Abstract

Background: The pathogenesis of Alzheimer’s disease (AD) is believed to be occurred by the production of neurotic plaques of the beta-amyloid peptide (Aβ) and deposition of them. Therefore, biomarkers of abnormal Aβ processing may represent before the AD clinical biomarkers, which could be benefit for a successful disease management that may prevent the AD development. The aim of this study is to investigate of plasma Aβ40,42 levels in Alzheimer's patients in Syria and thus determine whether they may have a potential role as biomarker for identifying and predicting AD.

Methods: In this cross-sectional study, the plasma levels of Aβ1-40 and Aβ1-42 were investigated in two groups represent Syrian population, AD group; clinically diagnosed AD patients (n=50) and CN group; cognitively normal participants (n=33). This study first determined the reference interval of plasma Aβ1-40 and Aβ1-42 for cognitively normal Syrian. Results were analyzed using SPSS, 24, depending on independent-samples t test, considering that the value of p < 0.05 is statistically significant.

Results: The results showed that the plasma levels of Aβ1-40 (p<0.001, OR=1.031, 95%CI: 1.012-1.051) and Aβ1-42 (p<0.001, OR=1.306, 95%CI: 1.145-1.490) were significantly higher in AD patients than in cognitively normal participants, and no significant association was shown between both of education and sex with plasma Aβ levels.

Conclusion: The plasma levels of Aβ1-40 and Aβ1-42 could be potential biomarkers for identifying and predicting AD.

Keywords: Alzheimer disease, Aβ40,42, Biomarkers, Syria

Introduction

According to the World Health Organization (WHO), worldwide, around 50 million people have dementia, and there are nearly 10 million new cases every year. The total number of people with dementia is expected to reach 82 million in 2030 and 152 million in 2050. Alzheimer’s disease (AD) is the most common form of dementia and could contribute to 60–70 percent of cases. World Health Organization reveals that about 60% of all people living with dementia worldwide are from a low to middle income countries (1).

AD is characterized by a gradual and progressive decline in cognitive functions and the presence of specific neuron and synapse loss in addition to the senile plaques and neurofibrillary tangles. For diagnosis of AD, the presence of neurotic plaques (composed of highly insoluble amyloid-β (Aβ) peptide in large part) in the brain parenchyma is needed. This concept suggests that a plaque deposition occurs as a result of chronic imbalance between

†What is “already known” in this topic:
Aβ is a biomarker that plays an important role in AD diagnosis, where it accumulates in the brain and forms plaques that lead to neurons damage. There are many studies, in several countries, that investigate Aβ plasma levels in AD patients and there is a contradiction in their results.

→What this article adds:
In Syria, there are no studies on the normal and pathological plasma values of Aβ. It is the first study on plasma levels of Aβ in AD patients in Syrian population.
Plasma Aβ in Syrian AD patients

production the amyloid-beta peptide and clearance of it (2).

The beneficial roles of amyloid-β involve repairing leaks in the blood-brain barrier (BBB), contributing in healing the injury, protecting the body from infections and controlling synaptic perform. Evidence for these putative roles comes from in vivo and in vitro studies, which showed that amyloid-β generation increases rapidly in a physiological challenge response and usually reduces once healing (3).

A biomarker or biological marker, assesses as an index of normal biological functions, pathogenetic conditions or responses to a therapeutic procedure. A biological marker can evaluate as an indicator of healthiness and illness (4).

Amyloid precursor protein (APP) gene is expressed in the brain and other parts of the body tissues. The molecular mechanism implicated in APP breakage down and amyloid-β synthesis has yet to be determined precisely (5).

Amyloid-β peptide is produced by a number of actions of alpha (α), beta (β) and gamma (γ) secretases on APP. Amyloid-β is generated in the endoplasmic reticulum (ER), Golgi apparatus and endosomal compartment by the action of β-secretase and γ-secretase (6). Therefore, several amyloid-β pieces have been produced, but those ending at location 40 (Aβ1-40) are the most plentiful (approximately 80-90 percent), then those ending at location 42 (Aβ1-42, approximately 5-10 percent). The somewhat longer species of amyloid-β, mainly Aβ1-42, have more hydrophobicity and fibrillogenesis properties, and they are the mainly pieces positioned into the brain (7).

Taking cerebrospinal fluid (CSF) samples is an annoying procedure with probable side effects, with the difficulties in screening of patients and making follow-up studies of the same patient for many years. So, there is an urgent need to do researches for determining biomarkers in other body fluids such as blood to make an accurate diagnosis of Alzheimer’s disease (8).

It is not comprehended yet how the blood molecule level associates with pathological alterations in the brain, particularly in Alzheimer’s disease. Therefore, identifying biomarkers in the blood that associate with Alzheimer’s disease must initiates with established biomarkers in CSF, such as biomarkers linked to amyloid-β and tau protein (4). Furthermore, there is no accepted reference values for amyloid-β in the plasma. A study of the reference values of Aβ in the plasma for cognitively normal Korean adults revealed that the 95th percentile reference values for Aβ1-40 were 127-331 pg/mL and for Aβ1-42 were 2.31-19.84 pg/mL (9). Another study in Poland showed that the plasma levels of Aβ1-40 and Aβ1-42 in control group were 160.1±15.2 pg/mL and 36.3±6.3 pg/mL, respectively (10). A study in USA found that the Aβ40 and Aβ42 plasma levels in control were 211.4±74.4, 31.6±14.0 pg/mL, respectively (11). Further researches are needed to identify clear reference interval in other countries.

In Syria, there are no studies on the normal and pathological plasma values of Aβ. So that, there is an urgent need to more studies related to this field. The fact that the pathophysiological alterations associated with Alzheimer’s disease begin several years before the appearance of clin-
Results

**Aβ1-40 and Aβ1-42 levels in AD group and CN group**

Plasma Aβ levels were investigated in 83 subjects; AD group (clinically diagnosed AD patients, n=50; 19 men and 31 women, 41 workers and 9 employees) and CN group (control group of cognitively normal subjects, n=33; 15 men and 18 women, 24 workers and 9 employees) (Table 1).

The comparison between both groups showed that the plasma levels of both Aβ1-40 and Aβ1-42 were higher in AD patients (AD group) than in cognitively normal participants (CN group) and this augmentation of Aβ was significant for both Aβ1-40 (p<0.001, OR=1.031, 95%CI: 1.012-1.051) and Aβ1-42 (p<0.001, OR=1.306, 95%CI: 1.145-1.490), taking into account that individuals in both groups are of the same age group and that they are matched in gender and the number of the educated and uneducated, and no significant difference was shown between both groups (AD and CN) with regard to age, education and sex (p>0.05) (Table 1).

Figure 1 shows the results of Aβ1-40 levels in AD group and CN group; 155.95±39.08 pg/mL and 118.96±34.94 pg/mL, respectively. Also this figure shows the mean values of Aβ1-42 levels in AD group and CN group; 25.25±22.16 pg/mL and 8.39±6.59 pg/mL respectively.

**Levels of Aβ1-40, Aβ1-42 according to gender and Job**

Table 2 shows that there is no significant difference in Aβ levels between the educated (employees) and the uneducated (workers) subjects in AD group. Our results show that there is also insignificant difference between Aβ

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**Table 1.** Characteristics of Subjects involved in the study and levels of Aβ1-40, Aβ1-42

| Variable    | AD (Groups) | CN | p     |
|-------------|-------------|----|-------|
| N           | 50          | 33 | 0.568 |
| Age > 60    | (60-100)    | (60-89) |     |
| Gender      | Female n (%)| 49 (59.04%) | 31 (62%) | 0.499 |
|             | Male n (%)  | 34 (40.96%) | 19 (38%) |     |
| Job         | Workers n (%)| 18 (21.69%) | 9 (18%)  | 0.502 |
|             | Employees n (%)| 65 (78.31%) | 41 (82%) |     |
| Aβ1-40 pg/mL| mean ± SD   | 155.95±39.08 | 118.96±34.94 | <0.001 |
| Aβ1-42 pg/mL| mean ± SD   | 25.25±22.16  | 8.39±6.59   | <0.001 |

AD: Alzheimer Disease, CN: Cognitively Normal, Aβ: Amyloid-β, SD: Std. Deviation

**Table 2.** Levels of Aβ1-40, Aβ1-42 according to gender and Job

| Sex | Female | Male | p     | Workers (uneducated) | p     | Employees (educated) | p     |
|-----|--------|------|-------|----------------------|-------|----------------------|-------|
| AD (n) | 31 | 19 | 41 | 9 |       |       |       |       |
| Aβ (1-40) pg/mL mean ± SD | 152.50± 28.04 | 161.47± 52.92 | 0.552 | 150.00± 19.86 | 0.550 | 159.00± 4.24 | 0.833 |
| Aβ (1-42) pg/mL mean ± SD | 23.16± 14.81 | 20.43± 9.70 | 0.518 | 15.48± 4.10 |       | 16.00± 0.40 |       |

AD: Alzheimer Disease, Aβ: Amyloid-β, SD: Std. Deviation
Discussion

**Aβ1-40 and Aβ1-42 levels in AD group and CN group**

The plasma levels of both Aβ1-40 and Aβ1-42 in our study are close to other studies (10, 14). Our results are in accordance with a study in Taiwanese cohorts that revealed a significant increase in the plasma levels of Aβ1-42 in mild cognitive impairment (MCIs) individuals, and in early stages of Alzheimer’s disease (15). The Aβ1–42 is less recurrent than Aβ1–40. However, it deposits much earlier and accumulates more quickly in comparison with Aβ1–40 (16).

Our results were consistent with the results of previous clinical studies (10, 14, 17) which had found also that the plasma levels of both Aβ1-40 and Aβ1-42 were higher in AD patients than in cognitively normal people. These results may be explained depending on the assumption of other studies which suggested that the circulating amyloid-β may infuse via BBB and promote the accumulation of amyloid-β in the brain. Since the expression of APP occurs in several tissues in addition to the brain. Therefore, the levels of amyloid-β can be detected in the blood (18). Normally, liver and kidneys facilitate the circulating amyloid-β systematic clearance through identified transporter. Thus, the circulating amyloid-β level increases when the systematic clearance is defective as in Alzheimer’s disease patients, in addition to that the free circulating amyloid-β would be augmented by the increasing of oxidative damage which happens in Alzheimer’s disease damage (18).

A study on rodents showed that the circulating amyloid-β may flow through the BBB (19), by identified receptor of advanced glycation end products (RAGE), and a RAGE up-regulation was noticed in Alzheimer’s disease human patients.

On the other hand, other studies (20, 21) found that the levels of plasma amyloid-β were lower in AD patients than in cognitively normal people. This may be due to the assumption of that the BBB won’t clear the amyloid-β from CSF into the blood through specific lipoprotein receptor related protein 1 (LRP-1) due to its dysfunction which could happen in Alzheimer’s disease, and thus contribute to aggregation of amyloid-β in the brain (22).

These conflicting results could be as a result of several factors that can affect the plasma amyloid-β peptide level as it has been suggested in some studies (23, 24), for instance, sex, age, levels of plasma proteins, function of kidney, race and stage of disease. Amyloid-β peptides in plasma are bound to other plasma proteins easily and broken down in the blood (25). So, the results of plasma amyloid-β could be affected by the levels of total protein.

Variance in studies cohort, such as cognitive decline stage, cognitive function estimation (by various examinations), treatment and other illnesses, all of these issues can affect the results of different studies (26). Plasma amyloid-β may be increased by alterations in renal function, since plasma amyloid-β is normally excreted via the kidneys (27). The traditional technique of quantifying the plasma amyloid-β is sandwich ELISA, but the plasma proteins and lipoproteins could affect immunological detection (28). In addition to that, soluble amyloid-β pieces bind to numerous proteins, for instance, albumin as well as other proteins. These complexes could affect ELISA immunoreactions and also influence the results (29).

**Levels of Aβ1-40, Aβ1-42 according to gender and Job**

Our results are consistent with those of some studies that have not found a significant correlation between amyloid-β levels and education (30). But it contrasts with other studies that have shown a statistical association with education (31). Our results show that there is also insignificant difference between Aβ levels in males and females in AD group, and this is consistent with the result of other study on African American that did not find a significant difference between men and women in terms of levels of amyloid beta (32), but it contradicted on the other hand with other clinical studies that showed a significant correlation between sex and levels of amyloid beta (31).

The limitations of this study are the relatively small sample size in addition to that the patients are not classified according to the stages of the disease. So, further researches and studies are recommended with considering the stages of disease, increasing size of sample, and adjusting the study conditions.

**Conclusion**

In conclusion, plasma beta-amyloid 40 and 42 may be important biomarkers and could help in Alzheimer’s disease diagnosis.

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**Conflict of Interests**

The authors declare that they have no competing interests.

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