and 95% CIs of plasma lipoprotein parameters plotted against medians for each quintile of total trans fatty acid content in erythrocytes (%), adjusted for age at blood draw, smoking status (never, past, current), body mass index (<25, 25 to 29, ≥30), physical activity (<8.1 metabolic equivalents [METs], 8.2 to 18.6 METs, ≥18.6 METs), alcohol intake (0 g/d, 1 to 4 g/d, 5 to 14 g/d, ≥15 g/d), parental history of MI before age 65 years (yes, no), and fasting status (yes, no). Bars indicate 95% CIs for these means. A, LDL cholesterol; B, HDL cholesterol; C, LDL to HDL ratio.

Further adjusted for the LDL to HDL ratio in the multivariable models (data not shown). Associations were attenuated after such adjustment. For example, the relative risk of CHD between extreme quartiles of total trans fatty acid content was attenuated from 3.3 to 2.2 (95% CI, 0.9 to 5.4; P for trend = 0.07). Similarly, the association for total 18:1 trans isomers was also attenuated, although a significant trend was still observed. The relative risk between extreme quartiles of total 18:1 trans isomers was reduced from 3.1 to 2.2 (95% CI, 1.0 to 5.2; P for trend = 0.02) after such adjustment. This suggests that part of the adverse effect of trans fat is mediated through changes in lipoprotein levels.

Plasma trans fatty acid content was also positively associated with the risk of CHD in multivariable analysis, although the linear trend was less clear. The relative risks (95% CI) for the second to the fourth quartile of plasma total trans fatty acid content were 1.3 (0.6 to 3.0), 2.5 (1.2 to 5.1), and 1.4 (0.7 to 3.2), respectively.
TABLE 4. Relative Risk (95% CI) of Coronary Heart Disease Associated With Trans Fatty Acid Content in Erythrocytes*

<table>
<thead>
<tr>
<th>Trans Fatty Acid†</th>
<th>1 (Lowest)</th>
<th>2</th>
<th>3</th>
<th>4 (Highest)</th>
<th>P for Trend‡</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total trans fatty acids</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (range)</td>
<td>1.17 (0.76 to 1.36)</td>
<td>1.50 (1.37 to 1.59)</td>
<td>1.72 (1.60 to 1.87)</td>
<td>2.23 (1.88 to 3.42)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Model 1 (matching factors)</td>
<td>1.0</td>
<td>1.8 (1.0 to 3.4)</td>
<td>1.7 (0.9 to 3.1)</td>
<td>2.7 (1.5 to 5.0)</td>
<td>0.01</td>
</tr>
<tr>
<td>Model 2 (multivariable)</td>
<td>1.0</td>
<td>1.6 (0.7 to 3.4)</td>
<td>1.4 (0.7 to 3.0)</td>
<td>2.7 (1.3 to 5.6)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Model 3 (model 2 plus n-3 and n-6 fatty acids)</td>
<td>1.0</td>
<td>1.6 (0.7 to 3.6)</td>
<td>1.6 (0.7 to 3.4)</td>
<td>3.3 (1.5 to 7.2)</td>
<td>0.01</td>
</tr>
<tr>
<td>Total 18:1 trans isomers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (range)</td>
<td>0.77 (0.48 to 0.93)</td>
<td>1.03 (0.94 to 1.10)</td>
<td>1.21 (1.11 to 1.32)</td>
<td>1.62 (1.33 to 2.68)</td>
<td>0.01</td>
</tr>
<tr>
<td>Model 1 (matching factors)</td>
<td>1.0</td>
<td>1.3 (0.7 to 2.4)</td>
<td>1.5 (0.8 to 2.7)</td>
<td>2.4 (1.4 to 4.3)</td>
<td>0.01</td>
</tr>
<tr>
<td>Model 2 (multivariable)</td>
<td>1.0</td>
<td>1.1 (0.5 to 2.3)</td>
<td>1.2 (0.6 to 2.5)</td>
<td>2.5 (1.2 to 5.0)</td>
<td>0.01</td>
</tr>
<tr>
<td>Model 3 (model 2 plus n-3 and n-6 fatty acids)</td>
<td>1.0</td>
<td>1.1 (0.5 to 2.4)</td>
<td>1.3 (0.6 to 2.7)</td>
<td>3.1 (1.5 to 6.7)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Total 18:2 trans isomers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (range)</td>
<td>0.25 (0.14 to 0.28)</td>
<td>0.31 (0.29 to 0.34)</td>
<td>0.38 (0.35 to 0.41)</td>
<td>0.50 (0.42 to 0.78)</td>
<td>0.01</td>
</tr>
<tr>
<td>Model 1 (matching factors)</td>
<td>1.0</td>
<td>1.2 (0.6 to 2.2)</td>
<td>2.1 (1.2 to 3.9)</td>
<td>2.2 (1.2 to 4.1)</td>
<td>0.01</td>
</tr>
<tr>
<td>Model 2 (multivariable)</td>
<td>1.0</td>
<td>1.5 (0.7 to 3.2)</td>
<td>2.3 (1.1 to 5.0)</td>
<td>2.2 (1.0 to 4.8)</td>
<td>0.03</td>
</tr>
<tr>
<td>Model 3 (model 2 plus n-3 and n-6 fatty acids)</td>
<td>1.0</td>
<td>1.5 (0.7 to 3.4)</td>
<td>2.5 (1.1 to 5.7)</td>
<td>2.8 (1.2 to 6.3)</td>
<td>&lt;0.01</td>
</tr>
</tbody>
</table>

* A total of 166 cases and 327 controls are included for analyses. Mean (range) of each quartile of trans fatty acid content in erythrocytes are based on the distributions among controls. The lowest quartile is the reference group. Model 1 is conditioned on the matching factors: age at blood draw, smoking status (never, past, current), fasting status (yes, no), and time of blood drawing. On the basis of model 1, multivariable model 2 is further controlled for body mass index (<25 kg/m², 25 to 29 kg/m², ≥29 kg/m²), educational status (≤8 years, 9 to 12 years, >12 years), parental history of MI before age 65 years (yes, no), history of hypertension (presence, absence), history of hypercholesterolemia (presence, absence), and history of diabetes (presence, absence). On the basis of model 2, multivariable model 3 is further controlled for long chain n-3 fatty acids and total n-6 fatty acids (both in quartiles) in erythrocytes.

†Total 18:1 trans isomers include 18:1n-9, 18:1n-9, and 18:1n-7 trans isomers. 18:2 trans isomers include 9t,12t 18:2n-6, 9t,12c 18:2n-6, and 9c,12t 18:2n-6 trans isomers. Total trans fatty acids include 16:1n-7, 18:1n-9, and 18:2 trans isomers, as well as 14:1n-5, 20:1n-9, and 20:2n-6 trans isomers, for which the contents are low in erythrocytes (mean <0.01).

‡ Estimates of P value for linear trend are based on linear scores derived from the medians of quartiles of trans fatty acid content among controls.

Fatty acid contents in adipose tissue and the risk of nonfatal MI were diminished.23 The fact that 18:1 trans isomers have different biophysical characteristics from 18:2 trans isomers29 leads to the hypothesis that these 2 classes of trans fatty acids may have different associations with CHD risk. Except for trans 16:1n-7, which exists exclusively in ruminant fats, 18:1 and 18:2 trans isomers exist in both partially hydrogenated oils and ruminant fats.30 In partially hydrogenated oils, elaidic acid (trans 18:1n-9) is the major trans isomer, whereas, in ruminant fats, vaccenic acid (trans 18:1n-7) is the major trans isomer.31 Thus, in the US diet, 18:1 trans isomers are the dominant form of trans fatty acids.31 In the present study, the erythrocyte 18:1 trans isomers were also more abundant than 18:2 trans isomers. However, when trans fatty acid content was expressed as a continuous variable for the same amount of increment in erythrocyte trans fatty acids, 18:2 trans isomers were associated with a higher relative risk of CHD than 18:1 trans isomers. In the Costa Rican population, which had higher dietary intake of 18:2 trans fat but relatively lower intake of 18:1 trans fat than our population, the 18:2 trans isomers in adipose tissue were associated with higher relative risks of CHD than 18:1 trans isomers.18 Two US studies have also found detrimental relationships between 18:2 trans isomers and cardiovascular end points.24,28 Therefore, although 18:2 trans fat accounts for only a small proportion of total trans fat intake in US, its potential adverse effects should not be overlooked.

Because humans cannot synthesize trans fatty acids, trans isomers in human tissues represent their dietary intake levels, although different tissues may reflect long-term intake with various precisions. The associations with CHD appeared to be stronger for erythrocyte trans fatty acid contents than for plasma contents. In the present study, erythrocyte trans fatty acid content was more strongly correlated with dietary trans fat intake than plasma. Thus, erythrocyte trans fatty acid content may be a better biomarker of long-term trans fat intake than plasma content, probably because erythrocytes have a longer half-life than plasma lipid fractions. An alternative explanation is that fatty acid contents in plasma lipid fractions, particularly chylomicrons, reflected very recent diet more than longer-term diet when the blood samples of our participants were considered nonfasting.

Of many potential mechanisms through which trans fatty acids may increase the risk of CHD, the effect of trans fatty acids on plasma lipoprotein profiles has been most extensively studied in clinical dietary trials. Mensink et al summarized results from 8 clinical trials that specifically examined the effect of 18:1 trans isomer intake in a meta-analysis.2 Results indicated that, of all classes of fatty acids, trans fatty acids had a strong effect raising serum LDL cholesterol concentrations and were the only class of fatty acids that did not raise HDL cholesterol concentrations in the process of
carbohydrate replacement. As a result, trans fatty acids had the strongest effect on raising total cholesterol to HDL ratio, which is a stronger predictor of CHD risk than total cholesterol.3 In the present study, erythrocyte total trans fatty acid contents were significantly correlated with the plasma LDL to HDL ratio. After further adjustment for this ratio, the association between trans fatty acids and CHD risk was only partially attenuated. This is consistent with previous observations that CHD risk associated with trans fat intake was higher than that predicted based on change in lipoprotein profiles.2,3,32 Trans fatty acids may increase the risk of CHD through other pathways, such as an increase in lipoprotein(a)5,6 and blood triacylglycerol concentrations9 and interference with essential fatty acids metabolism and eicosanoids balance by inhibition of delta-6-desaturase.33,34 Furthermore, trans fat intake has been shown to be associated with systemic inflammation, endothelial cell dysfunction, and insulin resistance.7,8 By their incorporation into the phospholipids in cell membranes, trans fatty acids may also alter the membrane function and decrease the membrane fluidity in a manner similar to saturated fat.35

The prospective design of the present study is a noteworthy strength; the occurrence of disease could not influence biomarker contents in erythrocytes and plasma. Moreover, we adjusted for major lifestyle and dietary risk factors for CHD and other classes of fatty acids in erythrocytes. To address whether these associations could be caused by changes of diet subsequent to the diagnosis of diabetes, we reanalyzed the data after exclusion of diabetic participants. Results did not change appreciably.

The present study is also subject to several limitations. Single baseline measurements of erythrocyte trans fatty acid content will not perfectly reflect long-term dietary intake, which is the variable of interest. However, because the occurrence of CHD would not affect these biomarkers, and because blood samples were analyzed in a way that case-control status could not influence the measurements, any measurement errors are likely to be random and therefore would attenuate the association with CHD risk. Because we examined the associations for individual isomers simultaneously, the possibility of false-positive results could not be fully excluded, although these analyses were planned a priori, and these associations were all significant. Lastly, in observational studies residual confounding can never be entirely ruled out.

In summary, erythrocyte trans fatty acid content was associated with an increased risk of CHD among US women. These associations could be only partially explained by plasma lipoprotein parameters. The present study provides further evidence of the potential adverse effects of trans fat intake on cardiovascular health. Trans fat intake has been substantially reduced in European countries, whereas intake in the US is relatively stable.36 Elimination of partially hydrogenated oils and other sources of trans fat from diet is likely to make an important contribution to the goal of reducing the burden of cardiovascular diseases.

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Disclosures
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**CLINICAL PERSPECTIVE**

Although previous cohort studies have consistently shown that high intake of trans fat was associated with an elevated risk of coronary heart disease (CHD), the association might be underestimated or overestimated because of the measurement errors of dietary instruments used in the cohort studies. Trans fatty acids in erythrocytes or plasma, which are biomarkers of dietary trans fat intake, are believed to be more objective in the measurement of long-term intake of trans fat. The current study examined the association between biomarkers of trans fatty acid intake and CHD risk among US women. In the present study, we demonstrated that high content of trans fatty acids, which included both 18:1 and 18:2 trans isomers, in erythrocytes was associated with an increased risk of CHD. In line with metabolic studies, we observed positive associations between these biomarkers and low-density lipoprotein cholesterol levels and inverse associations for high-density lipoprotein cholesterol levels. The elevated risk of CHD was only partially attenuated after adjustment of the blood lipid parameters, which suggests that trans fat intake may increase CHD risk through other mechanisms. The present study provides further evidence that higher consumption of trans fatty acids is associated with increased risks of CHD.

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