A n association between high levels of air pollutants and human disease has been known for more than half a century. Air pollution is composed of a heterogeneous mixture of compounds including ozone (O₃), carbon monoxide (CO), sulfur dioxide (SO₂), nitrogen oxides (NOₓ), liquids, and particulate matter (PM). Substantial epidemiological evidence implicates air pollution, particularly PM, as a major risk factor with serious consequences on human health.¹⁻³ Of particular interest in PM are the particles that are ≤10 µm in diameter (PM₁₀) because they are the PM that ultimately enters the lungs.⁴ PM is further divided into coarse (10 to 2.5 µm; PM₁₀⁻₂.₅), fine (<2.5 µm; PM₂.₅), and ultrafine (<0.1 µm; PM₀.₁) particles.¹ These particles are composed of solid and liquid components that originate from vehicle exhaust, road dust, smokestacks, forest fires, windblown soil, volcanic emissions, and sea spray. Particle size, surface area, and chemical composition determine the health risk posed by PM. Particulate and gaseous pollutants coexist in the air and may induce adverse health effects, whereas compelling data implicate PM as a major perpetrator of various types of human disease. PM rarely exists by itself within the ambient environment because gaseous and semivolatile/volatile compounds (ie, aldehydes and polycyclic aromatic hydrocarbons) are constantly changing and interacting. Many of these vapor-phase compounds attach to the surface of PM and/or by themselves form secondary aerosol particles.

Because of their small size, PM₂.₅ and PM₀.₁ are inhaled deeply into the lungs, with a portion depositing in the alveoli and entering the pulmonary circulation and presumably the systemic circulation. The adverse effects of PM on the cardiovascular system have been established in a series of major epidemiological and observational studies.⁵⁻⁹ Although life expectancy has been improved significantly since air pollution levels have been reduced,¹⁰⁻¹³ the mechanisms of the effects of air pollution on cardiovascular disease remain unclear. In this review, the primary effects of PM on the cardiovascular system are summarized, along with potential mechanisms involved in disease progression. In addition, PM-exaggerated cardiovascular-associated disorders such as obesity and metabolic syndrome are also described in relation to progression after PM exposure.

Cardiac Events and Hospital Admission
Cardiac function requires an appropriate interplay among 3 key components: balanced tone of the autonomic nervous system, adequate myocardial function as the motor unit, and rhythmic initiation and conduction of electric impulses to maintain the sequence and latency of atrial and ventricular activation and repolarization.¹⁴ PM exposure can result in significant changes in many cardiovascular indexes such as heart rate, heart rate variability, blood pressure, and blood coagulability.

Epidemiological studies have shown an association between air pollution and adverse health effects since the 1930s.¹⁵ In the 1970s, broad investigations were conducted on human health, in particular pulmonary and cardiovascular diseases.¹⁶⁻¹⁸ Since the 1990s, studies of air pollution and cardiovascular diseases have intensified, especially relative to cardiovascular mortality and hospital admission for sudden cardiac events.¹⁹⁻²³ Specifically, Burnett et al¹⁹ examined the effect of ambient air pollution on cardiac disease exaggeration by relating daily fluctuations in admissions to 134 hospitals for congestive heart failure in the elderly to daily variations in ambient concentrations of CO, NO₂, SO₂, O₃, and the coefficient of haze in the 10 largest cities in Canada for the 11-year period of 1981 to 1991. They found that the daily high-hour ambient CO concentration recorded on the day of admission displayed the strongest and most consistent association with hospitalization rates among the pollutants. The same group studied the ambient air pollution mix on cardiorespiratory disease exacerbation in the summers of 1992 through 1994 and found that the increase in O₃, NO₂, and SO₂ corresponded to an 11% and 13% increase in daily hospitalizations for respiratory and cardiac diseases, respectively. The inclusion of any one of the particulate air pollutants in multiple regression models did not increase these percentages.²⁰

In an examination of effect size estimates across large differences in both the levels of potential confounding factors and their correlation with airborne particle concentration, particle concentration was found to be a significant risk factor for elevated mortality, and the relative risk was for a 100-mg/m³ increase in total suspended particulate (TSP)
concentration. To separate the effects of different air pollutants, daily counts of admissions to all hospitals in Tucson, Ariz, for cardiovascular disease in persons age ≥65 years were analyzed and indicated that both PM$_{10}$ and CO were associated with increased risk of cardiovascular hospital admissions, with admissions increased by 2.75% for an interquartile range increase (23 mg/m$^3$) in PM$_{10}$ and by 2.79% for an interquartile range increase (1.66 ppm) in CO. It is increasingly recognized that exposure to ambient PM contributes to significant adverse health effects and is a risk factor for the development of ischemic cardiovascular events via exacerbation of atherosclerosis, coronary artery disease, and the triggering of myocardial infarction, even within hours after exposure. Studies have demonstrated a significant elevation in the incidence of life-threatening myocardial infarctions and cardiac arrhythmias in the immediate periods (hours to days) after exposure to high levels of atmospheric PM$_{2.5}$.

PM pollution is also linked to an increased risk for hospital admission for cardiovascular and respiratory diseases, increased risk of myocardial infarction among the elderly, triggering of acute cardiac decompensation in heart failure patients, and an increase in the rate of hospital admissions for exacerbation of congestive heart failure. Recently, variations in the relative risk of hospitalization associated with ambient exposure to PM$_{2.5}$ total mass and chemical composition were investigated in the United States from 1999 through 2005. This study found a positive, statistically significant association between county-specific estimates of the short-term effects of PM$_{2.5}$ on cardiovascular and respiratory hospitalizations and county-specific levels of vanadium, elemental carbon, or nickel PM$_{2.5}$ content, especially in the northeast region. There is a body of literature, from as early as the 1970s, indicating a correlation between air pollution and hospital admission for an acute event. Table 1 depicts selected investigations of air pollution and hospital admissions, particularly resulting from sudden cardiac events.

### Changes in Heart Rate and Cardiac Function

In an attempt to investigate associations between ambient PM and cardiovascular function in a repeated-measures study in Boston residents, exposure to PM$_{2.5}$ with an average concentration of 15.5 µg/m$^3$ was associated with decreased vagal tone, resulting in reduced heart rate variability. In another study that evaluated changes in mean heart rate and heart rate variability in humans, there was an association between exposure to PM$_{10}$ on a previous day of 100 µg/m$^3$ and significantly increased heart rate by 5 to 10 bpm, suggesting that changes in cardiac autonomic function, reflected by changes in mean heart rate and heart rate variability, may be part of the pathophysiological mechanism linking cardiovascular mortality and PM. In the Exposure and Risk Assessment for Fine and Ultrafine Particles in Ambient Air (ULTRA) study, elevations in PM predicted risk for exercise-induced ST-segment depression in subjects with coronary artery disease. Another study in 3827 participants who underwent cardiac magnetic resonance imaging between 2000 and 2002 found that participants living within 50 miles of a major roadway had a higher cardiac function–left ventricular mass index associated with PM$_{2.5}$ elevation, indicating chronic vascular end-organ damage from traffic-related environmental exposure. Several other studies have demonstrated a link between changes in heart rate and PM levels in mice and elderly humans. The possible mechanisms involved in these events include disturbances in cardiac autonomic control, reduction in cardiac vagal control, decreases in parasympathetic tone, and an imbalance in cardiac autonomic control.

### Thrombosis and Other Changes in Hemostasis

PM has been associated with transient increases in plasma viscosity, acute-phase reactants, and endothelial dysfunction, as well as altered autonomic control of the heart. The effect of intravenous or intratracheal administration of ultrafine polystyrene particles, diesel exhaust particles, or PM$_{2.5}$ on thrombus formation was investigated, indicating the effects of circulating particles on changes in hemostasis. In 3256 randomly selected men and women 25 to 64 years of age, high concentrations of SO$_2$, CO, and TSP were associated with increased plasma viscosity. The Holland group studied 330 deaths during 1986 to 1994 and found that embolisms and thrombotic changes were increased after exposure to CO, O$_3$, and SO$_2$. In a double-blind randomized crossover study, 20 healthy volunteers were exposed to dilute diesel exhaust and filtered air in the United Kingdom and Sweden; postexposure thrombus formation, coagulation, platelet activation, and inflammatory markers were measured. These investigators found that diesel exhaust inhalation increased thrombus formation and platelet-neutrophil and platelet-monocyte aggregates.

Other epidemiological data link PM exposure to an augmentation of systemic inflammation as measured by C-reactive protein, an acute-phase protein associated with adverse outcomes in patients with unstable ischemic syndromes. In this prospective cohort survey in 1984 to 1985 with a 3-year follow-up of 631 randomly selected men 45 to 64 years of age who were free of cardiovascular disease at entry, the odds of observing C-reactive protein concentrations >5.7 mg/L (>90th percentile) tripled at normal ambient PM concentrations, and increases of 26 µg/m$^3$ total suspended particles (mean of 5 days) raised the odds of having a C-reactive protein level 50% greater than the 90th percentile. Increased levels of fibrinogen, platelets, and white blood cell counts were also associated with exposure to TSP.

The regulation of fibrinolysis is another important aspect of endothelial function. Small areas of endothelial denudation and thrombus deposition are a common finding on the surface of atheromas and are usually subclinical. Therefore, endogenous fibrinolysis of the lesion might prevent thrombus propagation and vessel occlusion. Nevertheless, under adverse proinflammatory states or imbalances in the fibrinolytic system, microthrombi may propagate and ultimately lead to arterial occlusion and tissue infarction. In a series of double-blind, randomized crossover studies, both healthy men and patients with stable coronary artery disease were exposed to dilute diesel exhaust (PM, 300 µg/m$^3$) for 1 hour while performing intermittent exercise, and were then
Table 1. The Effect of Air Pollution on Acute Hospital Admission

<table>
<thead>
<tr>
<th>Authors</th>
<th>Key Findings</th>
<th>Diseases</th>
<th>Pollutants</th>
<th>Subjects</th>
<th>Year</th>
<th>Location</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burnett et al</td>
<td>Exposure associated with 11% and 13% increased daily hospitalizations for respiratory and cardiac diseases, respectively</td>
<td>Respiratory and cardiac diseases</td>
<td>PM$_{10}$, O$_3$, NO$_2$, SO$_2$, CO</td>
<td>Not specific</td>
<td>1992–1994</td>
<td>Ontario, Canada</td>
<td>20</td>
</tr>
<tr>
<td>Dominici et al</td>
<td>Short-term exposure to PM$_{2.5}$ associated with increased hospital admission for cardiovascular and respiratory diseases</td>
<td>Cardiovascular and respiratory disease</td>
<td>PM$_{2.5}$</td>
<td>&gt;65 y of age</td>
<td>1999–2002</td>
<td>204 US counties</td>
<td>27</td>
</tr>
<tr>
<td>Wellenius et al</td>
<td>Exposure associated with increased hospital admission for CHF</td>
<td>CHF</td>
<td>PM$_{10}$</td>
<td>≥65 y of age</td>
<td>1986–1999</td>
<td>7 US cities</td>
<td>30</td>
</tr>
<tr>
<td>Bell et al</td>
<td>Strong relationship between PM$<em>{2.5}$ and hospitalization for respiratory and cardiovascular diseases, especially in the Northeast region, with a 1.49% increase in hospitalizations of cardiovascular diseases per 10-μg/m$^3$ increase in same-day PM$</em>{2.5}$</td>
<td>Respiratory and cardiovascular diseases</td>
<td>PM$_{2.5}$</td>
<td>≥65 y of age</td>
<td>1999–2005</td>
<td>202 US counties</td>
<td>31</td>
</tr>
<tr>
<td>Bell et al</td>
<td>Higher PM$_{2.5}$ content of nickel, vanadium, and elemental carbon associated with higher risk of cardiovascular and respiratory hospitalizations</td>
<td>Cardiovascular and respiratory diseases</td>
<td>PM$_{2.5}$ and chemical composition</td>
<td>≥65 y of age</td>
<td>1999–2005</td>
<td>106 US counties</td>
<td>32</td>
</tr>
<tr>
<td>Morgan et al</td>
<td>Exposure associated with increased hospitalization for respiratory and heart disease, with increase in daily maximum 1-h particulate concentration associated with an increase of 3.01% in COPD and 2.82% in heart disease admissions</td>
<td>Respiratory and heart disease</td>
<td>PM$_{2.5}$, O$_3$, NO$<em>2$, PM$</em>{10}$</td>
<td>All ages</td>
<td>1990–1994</td>
<td>Sydney, Australia</td>
<td>34</td>
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<tr>
<td>Schwartz et al</td>
<td>Exposure associated with hospital admissions for heart disease, with daily variation in PM$_{10}$ associated with 2.48% increase and daily variation in CO associated with 2.79% increase</td>
<td>Heart disease</td>
<td>PM$_{10}$, CO</td>
<td>≥65 y of age</td>
<td>1988–1990</td>
<td>8 US counties</td>
<td>35</td>
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<tr>
<td>Prescott et al</td>
<td>Exposure associated with emergency hospital admission for cardiac and respiratory disease, positive association with PM$_{10}$ and negative association with O$_3$</td>
<td>Cardiac and respiratory disease</td>
<td>PM$_{10}$, CO, NO$_2$, O$_3$</td>
<td>All ages</td>
<td>1981–1995</td>
<td>UK</td>
<td>36</td>
</tr>
<tr>
<td>Linn et al</td>
<td>Exposure associated with increased hospitalization for cardiopulmonary illness, with a 25th to 75th percentile increase in CO predicting an increase of 4% in cardiovascular admission; NO$<em>2$ and PM$</em>{10}$ but not O$_3$ showed similar increases in cardiovascular disease</td>
<td>Cardiopulmonary disease</td>
<td>PM$_{10}$, CO, NO$_2$, O$_3$</td>
<td>All ages</td>
<td>1992–1996</td>
<td>Los Angeles, US</td>
<td>37</td>
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<tr>
<td>Janssen et al</td>
<td>PM$_{10}$ associated with hospital admissions, especially for cardiovascular disease, in 14 cities in summer and winter</td>
<td>Cardiovascular disease</td>
<td>PM$_{10}$</td>
<td>Not specific</td>
<td>1993</td>
<td>14 US cities</td>
<td>38</td>
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<tr>
<td>Wong et al</td>
<td>Air pollution similarly associated with daily cardiopulmonary admissions in both cities, with significant positive association observed with PM$_{10}$, NO$_2$, SO$_2$, and O$_3$ in both cities</td>
<td>Cardiorespiratory disease</td>
<td>PM$_{10}$, O$_3$, SO$_2$, NO$_2$</td>
<td>All ages</td>
<td>1992–1997</td>
<td>Hong Kong, London</td>
<td>39</td>
</tr>
<tr>
<td>McGowan et al</td>
<td>PM$<em>{10}$ exposure associated with cardiopulmonary admission, with 3.37% increase in respiratory admissions and 1.26% rise in cardiac admissions for each interquartile rise in PM$</em>{10}$</td>
<td>Cardiorespiratory disease</td>
<td>PM$_{10}$, CO, SO$_2$, NO$_2$</td>
<td>All ages</td>
<td>1988–1998</td>
<td>New Zealand</td>
<td>40</td>
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<tr>
<td>Mann et al</td>
<td>Exposure associated with hospital admission for myocardial infarction, with a 1-ppm increase in CO associated with a 3.60% increase in same-day IHD admissions with a secondary diagnosis of CHF, a 2.99% increase in persons with a secondary diagnosis of AR, and a 1.62% increase in IHD admissions in persons without either secondary diagnosis</td>
<td>Myocardial infarction</td>
<td>PM$_{10}$, NO$_2$, CO</td>
<td>≥60 y of age</td>
<td>1988–1995</td>
<td>California</td>
<td>41</td>
</tr>
<tr>
<td>Koken et al</td>
<td>Exposure associated with increased hospitalization for cardiovascular disease, with O$_2$ associated with an increase in the risk of hospitalization for acute myocardial infarction, coronary atherosclerosis, and pulmonary heart disease; SO$_2$ for cardiac dysrhythmias; and CO for congestive heart failure</td>
<td>Cardiovascular disease</td>
<td>PM$_{10}$, CO, SO$_2$, O$_3$, NO$_2$</td>
<td>&gt;65 y of age</td>
<td>1993–1997</td>
<td>Colorado</td>
<td>42</td>
</tr>
<tr>
<td>Fung et al</td>
<td>Exposure to SO$_2$ associated with daily cardiac hospital admission, with a percentage increase in daily admission of 2.6% for current-day SO$_2$, 4.0% for 2-d mean level, and 5.6% for 3-d mean level for an increase in interquartile range of 19.3 ppb; the contributing effect of SO$<em>2$ remained significant for all 3 levels when PM$</em>{10}$ was included</td>
<td>Cardiac disease</td>
<td>SO$<em>2$, PM$</em>{10}$</td>
<td>≥65 y of age</td>
<td>1995–2000</td>
<td>Ontario, Canada</td>
<td>43</td>
</tr>
</tbody>
</table>

(Continued)
challenged by intrabrachial bradykinin, acetylcholine, sodium nitroprusside, and verapamil. Although there was a dose-dependent increase in blood flow with each vasodilator, this response was attenuated by bradykinin, acetylcholine, and sodium nitroprusside infusions 2 hours after exposure to diesel exhaust, which persisted at 6 hours. Bradykinin caused a dose-dependent increase in blood flow with each vasodilator, this effect persisted for 6 hours after the initial exposure,79 with the magnitude of this reduction comparable to that seen in cigarette smokers.82 This antifibrinolytic effect further underscores the prothrombotic potential of air pollution, especially under circumstances of vascular injury.

Baccarelli et al83 performed several studies of air pollution exposure and changes in blood homeostasis. To investigate the association between pollution levels (PM$_{10}$, CO, NO$_2$, O$_3$, and O$_{3}$) and changes in global coagulation tests such as prothrombin time and activated partial thromboplastin time, 1218 normal subjects from the Lombardia region in Italy.
were tested. Results showed that air pollution is associated with changes in global coagulation function, suggesting a tendency toward hypercoagulability after short-term exposure to air pollution. The effects of exposure to PM$_{10}$ on the risk of developing deep vein thrombosis in 870 patients and 1210 control subjects from the Lombardy region in Italy between 1995 and 2005 were then tested, with findings suggesting that long-term exposure to PM$_{10}$ is associated with altered coagulation function and deep vein thrombosis risk. Using distance from roads as a proxy for traffic exposure to further investigate whether living near major traffic roads increased the risk of deep vein thrombosis, they examined 663 patients with deep vein thrombosis of the lower limbs and 859 age-matched control subjects from cities with populations of $>15$ 000 inhabitants in the Lombardia region in Italy from 1995 through 2005. They found that the risk of developing deep vein thrombosis was increased for subjects living near a major traffic road compared with those living farther away, which was approximately linear over the observed distance range and was not modified after adjustment for background levels of PM, indicating that living near major traffic roads is associated with an increased risk of developing deep vein thrombosis. A summary of these effects is presented in Table 2.

**Table 2. Effect of Air Pollution on Changes in Blood Homeostasis**

<table>
<thead>
<tr>
<th>Authors</th>
<th>Key Findings</th>
<th>Pollutants</th>
<th>Subjects</th>
<th>Year</th>
<th>Location</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peters et al</td>
<td>Exposure associated with increased plasma viscosity, with an odds ratio of 3.6 for plasma viscosity above the 95th percentile of the distribution comparing measurements during the air pollution episode with nonepisode measurements in men and an odds ratio of 2.3 for women</td>
<td>TSP, SO$_2$, CO</td>
<td>25–64 y</td>
<td>1984–1985</td>
<td>Augsburg, Germany</td>
<td>72</td>
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<tr>
<td>Hoek et al</td>
<td>Exposure associated with increased embolism, thrombosis, and mortality, with heart failure deaths responsible for $\sim$30% of the cardiovascular deaths related to PM$_{10}$, SO$_2$, CO, and NO$_2$</td>
<td>PM$_{10}$, CO, SO$_2$, NO$_2$</td>
<td>All ages</td>
<td>1986–1994</td>
<td>The Netherlands</td>
<td>73</td>
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<tr>
<td>Lucking et al</td>
<td>Exposure associated with increased ex vivo thrombus formation and in vivo platelet activation, with thrombus formation under low- and high-shear conditions increased by 24% and 19%, respectively</td>
<td>Diesel exhaust</td>
<td>21–44 y</td>
<td>2008</td>
<td>UK, Sweden</td>
<td>74</td>
</tr>
<tr>
<td>Mills et al</td>
<td>Exposure associated with inhibition of endogenous fibrinolytic capacity, with a greater increase in the ischemic burden during exposure to diesel exhaust</td>
<td>Diesel exhaust</td>
<td>59–61 y</td>
<td>2007</td>
<td>UK</td>
<td>81</td>
</tr>
<tr>
<td>Baccarelli et al</td>
<td>Exposure associated with changes in global coagulation function, with PT shorter with higher PM$_{10}$ and NO$_2$</td>
<td>PM$_{10}$, NO$_2$, SO$_2$, CO, O$_3$</td>
<td>11–84 y</td>
<td>1995–2005</td>
<td>Italy</td>
<td>83</td>
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<tr>
<td>Baccarelli et al</td>
<td>Exposure associated with altered coagulation function and DVT risk, with each increase of 10 $\mu$g/m$^3$ in PM$_{10}$ associated with a 70% increase in DVT risk</td>
<td>PM$_{10}$</td>
<td>18–84 y</td>
<td>1995–2005</td>
<td>Italy</td>
<td>84</td>
</tr>
<tr>
<td>Baccarelli et al</td>
<td>Living near major traffic roads associated with increased risk of DVT, with the increase in DVT risk approximately linear over the observed distance range from 718 to 0 m</td>
<td>Not specific (distance from major roads)</td>
<td>18–84 y</td>
<td>1995–2005</td>
<td>Italy</td>
<td>85</td>
</tr>
<tr>
<td>Ray et al</td>
<td>Exposure associated with activated circulating platelets and increased leukocyte-platelet aggregates, with the MFI of CD11b on the surface of circulating monocytes and PMN of biomass users increased by 50% and 68%, respectively, and a 62% and 48% increase in MFI observed in CD18 expression on the surface of these cells in biomass users</td>
<td>PM$<em>{2.5}$, PM$</em>{10}$</td>
<td>21–60 y</td>
<td>2003–2004</td>
<td>India</td>
<td>86</td>
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</tbody>
</table>

DVT indicates deep venous thrombosis; MFI, mean fluorescence intensity; PMN, polymorphonuclear leukocytes; and PT, prothrombin time.

**Atherosclerosis**

The main pathway by which PM contributes to increased cardiac risk is by initiating and promoting atherosclerotic progression, the underlying cause of most cardiovascular diseases. Atherosclerotic lesions can lead to ischemia of
the heart, brain, or extremities. The disruption of a vulnerable but not necessarily stenotic atherosclerotic plaque in response to hemodynamic stress has been suggested as a mechanism that can trigger a myocardial infarction. Air pollution may induce atherosclerosis in the peripheral arteries, coronary arteries, and aorta. Short-term exposure to elevated PM has been associated with increased acute cardiovascular mortality, especially with an at-risk subset of the population, whereas prolonged exposure has been considered a causative factor for atherosclerosis. In an epidemiological study, Pope et al reported that PM2.5 exposure is a risk factor for cause-specific cardiovascular disease mortality via mechanisms that likely include pulmonary and systemic inflammation, accelerated atherosclerosis, and altered cardiac autonomic function.

The precise pathway through which PM induces the initiation and progression of atherosclerosis has not been determined, but 2 hypotheses have been proposed and assessed experimentally. The original hypothesis proposed that inhaled particles provoke an inflammatory response in the lungs, with consequent release of prothrombotic and inflammatory cytokines into the circulation. The alternative pathway proposed that inhaled, insoluble PM2.5 or PM0.1 could rapidly translocate into the circulation, with the potential for direct effects on homeostasis and cardiovascular integrity. The ability of PM0.1 to cross the lung-blood barrier is likely to be influenced by a number of factors, including particle size and charge, chemical composition, and propensity to form aggregates. Once in the circulation, PM0.1 can interact with the vascular endothelium or have direct effects on atherosclerotic plaques, causing local oxidative stress and proinflammatory effects similar to those seen in the lungs. Through either direct translocation into the circulation or secondary pulmonary-derived mediators, PM augments atherogenesis and causes acute adverse thrombotic and vascular effects.

In a series of animal models, mice fed high-fat chow and exposed to ambient PM2.5 demonstrated marked increases in plaque area, macrophage infiltration, expression of the inducible isoform of nitric oxide synthase, increased generation of reactive oxygen species, and greater immunostaining for the vascular endothelium or have direct effects on atherosclerotic plaques, causing local oxidative stress and proinflammatory effects similar to those seen in the lungs. Through either direct translocation into the circulation or secondary pulmonary-derived mediators, PM augments atherogenesis and causes acute adverse thrombotic and vascular effects.

A panel study in Los Angeles provided the first evidence of a link between long-term PM exposure and atherosclerosis in humans. This study, using data from 798 participants in 2 clinical trials, found that a 10-µg/m3 increase in PM2.5 was associated with an increase in carotid intima-media thickness, an ultrasonic measure of atheroma. For a cross-sectional exposure contrast of 10 µg/m3 PM2.5, carotid intima-media thickness increased by 5.9% (95% confidence interval, 1 to 11). Adjustment for age reduced the coefficients, but further adjustment for covariates indicated robust estimates in the range of 3.9% to 4.3%. Among older subjects (≥60 years of age), women, never smokers, and those reporting lipid-lowering treatment at baseline, the associations of PM2.5 and carotid intima-media thickness were larger, with the strongest associations in women 60 years of age (15.7%; 95% confidence interval, 5.7 to 26.6), suggesting that long-term ambient PM exposure may affect the development of atherosclerosis in humans. In a study examining the role of traffic-related, long-term exposure to PM2.5 (mean concentration, 22.8 µg/m3) in 4494 adult participants from the Heinz Nixdorf Recall Study, a 50% reduction in the distance between the residence and a main road resulted in a 10.2% increase in coronary artery calcification. These studies support the concept that air pollution causes a progression of atherosclerosis. In a cross-sectional analysis, Allen et al investigated exposure to PM2.5 and residential proximity to major roads in relation to abdominal aortic calcification, a sensitive indicator of systemic atherosclerosis. Aortic calcification was measured by computed tomography among 1147 persons in 5 US metropolitan areas enrolled in the Multi-Ethnic Study of Atherosclerosis. They found a slightly elevated risk of aortic calcification with a 10-µg/m contrast in PM2.5, and the PM2.5-associated risk of aortic calcification was stronger among participants with long-term residence near a PM2.5 monitor and among participants not recently employed outside the home. Their findings revealed a strong relationship between ambient PM and systemic oxidative stress. Their data showed that exposure to concentrated ultrafine PM rich in polycyclic aromatic hydrocarbons produced more inflammation, systemic oxidative stress, and atheroma formation than the fine fraction in apolipoprotein E–knockout mice. In the Watanabe heritable hyperlipidemic rabbit model, 4-week exposure to ambient PM10 resulted in dose-dependent alveolar and systemic inflammatory responses and progression of atherosclerosis in the coronary arteries and aorta. The volume fraction of coronary atherosclerotic lesions was increased in response to PM10 exposure. The atherogenic effects were correlated with the extent of PM phagocytosed by alveolar macrophages in the lung and coupled with an enhanced release of bone marrow monocytes. These precursors of macrophages play a key role in atherogenic inflammatory responses. In addition, exposure to PM10 caused an increase in plaque cell turnover and extracellular lipid pools in coronary and aortic lesions, as well as in the total amount of lipids in aortic lesions. Therefore, progression of atherosclerosis and increased vulnerability to plaque rupture may underlie the relationship between PM and increased cardiovascular death.
Table 3. Effect of Air Pollution on the Development of Atherosclerosis

<table>
<thead>
<tr>
<th>Authors</th>
<th>Key Findings</th>
<th>Pollutants</th>
<th>Subjects</th>
<th>Year</th>
<th>Location</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pope et al</td>
<td>Exposure associated with acute ischemic coronary events (unstable angina and myocardial infarction), with PM$_{2.5}$ elevated by 10 µg/m$^3$ associated with increased risk of acute ischemic coronary events of 4.5%</td>
<td>PM$_{2.5}$</td>
<td>Adults</td>
<td>1994–2004</td>
<td>US</td>
<td>8</td>
</tr>
<tr>
<td>Kunzli et al</td>
<td>Exposure associated with an increase in CIMT; with a cross-sectional exposure contrast of 10 µg/m$^3$ PM$_{2.5}$, CIMT increased by 5.9%</td>
<td>PM$_{2.5}$</td>
<td>≥40 y</td>
<td>1998–2003</td>
<td>California</td>
<td>96</td>
</tr>
<tr>
<td>Hoffmann et al</td>
<td>Long-term residential exposure associated with coronary atherosclerosis, with a reduction in the distance between the residence and a major road by half associated with a 7.0% higher CAC</td>
<td>PM$_{2.5}$</td>
<td>45–74 y</td>
<td>2000–2003</td>
<td>Germany</td>
<td>97</td>
</tr>
<tr>
<td>Allen et al</td>
<td>Associations with systemic atherosclerosis stronger among participants with less exposure, with elevated risk of aortic calcification with a 10-µg/m$^3$ contrast in PM$_{2.5}$</td>
<td>PM$_{2.5}$</td>
<td>45–84 y</td>
<td>2000–2002</td>
<td>US</td>
<td>98</td>
</tr>
</tbody>
</table>

CIMT indicates carotid intima-media thickness; CAC, coronary artery calcification.

Atherosclerosis. A summary of these effects on the development of atherosclerosis is presented in Table 3.

Vasomotor Tone Alterations and Hypertension

The effect of air pollution on vascular dysfunction and blood pressure change has been investigated in both humans and animals for years. In 2607 men and women 25 to 64 years of age who participated in the Augsburg Monitoring of Trends and Determinants in Cardiovascular Disease survey in association with air pollution episodes in Europe in January 1985, continuous concentrations of TSP and SO$_2$ were associated with an increase in systolic blood pressure.99 In an investigation of 40 healthy white male nonsmokers with PM$_{2.5}$, CIMT increased by 5.9%.

In an investigation of the associations between PM$_{2.5}$ and blood pressure during 631 repeated visits for cardiac rehabilitation in 62 Boston residents with cardiovascular disease, data analyses indicated that for an increase from the 10th to the 90th percentile in mean PM$_{2.5}$ levels during the 5 days before the visit (10.5 µg/m$^3$), there was a 2.8-mm Hg increase in resting systolic, a 2.7-mm Hg increase in resting diastolic, and a 2.7-mm Hg increase in resting mean arterial blood pressure. The mean PM$_{2.5}$ level during the 2 preceding days (13.9 µg/m$^3$) was associated with a 7.0-mm Hg increase in diastolic and a 4.7-mm Hg increase in mean arterial blood pressure during exercise in persons with resting heart rate ≥70 bpm, but it was not associated with an increase in blood pressure during exercise in persons with heart rate <70 bpm.100 In a study conducted in Italy comparing 68 traffic policemen and 62 control subjects (all male) at rest and during a symptom-limited incremental exercise test, 26 traffic policemen and none of the control subjects experienced exercise-induced ECG abnormalities or hypertension, and the traffic-exposed group demonstrated a number of significant changes in cardiorespiratory measures on exercise testing, suggesting that long-term occupational exposure to urban pollutants reduces resistance to physical effort and increases the risk of cardiovascular and respiratory effects.101

In an investigation of 40 healthy white male nonsmokers spontaneously breathing ambient air in Paris, France, gaseous pollutants were found to affect large-artery endothelial function, whereas PM exaggerated the dilatory response of small arteries to ischemia.102 In detail, reactive hyperemia was significantly and positively correlated with PM$_{10–2.5}$. An increase in PM$_{10–2.5}$ during the span of 2 weeks, was significantly correlated with an increase in reactive hyperemia. Endothelial function was impaired by ordinary levels of pollution in healthy young male subjects in an urban area and may be reduced by 50% between the least and the most polluted day.103 Potential mechanisms for PM-associated changes in blood pressure have been suggested to include an increase in sympathetic tone and/or the modulation of basal systemic vascular tone. Two studies showing associations between air pollution and blood pressure followed up subjects with chronic obstructive pulmonary disease. Linn et al104 found that an increase of 33 µg/m$^3$ ambient PM$_{10}$ was associated with a 5.7-mm Hg increase in systolic blood pressure. In contrast, Brauer et al105 studied 16 nonsmoking chronic obstructive pulmonary disease patients residing in Vancouver equipped with a PM$_{2.5}$ monitor for seven 24-hour periods. They found that although no associations between air pollution and lung function were statistically significant, weak associations were observed between particle concentrations and increased supraventricular ectopic heartbeats and decreased systolic blood pressure. No consistent associations were observed between any particle metric and diastolic blood pressure, heart rate, heart rate variability (root mean square of successive differences or SD of normal to normal), symptom severity, or bronchodilator use. Of the pollutants measured, ambient PM$_{10}$ was most consistently associated with health parameters. In nonsmoking healthy and asthmatic volunteers exposed to concentrated fine ambient particulates (CAP) compared with filtered air, systolic blood pressure was decreased in asthmatics and increased in healthy subjects during CAP exposure relative to filtered air. Cardiovascular (but not respiratory) symptoms increased slightly with CAP in both groups. However, in 25 healthy adults exposed to 2-hour inhalation of ≈150 µg/m$^3$ of CAP plus O$_3$, exposure to CAP plus O$_3$ caused a significant brachial artery vasocon-
striction compared with filtered-air inhalation, suggesting that PM2.5 CAP exposure (with or without O3) was inversely associated with systolic blood pressure in asthmatics but positively associated in healthy subjects.

In addition to the epidemiological and clinical studies, animal studies have provided evidence related to the mechanism of action of air pollution exposure–induced changes in blood pressure. In an angiotensin II–induced hypertensive Sprague-Dawley rat model, exposure to concentrated ambient PM2.5 for 10 weeks induced prolonged blood pressure recovery compared with the filtered air–exposed group.

In this study, aorto-vasoconstriction to phenylephrine was potentiated with exaggerated relaxation to the rho-kinase (ROCK) inhibitor Y-27632 and an increase in ROCK-1 messenger RNA levels and superoxide production in the PM2.5–exposed group, suggesting that short-term PM2.5 exposure exaggerates hypertension through superoxide-mediated upregulation of the Rho/ROCK pathway. Subsequently, in a murine model exposed to concentrated ambient PM2.5 for 12 weeks followed by a 14-day infusion of angiotensin II in conjunction with fasudil, a Rho kinase antagonist, PM2.5 exposure was found to potentiate angiotensin II–induced hypertension, which was abolished with fasudil treatment. In addition, PM2.5 exposure increased angiotensin II–induced cardiac hypertrophy, collagen deposition, and cardiac and vascular RhoA activation, suggesting that cardiovascular health effects are indeed the results of air pollution exposure.

Other Cardiovascular-Associated Events
Air pollution exposure has been linked to cerebrovascular diseases such as stroke. In a study conducted in England and Wales in the early 1980s, stroke mortality showed strong correlations with atmospheric pollution levels in both the winter and summer. These correlations were strengthened by standardization for season and temperature. By examining death certificates in Philadelphia on 5% of the days with the highest particulate air pollution and 5% of the days with the lowest particulate air pollution during the years 1973 to 1980, the researchers showed that the relative risk of dying of a stroke was elevated on days of high pollution. The effect of air pollution exposure on stroke was also confirmed in Japan in 1980 to 1995 during the summer season.

In a recent investigation examining the association of long-term exposure to PM2.5 with cardiovascular events, 65,893 postmenopausal women without previous cardiovascular disease in 36 US metropolitan areas from 1994 to 1998 were studied. The results showed that each increase of 10 μg/m3 was associated with a 24% increase in the risk of a cardiovascular event and a 76% increase in the risk of death resulting from cardiovascular disease. The risk of cerebrovascular events was also associated with increased levels of PM2.5.

Air pollution has recently been linked to diabetes mellitus and obesity. A study conducted in 270 Boston residents that measured 24-hour average ambient levels of air pollution (PM2.5, particle number, black carbon, and sulfates) 500 m from the patient examination site found that diabetes mellitus confers vulnerability to the effects of particles associated with coal-burning power plants and traffic. Recently, in a high-fat diet–induced obesity mouse model, PM2.5–exposed mice exhibited marked whole-body insulin resistance, systemic inflammation, and an increase in visceral adiposity. These were all associated with abnormalities in vascular relaxation to insulin and acetylcholine, increased adipose tissue macrophages, and increased inflammatory cell adhesion in the microcirculation, providing a new link between air pollution and type 2 diabetes mellitus.

Conclusions
Cardiovascular diseases have caused significant human and public health burden, with sustained reductions in air pollution exposure associated with increased life expectancy. Although significant improvements have been achieved in terms of air quality in the past decades, “clear sky visibility” over land has decreased globally over the past 30 years (except in Europe), indicating that we still have a long way to go in reducing air pollution levels and associated diseases. Future investigations into air pollution–induced cardiovascular diseases must not only include more studies to determine the mechanisms of action but also examine the role of each specific component of air pollution to determine what combination of particles is to blame for this sudden increase in environment-induced health concerns. This information is paramount for policy makers to determine acceptable levels of air pollution and to design ways to minimize the harmful effects of particles on the body.

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