Influence of Apolipoprotein E, Smoking, and Alcohol Intake on Carotid Atherosclerosis

National Heart, Lung, and Blood Institute Family Heart Study

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Background—Apolipoprotein E (apoE) isoforms and lifestyle factors play an important role in the development of coronary heart disease. The association of apoE and carotid atherosclerosis remains controversial.

Methods—We investigated the relation of apoE, cigarette smoking, alcohol drinking, and their interaction with carotid atherosclerosis on 544 individuals free of coronary heart disease in the National Heart, Lung, and Blood Institute (NHLBI) Family Heart Study. Atherosclerotic lesions of the carotid arteries were detected through high-resolution ultrasound.

Results—Subjects in the apoE4 group had lower blood pressure, lower high-density lipoprotein cholesterol, and higher low-density lipoprotein cholesterol. In a multivariate logistic regression model, apoE isoforms and alcohol consumption were not significantly associated with the prevalence odds of carotid atherosclerosis (P=0.94 and 0.98, respectively, for trend). In contrast, compared with those who never smoked, the prevalence odds ratios for carotid atherosclerosis were 1.7 [95% confidence interval (CI), 1.1 to 2.7], 2.8 (95% CI, 1.2 to 6.2), and 1.9 (95% CI, 0.7 to 5.5) for former smokers, current smokers of 1 to 20 cigarettes per day, and current smokers of >20 cigarettes per day, respectively (P=0.0018 for trend). We did not find evidence of an interaction between apoE and alcohol consumption. Our data suggested a synergistic effect between the apoE allele ε4 and smoking on carotid atherosclerosis: odds ratios were 1.7 (95% CI, 0.8 to 3.6) for smoking alone, 1.0 (95% CI, 0.6 to 1.8) for ε4 alone, and 3.7 (95% CI, 1.1 to 3.6) for the joint presence of the apoE allele ε4 and smoking.

Conclusions—Smoking but not alcohol consumption or apoE is associated with an increased odds of carotid atherosclerosis. Our data suggest a synergistic effect between the apoE allele ε4 and smoking on carotid atherosclerosis. (Stroke. 2002;33:1357-1361.)

Key Words: apolipoproteins ■ atherosclerosis ■ carotid arteries ■ cigarette smoking
In this study, we used data collected on 544 individuals (from 346 families who were randomly selected) in the National Heart, Lung, and Blood Institute (NHLBI) Family Heart Study who were free of CHD and diabetes mellitus to evaluate (1) whether apoE isoforms, smoking, and current alcohol intake are associated with carotid atherosclerosis and (2) whether the apoE allele $e_i$ interacts with smoking or alcohol intake to influence carotid atherosclerosis.

Materials and Methods

Study Population

The NHLBI Family Heart Study is a multicenter, population-based study designed to identify and evaluate genetic and nongenetic determinants of CHD, preclinical atherosclerosis, and cardiovascular risk factors. A detailed description of the methods and design has been given elsewhere.3 Data were collected on 592 families who were randomly selected and 661 families who were chosen because of higher-than-expected CHD rates among family members. Each subject gave informed consent, and the study protocol was reviewed and approved by the institutional review boards of each participating institution. Of 681 individuals with information on both apoE genotype and carotid ultrasound, 137 were excluded from the present analyses for the following reasons: (1) E2/E4 genotype resulting from a classification problem (n = 14), (2) prevalent CHD (n = 62), (3) prevalence of diabetes mellitus (n = 42), (4) cholesterol-lowering medication (n = 7), or (5) missing covariates (n = 12).

Assessment of Carotid Artery Lesions

Using high-resolution B-mode ultrasound, trained technicians measured carotid IMT according to the Atherosclerosis Risk in Communities (ARIC) protocol.34 Measurements of IMT were derived in the far wall of 3 segments of the right and left extracranial carotid arteries: the common carotid artery (1 cm proximal to the dilatation of the carotid bulb), the bifurcation (the 1-cm segment proximal to the flow divider), and the internal carotid artery (the 1-cm segment in the internal branch distal to the flow divider). B-mode images were recorded on high-resolution, 3/4-in, high-end cassettes. At the central reading station, trained readers measured IMT at various points in each of the 3 carotid artery segments according to a standardized protocol. Estimates of the site-specific reliability coefficients were 0.77, 0.73, and 0.70 for mean carotid far-wall IMT at standardized protocol. Estimates of the site-specific reliability coefficients were 0.77, 0.73, and 0.70 for mean carotid far-wall IMT at the carotid bifurcation, internal artery, and common carotid artery, respectively. Based on the ultrasound images, it was determined whether an atherosclerotic lesion was present in the segment visualized. For each subject, the total number of lesions was recorded. For these analyses, carotid atherosclerosis was present if at least 1 lesion was detected.

Blood Collection and Assays

Blood samples were collected from fasting subjects and spun at 3000g for 10 minutes at 4°C. Sera were stored at −70°C until shipped periodically to a central laboratory at the Fairview-University Medical Center in Minneapolis, Minn, for processing. LDL was estimated by the method of Friedewald et al39 except in subjects with triglycerides >400 mg/dL, whose LDL was measured by ultracentrifugation. Total cholesterol and triglyceride concentrations were measured with a Roche COBAS FARA high-speed centrifugal analyzer (Roche Diagnostic Systems).40 HDL cholesterol was measured after precipitation of the other lipoprotein fractions by dextran sulfate.41

ApoE genotyping was performed with polymerase chain reaction to amplify a 267–base pair fragment from exon 4 of the apoE gene.42 The polymerase chain reaction product was digested with the HhaI restriction endonuclease (an isoschizomer of CfoI), which results in a specific banding pattern for the 3 isoforms of the apoE protein when separated by polyacrylamide gel electrophoresis and silver stained. ApoE categories were created as followed: E2 (E2/E2 or E2/E3), E3 (E3/E3), and E4 (E4/E4 or E3/E4).

Smoking and Alcohol Data

Information on cigarette smoking was obtained by questionnaire. Participants were asked if they had ever smoked cigarettes and, if so, whether they were current smokers. The number of cigarettes smoked per day was obtained for current smokers. This information was used to classify each participant as never smoked, former smoker, or current smoker of 1 to 20 or >20 cigarettes per day. Alcohol information was self-reported. The average number of drinks (beer, spirits, and wine) consumed per week on average over the past 12 months was recorded. This information was used to compute the total ethanol content. Each subject was classified as current nondrinker or current drinker of 1 to 12, 12.1 to 24, or >24 g/d ethanol.

Other Variables

Anthropometric data were collected with subjects wearing scrubsuits. A balance scale was used to measure body weight, and height was measured with a wall-mounted vertical ruler. Body mass index was computed as weight (kilograms) divided by the height (meters) squared. Hypertension was defined as systolic blood pressure of at least 140 mm Hg, diastolic blood pressure of at least 90 mm Hg, or use of medication for hypertension. Information on physical activity (minutes per day of leisure activity) was obtained by interview.

Statistical Analysis

Because the apoE allele $e_i$ has been associated with a higher risk of CHD,4,4 we used the presence or absence of allele $e_i$ (yes/no) and dichotomized current smoking (yes/no) and current drinking (yes/no) to evaluate interaction. For the apoE and smoking interaction, we created the following mutually exclusive categories: (1) absence of $e_i$ allele and no smoking, (2) absence of $e_i$ allele and smoking, (3) presence of $e_i$ allele and no smoking, and (4) presence of $e_i$ allele and smoking. Similar categories were generated for allele $e_4$ and alcohol intake.

We used analysis of variance to compare characteristics across apoE isoforms for continuous variables and $\chi^2$ analysis for categorical variables. We fitted a logistic regression model to assess the relation of different exposure variables and the presence of carotid atherosclerosis. Because of the familial clustering among individuals in this study, we used generalized estimating equations to account for familial clustering. The simple model adjusted for age and sex. The multivariate model controlled for age, sex, body mass index, physical activity, LDL, HDL, smoking, systolic blood pressure, and history of hypertension. Further adjustment for education, field center, and exercise did not alter the results.

Results

Of the 544 participants analyzed, 299 (55%) were women and 245 (45%) were men. The mean ± SD age was 56.4 ± 10.1 years (range, 26.4 to 78.0 years). As expected, E3/E3 was the most prevalent genotype (n = 337), followed by E3/E4 (n = 130), E2/E3 (n = 65), E4/E4 (n = 10), and E2/E2 (n = 2). The allele frequency distributions of $e_2$, $e_3$, and $e_4$ were 6%, 80%, and 14%, respectively, and the observed genotype distributions of E3/E3 (61.9%), E3/E4 (23.9%), E2/E3 (11.9%), E2/E2 (0.4%), and E4/E4 (1.8%) were in Hardy-Weinberg equilibrium ($P$ = 0.61).

Table 1 gives characteristics of the study participants. Compared with other isoforms, subjects with allele $e_4$ had lower blood pressure, lower HDL cholesterol, higher LDL cholesterol, and lower prevalence of hypertension.

In a logistic regression model adjusted for age and sex, apoE isoforms were not associated with a significantly increased odds of carotid atherosclerosis ($P$ = 0.85, Table 2). Additional adjustment for other covariates did not alter the results (Table 2). There was no significant association between alcohol consumption and prevalence odds of carotid atherosclerosis ($P$ = 0.98 for trend; Table 2). Smoking was related to the prevalence odds of carotid atherosclerosis. Compared with those who never smoked, mul-
TABLE 1. Characteristics of the Study Population

<table>
<thead>
<tr>
<th>Subject Variables</th>
<th>E2 (E2/E2 or E2/E3; n=67)</th>
<th>E3 (E3/E3; n=337)</th>
<th>E4 (E4/E4 or E3/E4; n=140)</th>
<th>P*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y</td>
<td>55.7±11.1</td>
<td>57.2±9.8</td>
<td>55.0±10.1</td>
<td>0.08</td>
</tr>
<tr>
<td>Body mass index, kg/m²</td>
<td>27.5±4.9</td>
<td>27.9±5.8</td>
<td>28.0±5.0</td>
<td>0.78</td>
</tr>
<tr>
<td>Systolic BP, mm Hg</td>
<td>117.7±13.6</td>
<td>118.5±17.6</td>
<td>114.1±15.3</td>
<td>0.03</td>
</tr>
<tr>
<td>Diastolic BP, mm Hg</td>
<td>70.9±9.1</td>
<td>68.8±9.3</td>
<td>67.7±9.6</td>
<td>0.07</td>
</tr>
<tr>
<td>HDL cholesterol, mmol/L</td>
<td>1.3±0.4</td>
<td>1.4±0.4</td>
<td>1.2±0.3</td>
<td>0.0007</td>
</tr>
<tr>
<td>LDL cholesterol, mmol/L</td>
<td>2.9±0.8</td>
<td>3.3±0.8</td>
<td>3.4±0.9</td>
<td>0.0001</td>
</tr>
<tr>
<td>Alcohol intake, g/d</td>
<td>4.6±10.2</td>
<td>4.7±9.9</td>
<td>3.9±9.7</td>
<td>0.72</td>
</tr>
<tr>
<td>Exercise, min/d</td>
<td>25.9±33.9</td>
<td>30.4±34.3</td>
<td>25.5±35.2</td>
<td>0.30</td>
</tr>
<tr>
<td>Male sex, %</td>
<td>41.8</td>
<td>44.2</td>
<td>48.6</td>
<td>0.58</td>
</tr>
<tr>
<td>Hypertension, %</td>
<td>19.4</td>
<td>30.6</td>
<td>17.1</td>
<td>0.004</td>
</tr>
</tbody>
</table>

BP indicates blood pressure.

*Probability values were obtained by use of ANOVA for continuous variables and χ² for categorical variables.

TABLE 2. Prevalence ORs and 95% CIs of Carotid Artery Lesion According to ApoE Isoforms, Smoking, and Alcohol Consumption

<table>
<thead>
<tr>
<th>ApoE isoform*</th>
<th>Subjects/Total, n</th>
<th>Adjusted for Age and Sex</th>
<th>Multivariate Model</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>E3</td>
<td>90/337</td>
<td>1.0</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>E2</td>
<td>18/67</td>
<td>1.0 (0.6–2.1)</td>
<td>1.2 (0.6–2.2)</td>
<td></td>
</tr>
<tr>
<td>E4</td>
<td>37/140</td>
<td>1.2 (0.7–1.9)</td>
<td>1.1 (0.7–1.9)</td>
<td></td>
</tr>
<tr>
<td>P for trend</td>
<td></td>
<td>0.85</td>
<td>0.94</td>
<td></td>
</tr>
<tr>
<td>Cigarette smoking†</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>69/330</td>
<td>1.0</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Former</td>
<td>56/160</td>
<td>1.7 (1.1–2.6)</td>
<td>1.7 (1.1–2.7)</td>
<td></td>
</tr>
<tr>
<td>Current, 1–20 cigarettes/d</td>
<td>15/39</td>
<td>2.8 (1.3–5.9)</td>
<td>2.8 (1.2–6.2)</td>
<td></td>
</tr>
<tr>
<td>Current, &gt;20 cigarettes/d</td>
<td>5/15</td>
<td>1.8 (0.6–5.6)</td>
<td>1.9 (0.7–5.5)</td>
<td></td>
</tr>
<tr>
<td>P for trend</td>
<td></td>
<td>0.0023</td>
<td>0.0018</td>
<td></td>
</tr>
<tr>
<td>Alcohol intake*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current nondrinker</td>
<td>96/369</td>
<td>1.0</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Current drinker, 1–12 g/d</td>
<td>26/105</td>
<td>1.0 (0.6–1.7)</td>
<td>0.8 (0.5–1.5)</td>
<td></td>
</tr>
<tr>
<td>Current drinkers, 12.1–24 g/d</td>
<td>12/39</td>
<td>1.4 (0.6–3.1)</td>
<td>1.0 (0.4–2.4)</td>
<td></td>
</tr>
<tr>
<td>Current, &gt;24 g/d</td>
<td>11/31</td>
<td>1.3 (0.6–3.2)</td>
<td>1.1 (0.4–2.8)</td>
<td></td>
</tr>
<tr>
<td>P for trend</td>
<td></td>
<td>0.43</td>
<td>0.98</td>
<td></td>
</tr>
</tbody>
</table>

*Multivariate model adjusted for age, sex, body mass index, exercise, smoking, LDL and HDL cholesterol, systolic blood pressure, and hypertension.
†Multivariate model adjusted for age, sex, body mass index, exercise, smoking, LDL and HDL cholesterol, systolic blood pressure, and hypertension.

suggesting a synergistic effect between smoking and the ε₄ allele. There was no significant evidence for an interaction between alcohol consumption and the ε₄ allele (Table 3).

Discussion

Although the genetic polymorphism of apoE is an important factor for cardiovascular risk and the development of CHD, data are mixed on whether apoE is associated with carotid artery atherosclerosis. The most important effect of apoE seems to be on the level of LDL cholesterol, in which a strong interaction between apoE and smoking has been demonstrated. Although epidemiological studies have shown that cigarette smoking is associated with increased risk of carotid atherosclerosis and that moderate alcohol intake may lower the risk of cardiovascular disease, it is not known whether the apoE allele ε₄ interacts with smoking and/or alcohol to influence the risk of carotid atherosclerosis. In this study, we examined participants free of CHD and diabetes mellitus and found evidence that smoking but not alcohol consumption or apoE isoforms was significantly related to the prevalence odds of carotid atherosclerosis. Although there was no interaction between alcohol and the apoE allele ε₄, our findings suggested that smoking and the ε₄ allele may have synergistic effects on the prevalence odds of carotid atherosclerosis. These effects of smoking alone and its interaction with the apoE allele ε₄ were independent of LDL cholesterol.

Hixson found that apoE was associated with atherosclerosis of the aorta in young men. In another study of nondiabetic subjects free of cardiovascular disease, apoE4 was associated with increased thickness of the carotid artery wall. In both studies, the observed effects were independent of serum cholesterol. Other investigators have reported a positive association between apoE and carotid IMT. In contrast, Guz et al found no association between the apoE polymorphism and carotid IMT in 269 hemodialysis patients. In a study of young adults (n=150) free of cardiovascular disease, Sass et al found no association between the apoE allele ε₄ and carotid IMT. Furthermore, Kogawa and colleagues found no evidence of an association between the apoE allele ε₄ and carotid IMT. The heterogeneity of these results merits comment. It is possible that chance may have played a role in some of the positive studies. In addition, other determinants of atherosclerosis such as smok-
The effect of smoking were independent of LDL cholesterol and were greater in the presence of the apoE allele $\epsilon_4$.

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