The once-settled roles of all dietary fatty acid classes vis-à-vis coronary heart disease (CHD) appear to be under fire these days. For decades it had been received wisdom that saturated fats are bad and that margarines should replace butter to reduce the risk for heart attacks. But a recent *Time* magazine cover that screamed, “EAT BUTTER” illustrates this changing perspective. Olive oil, the poster child of the Mediterranean diet and a rich source of oleic acid, has long been revered as cardioprotective, but recent meta-analyses and animal-feeding trials,4 and now linoleic acid (LA), the principal vegetable oil–derived omega-6 fatty acid, once taken as a medicine by the tablespoon to lower cholesterol, is now being accused of causation, not preventing, heart disease.5 The only class that seems to be holding its own is the industrially produced *trans* fats, which, although clearly promoting CHD, are also slowly disappearing from the American diet.6 Understandably, the American public is becoming jaded when it comes to official proclamations of what constitutes a healthy fat.

Omega-6 Fatty Acids and Cardiovascular Disease
Friend, Not Foe?

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**Article see p 1568**

In this context, careful examination of the dietary patterns of large numbers of individuals followed for many years as they relate to CHD can help bring perspective. Such is the contribution of Farvid et al7 in this issue of *Circulation*. These investigators performed the largest systematic review and meta-analysis to date examining the relations between omega-6 fatty acid (essentially LA) intake and CHD morbidity and mortality. Using data from both published and unpublished studies (via direct investigator contact), Farvid et al7 included 12 cohort studies involving ≈290,000 individuals, among whom there were ≈11,000 CHD events and ≈4500 CHD deaths. Intakes of LA were estimated by a variety of dietary questionnaires, and follow-up ranged from 5 to 30 years. Comparing the highest- with the lowest-intake groups, risk for CHD events was lower by 14% and for CHD death by 17%, both statistically significant. The effects on total mortality rates would have been of interest as well, but such data were not available. The authors note that several studies have sought effects of dietary LA on cancer outcomes but have found none.

The fact that these relations with CHD were observed using such blunt instruments as dietary questionnaires suggests that the findings are robust. The observation that replacing either saturated fats or carbohydrates with vegetable oils produced essentially the same CHD benefit suggests that it is not the nutrient being replaced by LA that affords the benefit but the LA itself. Finally, because the LA effect was independent of the intake of α-linolenic acid (ALA, the plant omega-3 fatty acid found primarily in soybean oil, of which 6% of fatty acids are ALA and 54% LA), the benefit observed cannot be attributed to consumption of ALA alone, as some have hypothesized.5

These findings contrast with those of a recent article by Chowdhury et al,8 who reported, based on the results of 8 prospective cohort studies, that there was no association (hazard ratio, 0.98 [95% CI, 0.94–1.02]) between omega-6 fatty acid intake (not LA, per se) and “coronary disease” (defined as fatal or nonfatal myocardial infarction, CHD, coronary insufficiency, coronary death, angina, or angiographic coronary stenosis). Some of the possible reasons for this discrepancy are discussed in Farvid et al.7

**Omega-6 Are Proinflammatory?**

As noted earlier, some investigators have proposed that LA intakes in America are excessive,4 and, far from reducing risk for inflammatory diseases like CHD, may actually be increasing risk.5 This perspective builds on the following logic: LA is a precursor for arachidonic acid (AA), AA is the substrate for the production of certain proinflammatory eicosanoids and CHD is a disease with major inflammatory components. Therefore higher intakes of LA may increase the risk for CHD. Although not intrinsically illogical, this perspective fails to consider several inconvenient facts. First, as noted by Farvid et al,7 wide variations in LA intake do not materially affect circulating or cellular AA levels. Rett and Whelan5 performed a systematic review of 36 studies in which dietary LA was either reduced by ≤90% or increased by as much as 6-fold. In neither case were plasma phospholipid levels of AA altered. The authors concluded, “Our results do not support the concept that modifying current intakes of dietary linoleic acid has an effect on changing levels of arachidonic acid in plasma, serum or erythrocytes in adults consuming Western-type diets.”9
Second, studies testing the effect of LA on inflammatory status in humans have routinely found nothing. Johnson and Fritsche reviewed 15 trials meeting their inclusion criteria and concluded that, “virtually no evidence is available from randomized, controlled intervention studies among healthy, noninfant human beings to show that addition of LA to the diet increases the concentration of inflammatory markers.”10 Indeed, when Asp et al11 gave 35 postmenopausal women with type 2 diabetes mellitus additional safflower oil for 16 weeks, they observed significant decreases in C-reactive protein and hemoglobin A1c and increases in high-density lipoprotein cholesterol. The 8 g of oil per day increased their LA intake from 6.8% to 9.8% energy and raised plasma phospholipid LA levels by 2% to 4%.

Another concern with increasing LA intake is that it will lower blood levels of the long-chain omega-3 fatty acids eicosapentaenoic acid (EPA) and docosahexaenoic acid,12 presumably by slowing conversion of ALA to EPA or by competing with these 2 fatty acids for esterification sites in membrane phospholipids. To the extent that EPA and docosahexaenoic acid are cardioprotective, such an effect would be counterproductive. However, again, there is a gap between theory and fact. For example, Liou et al13 increased the LA intake from 3.8% to 10.5% of total energy in the diets of 22 men for 4 weeks. The high-LA diet did lower plasma phospholipid EPA levels by the same amount (from 3.0% to 3.4%), leaving the sum of EPA plus docosahexaenoic acid (4.0%) unaffected. They also observed no effects on inflammatory markers or platelet aggregation with the high-LA diet.

When Chowdhury et al2 examined the relationship between circulating fatty acids (ie, biomarkers) and CHD, the omega-6 story became more complicated. There was no association between LA levels and disease, but contrary to the omega-6-are-inflammatory hypothesis, in 10 studies including some 23000 individuals with more than 3700 CHD events, higher levels of circulating AA, the presumed toxic mediator, were associated with lower risk for CHD events (hazard ratio, 0.83 [95% CI, 0.74–0.92]).

LA Metabolites

As noted, the LA-is-harmful hypothesis depends heavily on the view that an LA metabolite, AA, is converted to potent pro-inflammatory signaling molecules. But AA is not the only LA metabolite with potential effects on CHD; LA itself can be converted to a wide variety of bioactive molecules. For example, nitrated LA has been shown to have cardioprotective effects.14 It can reduce cardiac ischemic injury by facilitating mitochondrial uncoupling, and it has been reported to inhibit platelet and neutrophil function, inhibit lipopolysaccharide-induced cytokine release from monocytes, improve insulin sensitivity, and relax preconstricted aortic rings.14 In addition, nitrated LA is a powerful ligand for peroxisome proliferation-activated receptor-γ,15 a nuclear transcription factor that controls cell differentiation, as well as production of metabolic and anti-inflammatory signaling molecules. At physiologically relevant levels, nitrated LA rivals the effects of the thiazolidinediones on peroxisome proliferation-activated receptor-γ.15 Nitrated LA (as well as nitrated AA) can be esterified in cell membrane (and lipoprotein) phospholipids and cholesteryl esters. Hence,
the possibility of targeted delivery of these signaling molecules via lipoprotein receptors exists. Beyond that, LA can also be converted to a growing number of oxygenated metabolites (ie, oxylipins) by cyclo-oxygenase, lipoxygenases, or cytochrome P-450 epoxygenases (Figure). As just 1 example of the potential physiological effects of LA oxylipins, the antihypertensive effects of LA may be mediated, at least in part, by LA diols and triols, which may inhibit tubular sodium reabsorption and thereby facilitate sodium excretion in salt-sensitive individuals.16 LA can also be metabolized to dihomo-γ-LA (from which other bioactive lipids can be produced) and further to AA, which is the well-known precursor to prostaglandin E2, thromboxane A2, and leukotriene B4, all proinflammatory mediators. However, if one takes off the blinders and examines the entire AA metabolome, one finds a constellation of AA oxylipins (ie, prostaglandin H2, thromboxane A2, and leukotriene B4) and further to metabolites, including a variety of prostaglandins, leukotrienes, ligands for endocannabinoid receptors, lipoxins, isoprostanes, nitrated AA, and epoxides, among others (Figure). Some are proinflammatory but some are anti-inflammatory or promote the resolution of inflammatory insults. Often these effects have only been observed in certain cell/tissue types and under potentially nonphysiological conditions, and their effects in normal physiology or those of other metabolites remain to be discovered. The net impact on human metabolism (and CHD risk) of this multitude of products will ultimately be determined. The net impact on human metabolism (and CHD risk) of this multitude of products will ultimately be determined.18

Randomized Trials

Of course, the most direct way to test the hypothesis that higher LA intake reduces risk for CHD is to perform a randomized, controlled trial. This has been attempted many times, and the results of these studies have been fodder for multiple meta-analyses. Depending on which trials one includes, there is a significant reduction in risk,19 no effect,20 or a trend toward increased risk21 associated with higher omega-6 intakes. Space does not allow a consideration of the pros and cons of each approach. Suffice it to say that large-scale, multiyear intervention trials in which one major dietary component is modified (but be) is substituted for another are both difficult to conduct and to interpret because of the multiple variables involved. Hence, it has been argued that prospective cohort data should be given the same evidentiary weight as randomized, controlled trials in nutrition, because each has relevant strengths and weaknesses.22 The report from Farvid et al23 makes an important contribution in this regard. Importantly, their data (shown in their Figure 5) continue to support the recommendation of many health authorities for 5% to 10% of energy as LA.19,20

Disclosures

Dr Harris is the President of OmegaQuant Analytics, LLC, and a Senior Research Scientist at Health Diagnostic Laboratory Inc. Both of these laboratories offer fatty testing, the former for researchers and consumers and the latter for clinicians. He is also a consultant for Omthera Pharmaceuticals, Aker Biomarine Antarctica, and Tersus Pharmaceuticals. Dr Shearer has received support from the California Walnut Commission for investigator-initiated research.

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