Evolving targets for lipid-modifying therapy

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Abstract

The pathogenesis and progression of atherosclerosis are integrally connected to the concentration and function of lipoproteins in various classes. This review examines existing and emerging approaches to modify low-density lipoprotein and lipoprotein (a), triglyceride-rich lipoproteins, and high-density lipoproteins, emphasizing approaches that have progressed to clinical evaluation. Targeting of nuclear receptors and phospholipases is also discussed.

Keywords atherosclerosis; cholesterol; lipoproteins; triglycerides

Introduction

Ischemic heart disease and cerebrovascular disease due to atherosclerosis remain leading causes of death in the world. Lipoprotein abnormalities play a key role in the pathogenesis of these diseases. Low-density lipoprotein (LDL), triglyceride-rich lipoproteins, and high-density lipoprotein (HDL) may contribute to the development and progression of atherosclerosis and its complications. Numerous strategies to modify each of the principal classes of lipoproteins have been or are currently under investigation. This review primarily focuses on those approaches that have progressed to clinical evaluation or implementation.

LDL, triglyceride-rich lipoproteins, and HDL comprise the three principal lipoprotein classes. The primary function of LDL is to deliver essential cholesterol to peripheral tissues. Triglyceride-rich lipoproteins carry a cargo of energy substrate (fatty acids) from intestine to liver and to peripheral tissues for fat storage and oxidative metabolism. HDL participates in reverse cholesterol transport to remove excess cholesterol stores from peripheral sites for biliary excretion. Each lipoprotein class may affect the development and progression of atherosclerosis and its complications. Numerous strategies to modify each of the principal classes of lipoproteins have been or are currently under investigation (Table 1, Fig 1).

Targets for reduction of LDL and related atherogenic lipoproteins

Statin drugs have been the cornerstone of lipid-modifying therapy for more than a quarter century. Statins inhibit 3-hydroxy-3-methylglutaryl coenzyme A (HMG CoA) reductase, which is the rate-limiting step for cholesterol synthesis. A reduction in hepatic cholesterol synthesis and hepatocyte cholesterol concentration results in upregulation of LDL receptor expression on hepatocytes and enhanced clearance of LDL and other atherogenic lipoproteins from the circulation. Through this mechanism, statins can reduce concentrations of LDL-C by as much as 50–60%, with accompanying reductions of triglyceride-rich lipoproteins and modest increases in HDL-C. A large body of data from controlled clinical trials indicates that each 1 mmol/l reduction in LDL-C produced by statin treatment is associated with approximately 12% reduction in all-cause mortality and 20% reduction in cardiovascular morbidity (Baigent et al, 2005). At usual doses, statins reduce cardiovascular risk by 25–30%. Part of the clinical efficacy of statins may also be attributable to non-lipid, or ‘pleiotropic’ effects related to effects of HMG CoA reductase inhibition on isoprenoid intermediates in cholesterol biosynthesis (Davignon, 2004; Nohria et al, 2009; Zhou & Liao, 2010). However, substantial residual cardiovascular risk remains despite effective statin treatment. The extent to which this residual risk is attributable to lipoprotein abnormalities, and might be reduced by additional lipoprotein-modifying therapies, remains unknown. To date, no second lipid-modifying therapy, added to primary treatment with statins, has been proven to reduce cardiovascular risk. However, promising new targets and new approaches to established targets are being investigated.

Cholesterol absorption

Interference with cholesterol absorption can lower circulating concentrations of LDL-C. Bile acid sequestrants such as cholestyramine lower LDL-C levels up to 25%. As monotherapy, cholestyramine was shown to reduce the risk of myocardial infarction (Lipid Research Clinics Program, 1984). However, use of bile acid sequestrants is limited by gastrointestinal side effects, interference with absorption of other drugs, and exacerbation of hypertriglyceridemia.

A newer bile acid sequestrant, colesevelam, has a relatively low incidence of gastrointestinal side effects (Davidson et al, 1999).

A target for the inhibition of intestinal cholesterol absorption is Niemann-Pick C1-like 1 (NPC1L1). Ezetimibe inhibits cholesterol
A procedure used to remove a substance from blood circulation. Whole blood is drawn from the body by large catheter and separated into different blood components. The desired substance can then be removed, with reinfusion of remaining blood products to the body.

the process of cholesterol plaque deposition and inflammation along arterial walls. It can result in obstruction to blood flow and a tendency to thrombosis with sudden vessel occlusion.

large lipoprotein particle that carries dietary lipid and is rich in triglyceride.

macrophages or immune cells containing excess cholesterol, largely due to uptake of oxidized LDL.

ApoA1-containing lipoprotein; major function is reverse transport from peripheral sites to liver for excretion.

formed by action of lipases on very low-density lipoproteins, resulting in increased cholesterol and decreased triglyceride content and smaller size, compared with VLDL.

particles consisting of surface proteins and phospholipid and a neutral lipid core, functioning to transport of lipids throughout the circulation.

Major carrier of cholesterol esters to peripheral cells.

muscle disease that in general describes muscle weakness or pain.

carries triglycerides and cholesterol from liver to peripheral tissue and contains apolipoproteins B, C, and E.

absorption by blocking the function of NPC1L1 (Garcia-Calvo et al., 2005) and lowers LDL-C in patients by approximately 15%. In a study of patients with heterozygous familial hypercholesterolemia followed for 24 months, there was no difference in intima-media thickness with ezetimibe and simvastatin, compared with placebo and simvastatin (Kastelein et al., 2008). However, there are no data to date indicating whether or not the additional reduction of LDL-C resulting from addition of ezetimibe to statin translates into additional reduction of cardiovascular risk. This hypothesis is being tested in the IMPROVE-IT trial, with results expected in 2014 (Califf et al., 2010).

Squalene synthase acts downstream from HMG CoA reductase to convert farnesyl pyrophosphate to squalene, the first committed step in cholesterol biosynthesis. Inhibition of squalene synthase lowers plasma cholesterol levels without affecting the synthesis of upstream intermediates implicated in the development of myopathy with statins (Nishimoto et al., 2007). Lapaquistat acetate is a squalene synthase inhibitor that reduced LDL-C by 20% and lowered C-reactive protein levels by 25%. It progressed to evaluation in Phases 2 and 3 clinical trials. However, development of lapaquistat was halted due to two cases of severe liver enzyme elevation, coupled with evidence that the strategy might not reduce muscle toxicity (Stein et al., 2011). No other squalene synthase inhibitors have reached advanced stages of clinical development.

Expression of apolipoprotein B100

Apolipoprotein (apo) B-containing lipoproteins include LDL, very low-density lipoprotein (VLDL), and VLDL remnants. Because these lipoproteins may promote atherosclerosis, strategies to prevent expression of apoB are attractive. However, interference with hepatic export of apoB-containing lipoproteins also has the potential to promote hepatic steatosis.

Mipomersen is a 20-base, 2’-O-(2-methoxy) ethyl-modified antisense oligonucleotide that targets mRNA encoding apoB100. It reduces circulating levels of all lipoprotein species containing apoB100 in humans. In Phases 2 and 3 clinical trials of mipomersen as monotherapy or added to statins in patients with familial hypercholesterolemia (FH), LDL-C reductions of up to 47% were observed (Visser et al., 2012). Because mipomersen does not significantly affect intestinal apoB48 expression, intestinal fat absorption is unaffected and intestinal steatosis is avoided (Cooke et al., 2005). However, treatment with mipomersen was associated with injection site reactions, flu-like symptoms, and hepatic steatosis with elevated liver transaminases (Visser et al., 2012).

Mipomersen is currently approved for the treatment of homozygous familial hypercholesterolemia. However, the long-term benefit/risk profile remains to be determined and might be influenced by tolerability or hepatic safety. Other approaches to knockdown apoB100, including small interfering RNAs, are under investigation (Tadin-Strapps et al., 2011).

VLDL assembly – ACAT and MTP

Another approach to reduce LDL to prevent hepatic secretion of its precursor lipoprotein, VLDL, by interfering with the lipidation of apoB. Two enzymes involved in this process, acyl-CoA:cholesterol acyltransferase (ACAT) and microsomal triglyceride transfer protein (MTP), have been targeted.

ACAT1 and ACAT2 are expressed in macrophages as well as liver and intestine where they are involved in accumulation of cholesterol ester, foam cells, atherosclerosis, and providing cholesterol ester to secreted VLDL and chylomicrons (Lee et al., 2000; Leon et al., 2005). Surprisingly, clinical trials that used intravascular ultrasound to evaluate non-specific ACAT inhibitors demonstrated that treatment had a neutral to adverse effect on coronary atherosclerosis (Tardif et al., 2004; Nissen et al., 2006). The explanation may be related to toxic effects of increased free cholesterol in macrophages. Selective ACAT2 inhibition might remain a plausible approach to retard atherosclerosis (Ohshiro & Tomoda, 2011).

MTP transfers neutral lipids to nascent apoB and thereby affects the rate of VLDL and chylomicron synthesis. Loss-of-function mutation of MTP is the cause of abetalipoproteinemia, a condition with defective fat absorption and the absence of circulating apoB-containing lipoproteins. Lomitapide is a small molecule inhibitor of MTP that was shown to lower LDL-C levels by 50% in patients with homozygous FH and has been approved for the use in that condition (Cuchel & Rader, 2013). Although lomitapide is effective in lowering
| Target | Agent(s) | Primary site(s) of action | Principal effects on lipoproteins | Phase of clinical evaluation | Safety/tolerability issues |
|--------|----------|---------------------------|----------------------------------|-------------------------------|---------------------------|
| 3-hydroxy-3-methylglutaryl coenzyme A (HMG-CoA reductase) | Statins | Liver | LDL-C ↓↓ HDL-C ↔ ↑ TG ↓ | Approved for the use in dyslipidemia and atherosclerosis | Muscle and liver enzyme abnormalities |
| Bile acid sequestrant | Cholestyramine and others | Intestine | LDL-C ↓ HDL-C ↑ TG ↑ | Approved for the use in dyslipidemia | Gastrointestinal side effects; interference with absorption of other drugs; exacerbation of hypertriglyceridemia |
| Niemann-Pick C1-like protein | Ezetimibe | Intestine | LDL-C ↓ | Approved for the use in dyslipidemia | Well tolerated, no outcomes data |
| Squalene synthase | Lapuqastat | Liver | LDL-C ↓ HDL-C ↑ TG ↑ | Development halted in Phase 2–3 | Muscle and liver enzyme abnormalities |
| ApoB100 | Mipomersen | Liver | apoB ↓ LDL-C ↓↓ TG ↓ Lp(a) ↓ | Approved for the use in homozygous familial hypercholesterolemia | Hepatic steatosis, liver enzyme abnormalities, injection site reactions, flu-like symptoms |
| Acyl-CoA:cholesterol acyltransferase (ACAT) | Avasimibe, pactimibe, and others | Liver, intestine, macrophages | LDL-C ↓↓ TG ↓ Lp(a) ↓ | Development halted in Phase 2 | Neutral to adverse effect on atherosclerosis by imaging |
| Microsomal triglyceride transfer protein (MTP) | Lomitapide | Liver, intestine | LDL-C ↓↓ HDL-C ↓ TG ↓↓ Lp(a) ↓ | Approved for use in homozygous familial hypercholesterolemia | Hepatic and intestinal steatosis, liver enzyme abnormalities |
| Thyroid hormone receptors | Thymomimetics (eprotirome, sobetirome, and others) | Liver | LDL-C ↓↓ TG ↓ Lp(a) ↓ | Clinical development halted in Phase 3 | Reversible reductions in thyroxine and thyroid binding globulin, unclear clinical significance. Liver enzyme abnormalities |
| PCSK9 | Alirocumab (REGN727/SAR236553), evolocumab (AMG 145), PF-04950615 (RN316), and others | Liver, intestine | LDL-C ↓↓ Lp(a) ↓ TG ↓ HDL-C ↑ | Phase 3 | Mild injection site reactions |
| Lipoprotein (a) | Niacin/nicotinic acid | Adipose, liver | Lp(a) ↓ LDL-C ↓ HDL-C ↑ TG ↓↑ | Approved for the use in dyslipidemia | Flushing, liver enzyme and glucose abnormalities, hyperuricemia |
| LDL apheresis | | Serum | Lp(a) ↓ LDL ↓ | Approved for the use in familial hypercholesterolemia | Nausea, vomiting, flushing, angina, syncope, bleeding |
| Apo(a) antisense oligonucleotide 144367 | | Liver | Apo(a) ↓↓ (preclinical) | | |

### Strategies to reduce triglyceride-rich lipoproteins

| Target | Agent(s) | Primary site(s) of action | Principal effects on lipoproteins | Phase of clinical evaluation | Safety/tolerability issues |
|--------|----------|---------------------------|----------------------------------|-------------------------------|---------------------------|
| VLDL production/secreton, TG clearance | Eicosapentaenoic acid (EPA), docosahexaenoic acid (DHA) | Liver | TG ↓ LDL-C ↑ | Approved for the use in dyslipidemia | Gastrointestinal side effects |
| ApoC-III | Antisense oligonucleotide ISIS 304801, ISIS apoC-III-Rx | Liver | ApoC-III ↓↓ TG ↓ HDL-C ↑ | Phase 2 | Injection site reaction |
| Diacylglycerol acyltransferase (DGAT) | LCQ-908, AZD7687, PF-04620110, and others | Intestine, liver, adipose | TG ↓ | Phase 3 | Gastrointestinal symptoms |
**Table 1** (continued)

| Target                        | Agent(s)                                                                 | Primary site of action | Principal effects on lipoproteins | Phase of clinical evaluation | Safety/tolerability issues |
|-------------------------------|--------------------------------------------------------------------------|------------------------|-----------------------------------|-----------------------------|----------------------------|
| ApoE                          | ApoE mimetic peptide (AEM-28)                                            | Liver                  | Preclinical                       | Preclinical                 |                            |

**Strategies to increase HDL**

| G protein-coupled receptor    | Niacin/nicotinic acid                                                     | As above               | As above                         | As above                    | As above                   |
| Cholesteryl ester transfer protein | Torcetrapib, dalce trapib, evacetrapib, anacetrapib                      | Liver, circulation     | HDL-C ↑↑↑                        | LDL-C ↓↓                   | Torcetrapib phase 3 trial stopped prematurely due to harm. Dalce trapib phase 3 trial stopped due to futility. |
| Bromodomain and extra-terminal (BET) protein 2 | RVX-208                                                                 | Liver                  | HDL-C ↑                          | Large HDL↑                 | Liver enzyme abnormalities |
| Circulating lipoproteins      | HDL-mimetic CER-001, AT1-S261 (preclinical), MDCO-216, and others         | Serum                  | Preβ1, HDL ↑↑↑                   | TG ↑↑                      | Gastrointestinal symptoms, elevated triglycerides |
| ATP binding cassette transporter A1 and G1 (ABCA1 and ABCG1) | miR-33                                                                  | Liver, endothelium     | HDL-C ↑↑                        | Apo-AI ↑↑                  |                            |

**Nuclear receptor agonists**

| Liver X receptors             | LXR-623 and others                                                       | Liver, intestine       | HDL↑                             | Clinical development halted in Phase 2 | Induced lipogenesis and hyperglycemia. Dose dependent CNS effects |
| PPAR-α, γ, and/or δ           | Fibrates (PPAR-α, TZDs (PPAR-γ), and novel PPAR agonists)                 | PPAR-α: Liver, skeletal muscle PPAR-γ: adipose, vascular smooth muscle PPAR-δ: ubiquitous | PPAR-α: HDL-C ↑ TG ↓ PPAR-γ: HDL-C ↑ TG ↓ PPAR-δ: LDL-C ↓ (δ/δ) TG ↓ HDL-C ↑ LDL-C ↓ | Fibrates and TZDs approved for clinical use in dyslipidemia and diabetes. Development of dual α/γ activators halted in Phase 2 –3 Selective PPAR-δ and α/δ activators in early phase development | Decreased glomerular filtration rate (α), weight gain, fluid retention, congestive heart failure, bone fractures (γ). No long-term safety data for α/δ activators |

| Secretory and lipoprotein-associated phospholipase A2 | Varespladib, darapladib                                                 | Multiple cell types    | LDL-C ↓ VLDL ↓                  | Varespladib, darapladib terminated in Phase 3 | Varespladib increased adverse events after acute coronary syndrome |

Arrows indicate direction and magnitude of lipoprotein change. 
↑ or ↓ indicates 0–30% change (increase/decrease). 
↑↑ or ↓↓ indicates 30–60% change (increase/decrease). 
↑↑↑ or ↓↓↓ indicates > 60% change (increase/decrease). 
→ indicates neutral effect/no change.

LDL-C, its use is unlikely to extend beyond FH because of a high incidence of gastrointestinal symptoms related to malabsorption of fat and hepatic steatosis related to inhibition of hepatic lipid export (Cuchel et al, 2013).

**Thyromimetics or tiromes**

Thyroid hormone exerts tissue-specific effects, with the thyroid hormone receptor β1 isofrom (TR β1) predominating in liver and involved in cholesterol metabolism (Gullberg et al, 2000). TR β1 activation depletes intracellular cholesterol concentration, leading to increased expression of the LDL receptor in hepatocytes. Hypolipidemic effects of TR β1 activation are also increased biliary cholesterol excretion through stimulation of cholesterol 7a-hydroxylase (CYP7A1) expression (Lin et al, 2012), downregulation of sterol regulatory element-binding protein (SREBP)-1c (Hashimoto et al, 2006), and non-classical signaling pathways (Cordeiro et al, 2013).

The TR β1 agonists such as eprotirome have been evaluated in clinical trials. On a background of statin treatment, eprotirome lowered LDL-C up to 32%, associated with reductions of apoB, triglycerides, and Lp(a) (Ladenson et al, 2010). Eprotirome was effective in decreasing levels of atherogenic lipoproteins in patients with hypercholesterolemia (Angelín et al, 2014). However, a recent Phase 3 trial was terminated after liver injury was noted in humans and cartilage injury noted in preclinical data with dogs (Sjouke et al, 2014). Currently, there are no known plans to continue with its development.
PCSK9
broprotein convertase subtilisin/kexin type 9 (PCSK9) is a secreted protein that regulates the hepatic LDL receptor (LDLR), and in turn circulating levels of LDL-C (Akram et al., 2010; Do et al., 2013). When an LDL particle binds to a hepatocyte LDLR in the absence of PCSK9, the LDL/LDLR complex undergoes endocytosis. In the acidic endosome, the LDLR dissociates from LDL and is recycled back to the hepatocyte surface to receive another LDL cargo, while the LDL
undergoes lysosomal degradation. When LDL binds to LDLR in the presence of PCSK9, the LDLR does not dissociate from LDL and is instead channeled toward lysosomal degradation. This action reduces LDLR density on the surface of hepatocytes, allowing levels of LDL-C to rise.

Gain-of-function mutations in PCSK9 are a cause of familial hypercholesterolemia and premature coronary heart disease, while loss-of-function mutations are associated with lifelong low levels of LDL-C and substantially reduced coronary heart disease risk (Davignon et al., 2010). Statins increase the expression of PCSK9, an effect that may attenuate the LDL-C lowering produced with these agents (Dubuc et al., 2004). Conversely, therapeutic interference with PCSK9 expression or action with small interfering RNA or monoclonal antibody (Frank-Kamenetsky et al., 2008; Dias et al., 2012; Stein et al., 2012) allows greater recycling of LDLR to the hepatocyte surface, resulting in lower LDL-C levels. Phase 2 clinical trials have demonstrated efficacy of PCSK9 antibody in achieving LDL-C reductions of up to 73% when added on to statin background therapy. In this trial when atorvastatin dose was increased from 10 to 80 mg daily and PCSK9 antibody was added, LDL-C was reduced by 73%, as compared to a 17% reduction with atorvastatin 80 mg alone (Roth et al., 2012) (Fig 2). Large Phase 3 clinical trials are testing the efficacy of PCSK9 antibodies to reduce major adverse cardiovascular events (NCT01764633 and NCT01663402). Because inhibition of PCSK9 does not impair hepatic lipid export, this approach is unlikely to cause hepatic steatosis. However, it is premature to assess whether very low LDL-C levels achieved in some patients treated with PCSK9 antibodies will lead to adverse long-term effects, or whether immunologic reactions to the antibodies will occur.

Lipoprotein (a)

Lipoprotein (Lp)(a) is an LDL-like particle in which apoB is covalently bound to apo(a). Both moieties may mediate atherogenicity. Apo(a) is structurally similar to plasminogen and can interfere with plasminogen activation and fibrinolysis (Hancock et al., 2003). Lp(a) can also carry oxidized phospholipids that may be pro-inflammatory (Wiesner et al., 2013). Epidemiologic data suggest that a high level of Lp(a) is an independent risk factor for the development of cardiovascular disease (Erqou et al., 2009). Serum levels of Lp(a) are influenced by genetic factors (Boerwinkle et al., 1992), but not by diet or lifestyle factors (Thomas et al., 1997). In cohort studies, cardiovascular risk associated with Lp(a) is independent of smoking, diabetes, hypertension, as well as LDL-C (Luc et al., 2002) (Fig 3).

Niacin exerts the greatest Lp(a) lowering effects among currently available lipid-modifying therapies. However, a 21% average reduction in Lp(a) with niacin was not associated with a lower event rate in the niacin arm, compared with placebo. This may indicate either that Lp(a) is not causally related to risk or that niacin produced other undesirable effects that negated a
benefit of raising Lp(a) (Boden et al., 2011). PCSK9 antibodies lower Lp(a) concentrations by mechanisms as yet unknown (McKenney et al., 2012). Lipoprotein apheresis can also remove Lp(a) from the circulation. In a prospective observational study in patients with elevated Lp(a), the initiation of lipoprotein apheresis was accompanied by a reduced incidence of cardiovascular events (Leebmann et al., 2013). Novel approaches to the reduction of Lp(a) involve the use of antisense oligonucleotides. Mipomersen reduces Lp(a) by approximately 25% (Visser et al., 2012) and antisense oligonucleotide to apo(a) has been shown to lower Lp(a) concentrations in a Phase 1 clinical study (Viney et al., 2013). The latter approach may provide the best tool to determine whether Lp(a) plays a direct, causative role in cardiovascular disease.

**Targets for reduction of triglyceride-rich lipoproteins**

Triglyceride-rich lipoproteins include VLDL, chylomicrons and the remnant particles formed from them upon the action of lipases. These particles contain apoB, C, and E and are believed to be atherogenic. *Post hoc* and meta-analyses of statin trials suggest that higher level of triglyceride-rich lipoproteins and their associated cholesterol correlate with higher cardiovascular risk (Miller et al., 2008; Bruckert et al., 2011).

Niacin and fibrates reduce triglycerides and have been in therapeutic use for many years. Early studies of these agents indicated a cardiovascular benefit. Although subsequent studies utilizing these agents in addition to statins failed to show overall benefit (Boden et al., 2011), *post-hoc* analyses suggest that patients with significant baseline hypertriglyceridemia benefit from fibrates (Lee et al., 2011). Other strategies to reduce triglyceride-rich lipoproteins, outlined below, are under active investigation.

**Omega-3 fatty acids**

Population studies demonstrate that cohorts with low levels of eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA) have higher levels of cardiovascular risk. Omega-3 fatty acids are found in fish oils and plants and have been observed to lower triglyceride levels, improve endothelial function, and have favorable effects on thrombotic and arrhythmic potential. The triglyceride-lowering effects of omega-3 fatty acids are due to multiple mechanisms, including stimulation of transcription factors such as PPARα, increased hepatic and extrahepatic fatty acid oxidation, and decreased hepatic incorporation of fatty acids into triglyceride resulting in decreased VLDL synthesis (Shearer et al., 2012). Despite efficacy in triglyceride lowering, data indicating a cardiovascular benefit alone or when added to statins are inconclusive (Rizos et al., 2012). A concentrated formulation of EPA, eicosapent ethyl, is being evaluated for effects on lipoproteins, biomarkers of cardiovascular risk, and clinical cardiovascular outcomes (Ballantyne et al., 2012; NCT01492361).

**Apolipoprotein C-III**

ApoC-III is located on the surface of triglyceride-rich lipoproteins including VLDL, chylomicrons, and their remnants and is implicated in cardiovascular disease. High levels of apoC-III are associated with delayed clearance of VLDL (Aalto-Setala et al., 1992) and may exert pro-inflammatory effects at the level of the artery wall (Kawakami et al., 2006). Further supporting its atherogenic role, those with dysfunctional apoC-III have lower cardiovascular risk. In two recent genetic studies, subjects with loss-of-function mutations in the gene encoding apoC-III were noted to have 39–44% lower levels of triglycerides and ~40% lower risk of coronary heart disease (Jørgensen et al., 2014; TG and HDL Working Group, 2014). An apoC-III antisense oligonucleotide has demonstrated substantial reductions in apoC-III, triglycerides (Fig 4) in
addition to elevations of HDL-C, without inducing hepatic steatosis (Graham et al., 2013). This agent is currently being evaluated in patients with severe hypertriglyceridemia. The impact of this approach on cardiovascular risk has not yet been studied. ApoC-III is also present on HDL particles. It is uncertain whether ApoC-III on HDL conveys pro- or anti-atherogenic properties (Cho, 2009; Riwanto et al., 2013).

**Diacylglycerol acyltransferase (DGAT)**

DGAT is an enzyme expressed in small intestine, liver, and adipose tissue. DGAT isoform 1 is involved in a final committed step of triglyceride synthesis from diacylglycerol. Inhibition of the enzyme may work to reduce serum triglyceride concentrations. Small molecule inhibitors have been developed, but clinical application is likely to be limited by gastrointestinal side effects (Denison et al., 2014).

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**Figure 4. Effects of apolipoprotein C-III antisense oligonucleotide (ASO).**

(A) Effects of VLDL-associated apoC-III in mice. Mice were administered control ASO or one of two doses of apoC-III ASO for 6 weeks. Western blot demonstrates a dose-dependent reduction of VLDL-associated apoC-III protein. (B) Effects of apoC-III ASO on circulating apoC-III and triglycerides in healthy human volunteers. ASO was administered by subcutaneous injections with loading dose followed by three weekly doses of either 50, 100, 200, or 400 mg. A dose-dependent response was demonstrated, with up to 75% reduction in apoC-III and 50% reduction in triglycerides, sustained over 50 days [Reproduced with permission from Graham et al. (2013)].
Apolipoprotein E

ApoE is a ligand for receptor-mediated clearance of chylomicron and VLDL remnants, which are particles that may promote atherosclerosis directly or through the action of lipases to release toxic products of lipolysis (Goldberg et al., 2011). ApoE also participates in the biogenesis of HDL, as it is recycled from triglyceride-rich lipoproteins in the liver (Zannis et al., 2008). ApoE mimetic peptides have been developed that exert anti-inflammatory effects, promote HDL function in vitro (Zhao et al., 2011), and oppose atherosclerosis in vivo. In LDL receptor knockout mice prone to atherosclerosis, ApoE mimetic peptides reduce plasma cholesterol and the extent of vascular lesions (Handatu et al., 2013). One ApoE mimetic peptide, AEM-28, has been granted orphan drug status by the US Food and Drug Administration and may enter early phase clinical testing.

HDL and related atheroprotective lipoproteins

HDL particles and associated apolipoprotein A-I are believed to be anti-inflammatory and atheroprotective (Besler et al., 2012). Experimental data support the concept that HDL and/or apoA-1 have vascular anti-inflammatory effects. For example, administration of reconstituted HDL to animals has been shown to reduce expression of adhesion molecules in vascular endothelium and to attenuate the inflammatory response to experimental arterial injury (Nicholls et al., 2005). Additionally, HDL may promote the expression of endothelial nitric oxide synthase and exert anti-thrombotic effects (Barter et al., 2004). Several large population studies reported an inverse relationship between HDL-C levels and prospective risk of cardiovascular events (Castelli et al., 1986), independent of atherogenic lipoprotein levels (Di et al., 2009).

Figure 5. Effect of dalcetrapib on HDL-C and cardiovascular risk after ACS.

Dalcetrapib was administered to patients with recent ACS on background statin therapy. While dalcetrapib raised HDL-C by 30% compared with placebo (top), there was no difference between groups in the primary endpoint of death from coronary heart disease, non-fatal myocardial infarction, hospitalization for unstable angina, resuscitation after cardiac arrest, or stroke from presumed atherothrombotic cause (bottom) [Reproduced with permission from Schwartz et al (2012)].
HDL facilitates reverse cholesterol transport and cholesterol efflux from peripheral tissues. Subpopulations of HDL interact with different membrane bound transporters such as ATP binding cassette A1 (ABCA1), ATP binding cassette G1 (ABCG1), and scavenger receptor-B1 (SR-B1) to assist in cholesterol efflux (Acton et al., 1996; Vaughan & Oram, 2006). Cholesterol is transferred to HDL particles, esterified by lecithin/cholesterol acyltransferase (LCAT), and then transported to the liver for excretion.

Yet, agents that substantially raised HDL-C failed to demonstrate corresponding clinical benefit (Boden et al., 2011; Schwartz et al., 2012). In epidemiologic analyses, cardiovascular risk is mainly evident at the lowest levels of HDL-C and does not necessarily support risk reductions by raising HDL-C to very high levels. Moreover, the protein cargo of HDL may be altered in patients with vascular disease and less protective (Besler et al., 2012; Riwanto et al., 2013). Despite these caveats, numerous approaches to modify HDL concentration and/or function continue to be evaluated.

**Niacin**

Of currently available drugs, niacin is the most effective at raising HDL-C, increasing levels by as much as 33% (Illingworth et al., 1994). The lipid-modifying effects of niacin are thought to be mediated by activation of G protein-coupled receptors in adipose tissue and liver leading to reduced lipolysis and hepatic VLDL synthesis, respectively (Kamanna & Kashyap, 2008). While early data demonstrated cardiovascular benefit (Canner et al., 1986), more recent clinical trials have failed to demonstrate a clinical benefit of niacin in statin-treated patients (Boden et al., 2011). These data suggest that alternative HDL-targeted therapies are required if this approach is to achieve reductions in cardiovascular risk.

**Cholesteryl ester transfer protein inhibitors**

Cholesteryl ester transfer protein (CETP) promotes the movement of esterified cholesterol from HDL to VLDL and LDL particles, in exchange for triglyceride. Lower CETP activity has been associated with increased cardiovascular risk (Fayad et al., 2006; Vaughan & Oram, 2006). Cholesterol is transferred to HDL particles, esterified by lecithin/cholesterol acyltransferase (LCAT), and then transported to the liver for excretion.

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A unique approach to HDL therapeutics involves the selective delipidation of a patient’s HDL, which is subsequently reinfused. Potentially, the lipid-poor HDL has greater capacity for cholesterol efflux. A small imaging study demonstrated coronary plaque regression with this approach (Waksman et al., 2010).

**Mimetic peptides**

Synthetic production of apoA-I presents a considerable challenge. In contrast, an alternative approach is in preparing short peptide sequences that lack genetic homology to apoA-I, but similarly form an amphipathic helix and associate effectively with lipids. Preclinical studies using these peptides have demonstrated favorable effects on cholesterol efflux, LCAT activation, inflammatory and oxidative pathways, and ultimately atherosclerotic plaque (Datta et al., 2001; Bielicki et al., 2010). CER-001, an HDL-mimetic made up of apoA-I and phospholipids, has been associated with reduction of vascular inflammation and atherosclerotic progression after short-term administration in mice (Tardy et al., 2014) as well as cholesterol mobilization in humans. In a Phase 2 trial, the primary endpoint of reducing atheroma volume compared with placebo was not reached (Tardif et al., 2014). However, the safety profile has thus far been acceptable, and the drug may be effective in reverse lipid transport. Thus, further study in clinical trials may be warranted.
Reverse cholesterol transport targets
Increasing expression of ABCA-1 provides a potential opportunity to target a major factor implicated in cholesterol efflux, as opposed to simply increasing carrier (apoA-1 or HDL) capacity. However, work in this field has not advanced clinically.

Similarly, development of chemical inhibitors of microRNA elements implicated in the regulation of lipid metabolism may be beneficial. MicroRNA (miR)-33 is an intronic microRNA that suppresses ABCA-1 expression and reduces HDL-C levels (Rayner et al., 2010). Early preclinical experience with miR-33 inhibitors demonstrates variable effects on atherosclerosis in animal models (Marquart et al., 2013; Rotllan et al., 2013). Given the central role of LCAT in reverse cholesterol transport by HDL, LCAT agonists have been developed and are undergoing preclinical evaluation (Chen et al., 2012).

HDL functional modification
Given disappointing results of HDL-C raising therapies in recent clinical trials (Barter et al., 2007; Boden et al., 2011), there is increasing interest in qualitative features of HDL function. HDL particles circulate as a heterogeneous population of lipoproteins, differing in size, shape, protein, and lipid composition (Rosenson et al., 2011). Furthermore, mass spectrometry has demonstrated more than 100 individual proteins that can be carried on HDL particles, many with activities beyond lipid metabolism, and many that are altered in patients with vascular disease compared with healthy control (Riwanto et al., 2013). Data indicating that cholesterol efflux capacity is a better predictor of atherosclerotic burden than HDL-C concentration suggest that HDL quality may be a better indicator of the efficacy of novel HDL-targeted therapies (Haﬁane et al., 2014).

Other approaches affecting lipoprotein metabolism
Nuclear receptors
Nuclear receptors including liver X receptors (LXRs), peroxisome proliferator-activated receptors (PPARs), and farnesoid X receptors (FXR) play a central role in lipid metabolism. The reader is referred to other reviews for discussion of bile acid receptors, including FXRs (Porez et al., 2012).

Liver X receptor
LXRs are thought to serve as cholesterol sensors that when activated, increase biliary cholesterol excretion, reduce intestinal cholesterol absorption, and promote reverse cholesterol transport. LXR agonists have been demonstrated to attenuate atherosclerosis in animal models (van der Hoorn et al., 2011). However, a poten-tially limiting factor in clinical treatment with LXR agonists is the stimulation of hepatic lipogenesis (Fievet & Staels, 2009). LXR agonists have been demonstrated to attenuate atherosclerosis in animal models (Kappus et al., 2014). Some LXR agonists have been evaluated in early stage clinical trials (Katz et al., 2009; NCT00796575, NCT00836602, NCT01651273, NCT01651273), but their development for cardiovascular disease appears to have been halted. It remains uncertain whether agents can be developed to exploit the potential beneﬁts of LXR activation while avoiding hypertriglyceridemia and hepatic steatosis.

Peroxisome proliferator-activated receptors (PPARs)
PPARs (α, γ, or δ) play important roles in the regulation of fatty acid and lipoprotein metabolism. Among their principal actions, PPARα promotes fatty acid oxidation in liver and muscle, lowers circulating triglycerides and apoC-III, and raises HDL-C, PPARγ promotes fatty acid uptake by adipocytes and lowers circulating fatty acids, and PPARδ promotes fatty acid oxidation in muscle and adipose tissue. Fibrate and thiazolidinedione drugs are ligands of PPARs and PPARy, respectively. Early studies showed that gemﬁbrozil, a ﬁbrate, reduced cardiovascular morbidity and mortality (Frick et al., 1987; Robins et al., 2001). However, subsequent studies evaluating the addition of ﬁbrates to statins have not demonstrated clinical beneﬁt (ACCORD Study Group, 2010). Yet, meta-analysis indicates that ﬁbrates may confer clinical beneﬁt in patients with triglyceride levels at least 200 mg/dl, even with statin co-treatment (Bruckert et al., 2011). In this regard, it may be premature to conclude that ﬁbrates are inefﬁcacious in reducing residual cardiovascular risk. Composite evidence suggests cardiovascular efﬁcacy of pioglitazone, a thiazolidinedione (Lincoff et al., 2007). Yet, a dual PPAR-α/γ activator has failed to demonstrate clinical efﬁcacy (Lincoff et al., 2014). Selective PPAR-γ activators (Choi et al., 2012) and dual PPAR-α/δ activators (Cariou et al., 2013) have been evaluated in early phase clinical trials, but their cardiovascular efﬁcacy remains untested.

Phospholipase inhibitors
The phospholipase A2 family of enzymes hydrolyzes the sn-2 ester bond of phospholipids in cell membranes and circulating lipoproteins, generating metabolites that may inﬂuence vascular function and inﬂammation. Secretory phospholipase A2 (sPLA2) activity results in the generation of smaller, more atherogenic LDL particles and the generation of pro-inﬂammatory and oxidative metabolites within the artery wall (Hurt-Camejo et al., 2001). However, a Phase 3 study evaluating the sPLA2 inhibitor varespladib in patients with acute coronary syndrome demonstrated increased risk of recurrent myocardial infarction (Nicholls et al., 2014). Lipoprotein-associated phospholipase A2 (Lp-PLA2) is largely associated with LDL. Elevated plasma concentrations or activity is associated with greater cardiovascular risk. In early phase studies, the Lp-PLA2 inhibitor, darapladib, demonstrated favorable effects on lipid and inﬂammatory biomarkers and a reduction of the volume of necrotic core within atherosclerotic plaques (Serruys et al., 2008). However, a large outcome trial failed to demonstrate a beneﬁt of darapladib on cardiovascular death, myocardial infarction, or stroke (STABILITY Investigators, 2014).

Conclusion
LDL-C, triglyceride-rich lipoproteins, and HDL-C may each play a role in the development and progression of atherosclerosis and its complications. For more than a quarter century, statins have been the central element of lipid-modifying therapy to reduce cardiovascular risk. However, residual cardiovascular risk on statin treatment remains high. To date, no agent added to statins has yet been proven to provide incremental clinical beneﬁt. However, novel approaches to further reduce LDL, to target triglyceride-rich lipoproteins, and to increase the concentration or functionality of HDL are
under evaluation in basic investigations and in clinical trials, holding promise that tools to further reduce cardiovascular morbidity and mortality may be forthcoming.

Conflict of interest
Dr. Rose Do, through her institution, has received research support from Sanofi. Dr. Stephen Nicholls has received research support from Amgen, AstraZeneca, Cerenis, Novartis, Resverlogix, Eli Lilly, LipoScience, and Roche. He also serves as a consultant for Amgen, AstraZeneca, AtheroNova, Boehringer Ingelheim, Cerenis, CSL Behring, Eli Lilly, LipoScience, Merck, Novartis, Pfizer, Resverlogix, Roche, and Takeda. Dr. Gregory Schwartz, through his institution, has received research grants from Sanofi, F. Hoffmann-La Roche, and Anthera Pharmaceuticals.

For more information
International Atherosclerosis Society – scientific organization dedicated to advance research and therapy in the area of atherosclerosis and its complications. http://athero.org
National Lipid Association – scientific and medical organization dedicated to advance lipid management in clinical medicine. https://www.lipid.org/
National Heart Lung and Blood Institute of the National Institutes of Health – US government agency dedicated to basic and clinical research in cardiovascular disease, including atherosclerosis. Web site provides information for patients and healthcare/scientific professionals. http://www.nhlbi.nih.gov/health/health-topics/topics/atherosclerosis/

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