High Serum Aβ and Vascular Risk Factors in First-Degree Relatives of Alzheimer’s Disease Patients

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The main objective of this study was to determine whether elevated blood β-amyloid (Aβ) levels among the first-degree relatives of patients with Alzheimer’s Disease (AD) are associated with vascular risk factors of AD. Serum Aβ was measured in samples from 197 cognitively normal first-degree relatives of patients with AD-like dementia. Study participants were recruited as part of an ancillary study of the Alzheimer’s Disease Anti-Inflammatory Prevention Trial (ADAPT subpopulation). The ADAPT subpopulation was found to be similar in age, sex, and ethnicity to another cognitively normal cohort (n = 98). Using cross-sectional analyses, we examined the association of Aβ with blood pressure, lipid levels, apolipoprotein E genotypes, and the use of prescribed medication to treat vascular risk factors in the ADAPT subpopulation. Aβ1-42 was positively associated with age, use of antihypertensives, and serum creatinine, and we observed a marginal negative interaction on Aβ1-42 associated with systolic blood pressure and use of antihypertensives. Serum Aβ1-42 was associated with statin use and a positive correlation of Aβ1-42 with HDL was observed among statin nonusers. These findings suggest that high Aβ in the periphery among the family history-enriched cohorts may be due to enrichment of vascular risk factors and may reflect presymptomatic AD pathology. It remains to be determined whether the association of Aβ with medications used for treating vascular risk factors indicates prevention of AD. Longitudinal evaluation of blood Aβ in this cohort will provide a better understanding of the significance of this association in AD etiology.

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INTRODUCTION

Alzheimer’s Disease (AD) is characterized clinically by progressive cognitive impairment and pathologically by the presence of β-amyloid (Aβ) plaques and neurofibrillary tangles. The etiology of the rare early-onset familial form of AD has been attributed to mutations in the genes for amyloid precursor protein (APP) and presenilin 1/2 (PS1/2). These mutations lead to aberrant proteolytic processing by the β- and γ-secretases, followed by increased production of Aβ1-42 and Aβ1-40 fragments (1). Pathogenesis of the common late-onset AD (LOAD) remains unclear, although it is postulated that either excessive Aβ production or reduced Aβ clearance may result in the accumulation and deposition of Aβ in the brain. Therefore, evaluation of the underlying mechanisms with respect to Aβ clearance from the brain into cerebrospinal fluid and blood remains an area of active investigation.

Despite uncertainty regarding the origin of Aβ in the blood, several studies provide strong evidence for the association of altered blood Aβ levels with AD risk, onset, and progression (2–6). Among AD patients, an initial increase in blood Aβ1-42 is followed by a decrease (2), and an increase in Aβ1-42 over time was shown to be a significant predictor of conversion to mild cognitive impairment or AD (5). More recently, Aβ1-42 was shown to be higher in patients with mild cognitive impairment compared with both AD patients and controls (7). These findings suggest that alterations in blood Aβ levels may be a reflection of brain Aβ pathology.

Evidence for a significant heredity component to blood Aβ1-42 and Aβ1-40 levels comes from family-based genetic linkage analyses pointing to markers on chromosomes 10 (8) and an increase in plasma Aβ1-42 among the first-degree family members of patients with LOAD has also been observed (9). Mutations in PS1/2 genes are shown to influence blood Aβ1-42 levels in early-onset AD patients and their presymptomatic relatives (10,11). However, governance of elevated blood Aβ1-42 levels in the first-degree relatives of LOAD patients remains unexplained by these genes (9). Familial clus-
tering in LOAD is attributed to an increased occurrence of the apolipoprotein E (APOE) ε4 allele, but it accounts for only 13.7% of the AD incidence (12–14), and no relationship of blood Aβ1-42 with ε4 carrier status has been observed in the first-degree relatives of LOAD patients (9). Thus, a possibility remains for presence of other factors that may impact blood Aβ in the first-degree relatives of LOAD patients.

Vascular risk factors are shown to play a significant role in the etiology of LOAD (15). Several studies provide strong evidence that high blood pressure and hypercholesterolemia are associated with an increased risk of dementia, including AD (16–19). Therefore, we hypothesize that these vascular risk factors may impact blood Aβ levels. Support for this hypothesis comes from a study of two independent mouse models of hypertension, which demonstrated that chronic hypertension results in increased brain Aβ deposition in the cortex and hippocampus attributable to increased permeability of the blood-brain barrier. This finding suggests that chronic hypertension may be responsible for brain Aβ deposition by either reducing brain Aβ clearance or allowing entrance of peripheral Aβ into the brain (20). Cholesterol clearance pathways are also fundamental to AD pathophysiology, and a key receptor for lipoprotein, low-density lipoprotein (LDL)-receptor-related protein 1, has been shown to mediate Aβ clearance from the brain via its transport across the blood-brain barrier. Alteration in expression of LDL-receptor-related protein 1 and a receptor for advanced glycation end products in AD mouse models is shown to result in dysregulation of Aβ efflux/influx across the blood-brain barrier, further enhancing brain Aβ deposition (21). These findings suggest that chronic hypertension and a dysfunction in cholesterol efflux pathways may disrupt brain Aβ homeostasis.

It is widely accepted that the AD process begins decades before the presence of clinical symptoms, and the relevant peripheral Aβ levels associated with AD pathology may be those observed several years prior to the appearance of cognitive symptoms. The examination of vascular risk factors for AD and Aβ levels among cognitively normal individuals may provide insight into the potentially pathologic processes that may predispose individuals to an increased risk. The cognitively normal cohort with an enriched family history of AD-like dementia may be a high-risk population for development of this disease and an ideal group for evaluation of vascular risk factors of AD and blood Aβ levels. Therefore, in this study, we examined the potential association between serum Aβ1-40 and Aβ1-42 levels and vascular risk factors among cognitively normal first-degree relatives of patients with AD or related dementia.

MATERIAL AND METHODS

Study Population and Data Collection

The Alzheimer’s Disease Antiinflammatory Prevention Trial (ADAPT) was a multicenter trial funded by the National Institutes of Health to test the effects of nonsteroidal antiinflammatory drugs (NSAIDs) on the prevention of AD. The participants in ADAPT were selected based on the presence of a first-degree relative with AD-like dementia. The study intervention (celecoxib, 200 mg twice a day; naproxen sodium, 220 mg twice a day; or placebo) was randomly assigned to each participant. At eligibility determination a study-specific standard questionnaire was administered, which included questions pertaining to the presence of cardiovascular disease and associated vascular risk factors. Data were collected on history of angina, congestive heart disease, occurrence and number of strokes, and current and/or past use of medications for hypertension, hypercholesterolemia, and diabetes. Vital signs, such as blood pressure and weight, were also measured. To determine eligibility a physical exam was conducted by a medical doctor, and a brief neuropsychological battery was administered by trained psychometricians. A similar questionnaire aimed at gathering new occurrences of the above data during the length of the trial was administered at each semiannual in-person visit (physical exam and cognitive testing was performed at each annual visit). Blood samples were collected for safety monitoring at these visits, which included measurement (performed by Covance) of serum creatinine, total cholesterol, LDL, and high-density lipoprotein (HDL). Additional information on eligibility and methods is available at http://www.jhucc.com/adapt/manal43.pdf.

For this ancillary study, 197 cognitively normal participants (ADAPT subpopulation) were recruited from the Tampa Bay area and Sarasota (Florida site), and additional blood samples were collected at the semiannual visits to measure Aβ levels. Within the ADAPT subpopulation, we examined the association of Aβ with total cholesterol, LDL, HDL, systolic blood pressure (SBP), diastolic blood pressure (DBP), serum creatinine, and use of prescribed medications to treat vascular risk factors. Self reports of current use (at the time of the blood draw for this ancillary study) of angiotensin-converting enzyme inhibitors, angiotensin II receptor blockers, dihydropyridines, and nondihydropyridine calcium-channel blockers were combined into one single binary variable as antihypertensives use, and code was indicated by 1 for yes. Similarly, current use of statins was also coded as 1 into a separate binary variable. Aβ levels were also examined with the study treatment assignments and this was coded into a single categorical variable for which placebo was coded as 0, celecoxib as 1, and naproxen as 2.

Another cognitively normal group (non-ADAPT) was used only for comparison of general demographics, hypertension, hypercholesterolemia, diabetes, APOE genotypes, and serum Aβ with the ADAPT subpopulation. This non-ADAPT group consisted of 98 participants recruited from the local retirement centers in Tampa and Sarasota, Florida. Family history data were avail-
able for 82 of the non-ADAPT group, and 37 of those had a positive family history. For this non-ADAPT cohort, history of past or present occurrence of conditions such as hypertension, hypercholesterolemia, diabetes, and cardiovascular diseases, and current use of prescribed medications, was also collected by self-report via answers to an intake questionnaire. A mini-mental status examination was administered to determine cognitive status. In addition, these individuals maintained independent activities of daily living and were free of active neurological illness, psychiatric disorders, or other medical conditions that would potentially interfere with their cognitive performance. For both study groups, past or present occurrence of hypertension, hypercholesterolemia, and diabetes was coded as 1 in separate binary variables.

Ethical Considerations
The Western Institutional Review Board approved this study.

Sample Collection and Preparation and Aβ Measurements
Venous blood was collected in serum separator tubes (BD Diagnostics, Oxford, UK), allowed to clot for 30 min, centrifuged for 15 min at 1380 g, aliquoted, and immediately frozen at –80°C. The Aβ, aliquoted, was determined with either the Student t test or χ² statistics, based on the type of variable. Upon evaluation of normality, Aβ₁-42 levels were determined to be positively skewed. Therefore we used the Mann-Whitney test to determine group differences and the Spearman’s correlation coefficient (rho) to assess possible linear associations. The means and standard deviations were used to summarize symmetric continuous variables; and the medians and interquartile ranges (IQR) were used to summarize data with nonsymmetric distributions. Regression modeling was employed to examine the multivariate relationship of vascular risk factors with Aβ₁-40 and given the lack of normality of the Aβ₁-42 data, the bootstrap resampling approach was used to estimate standard errors. These analyses were exploratory; no adjustments were made for multiple testing, and therefore the results are interpreted cautiously.

RESULTS
Difference in hypertension, diabetes, hypercholesterolemia, APOE ε4 carrier status, and basic demographics were evaluated between the ADAPT subpopulation and the non-ADAPT group. Both groups were volunteer based and similar in age, sex, and ethnicity (Table 1). Comparison of Aβ₁-40 levels between these two groups revealed that Aβ₁-40 and Aβ₁-42/Aβ₁-40 ratios were higher in the ADAPT subpopulation than the non-ADAPT group (Table 1). Age was associated with Aβ₁-40 in both of these groups; a correction for age was applied, and the difference in Aβ₁-40 was no longer significant (Table 1). Age was not associated with Aβ₁-42, and sex was not associated with Aβ₁-42 or Aβ₁-40 levels. Though not significant, the proportion of individuals with APOE ε4 genotypes, hypertension, and diabetes was higher in the ADAPT subpopulation compared with non-ADAPT (Table 1). Frequency of individuals with hypercholesterolemia was significantly higher in the ADAPT subpopulation compared with non-ADAPT (Table 1).

The following analyses were performed only within the ADAPT subpopulation to determine possible relationships between the use of medications to

Table 1. Comparison of the non-ADAPT and ADAPT subpopulations. a

| Variable                  | Non-ADAPT subjects (n = 98) | ADAPT subpopulation subjects (n = 197) | P-value |
|---------------------------|----------------------------|--------------------------------------|---------|
| n (%)                     |                            |                                      |         |
| Female (%)                | 54 (55)                    | 91 (47)                              | 0.17    |
| White (%)                 | 96 (98)                    | 193 (98)                             | 0.68    |
| Diabetes (%)              | 8 (8)                      | 19 (10)                              | 0.74    |
| Hypertension (%)          | 55 (57)                    | 122 (62)                             | 0.39    |
| Hypercholesterolemia (%)  | 38 (39)                    | 103 (52)                             | 0.03    |
| APOE ε4 allele (%)        | 27 (28)                    | 63 (32)                              | 0.44    |
| Mean ± SD                 |                            |                                      |         |
| Age (years)               | 75.2 ± 8.21                | 76.8 ± 3.93                          | 0.07    |
| Serum Aβ₁-40 (pg/mL) a    | 132.6 ± 49.65              | 146.3 ± 54.59                        | 0.13    |
| Median (IQR)              |                            |                                      |         |
| Serum Aβ₁-42 (pg/mL) b    | 4.9 (2.9, 9.1)             | 12.0 (5.0, 22.9)                     | P < 0.001|
| Serum Aβ₁-42/Aβ₁-40       | 0.04 (0.02, 0.07)          | 0.08 (0.05, 0.15)                    | P < 0.001|

a Aβ₁-40 below detection limit for 9 individuals and Aβ₁-42 below detection limit for 18 individuals.

b Differences in Aβ₁-42 between the two groups are corrected for age.
between diastolic blood pressure with placebo, celecoxib, or naproxen were determined to be in Hardy-Weinberg equilibrium. No statistically significant differences with APOE genotype were observed, although median Aβ42 levels were generally lower in the ε4 carriers (non-ε4 carriers, median 12.14 pg/mL [IQR 4.85–24.16 pg/mL]; ε4 heterozygotes, median 10.56 pg/mL [IQR 6.49–22.53 pg/mL]; and ε4 homozygotes, median 10.11 pg/mL [IQR 3.72–16.90 pg/mL]).

**DISCUSSION**

Findings reported here show significantly higher Aβ42 among the ADAPT subpopulation (selected based on the presence of first-degree relatives with AD) compared with the non-ADAPT group. These findings are consistent with
those of Ertekin-Taner and colleagues showing elevated Aβ1-42 in another family history–enriched cohort (9). Although several studies have shown differences between APOE ε4 carriers and noncarriers with cognitive decline and disease progression, a clear association of APOE ε4 status with plasma Aβ has not yet been demonstrated (23,24). Therefore, we speculate that elevated Aβ1-42 among first-degree relatives of sporadic AD patients may be indicative of increased Aβ production due to genetic and/or other risk factors.

Alteration in cholesterol levels and homeostasis have been associated with AD pathology (18,19), although possible reduction in AD risk with statin use remains controversial owing to the inconsistancy of past findings (25). Furthermore, data from several recent studies, including data from another ADAPT ancillary study, suggest lowered risk of AD among statin users (26–28). However, plasma Aβ remains unaltered after statin treatment among AD or hypercholesterolemia patients (29). A significant increase in blood Aβ1-42 levels among statin users in the ADAPT subpopulation was observed and is similar to the findings among males from a non–family-based sample (30). Because individuals with hypercholesterolemia are likely to be statin users and also at increased risk for AD, it is possible that higher Aβ1-42 among statin users may be incidental and just a reflection of this increased risk of AD. However, longitudinal studies are required to determine the consequence of statin therapy on Aβ1-42 levels as it relates to AD risk.

Several studies show that HDL in human serum binds to Aβ via interaction with apoA, apoJ, and apoC-III (31–34). We found a significant positive correlation of HDL levels with Aβ1-42 levels among statin nonusers. Similarly, a previous study evaluating plasma Aβ1-42 among 18 healthy individuals found a correlation between HDL and Aβ1-42 (35). However, Mayeux and colleagues reported an association of HDL with Aβ1-40 instead (2). These discrepancies may be due to differences in population characteristics or disease stages, but nevertheless suggest a probable association of HDL with peripheral Aβ. Thus, these findings suggest that a positive association of Aβ1-42 with HDL may be due to its clearance from the brain. Longitudinal follow-up of this ADAPT subpopulation is required to fully understand this association between HDL and Aβ1-42.

As with Blasko and colleagues, we observed no association of Aβ1-42 with the use of anti-hypertensives (30). Instead, elevated Aβ1-40 among the ADAPT subpopulation on antihypertensives and a negative interaction between use of antihypertensives and SBP on Aβ1-40 levels were detected. These findings may suggest that among individuals not on antihypertensives, association of SBP and Aβ1-40 levels may be indicative of increased risk for AD and may reflect increased Aβ1-40 production. However, among individuals who use antihypertensives, the observed association with Aβ1-40 may indicate increased clearance from the brain, but further studies are required to fully understand the mechanisms behind increased production versus increased clearance with respect to blood Aβ measurements in sporadic AD.

Consistent with other reported studies, our study showed a significant positive association between Aβ1-40 and serum creatinine (2,36). The cause of this relationship is still unclear, and its examination may be helpful in furthering our understanding of AD pathology.

Naproxen, a nonselective cyclooxygenase inhibitor, has been shown to preferentially lower Aβ1-42 in vitro (37). Because the ADAPT cohort received NSAIDs, we evaluated the potential effect of these interventions on both Aβ1-40 and Aβ1-42 in the ADAPT subpopulation and found no difference between the effects of placebo, celecoxib, and naproxen treatments on Aβ1-40 and Aβ1-42 levels. Although data from a pooled study of six different cohorts suggest that reduced incidence of AD is associated with NSAID use, there was no apparent advantage attributed to Aβ-lowering compounds (38). More recently, a disease-modifying clinical trial for AD using R-flurbiprofen, a selective Aβ1-42-lowering NSAID, failed to show any efficacy (39). However, recent findings from the main ADAPT cohort show reduced incidence of AD in the naproxen group compared with the groups receiving celecoxib or placebo (40). Therefore, further investigation is required to determine the full impact of NSAIDs on AD pathogenesis and whether Aβ-lowering NSAID compounds have any effect on peripheral Aβ levels.

There is a growing consensus that changes in blood Aβ levels parallel AD onset and progression, although these findings remain discrepant with respect to specific species, that is, Aβ1-42 or Aβ1-40 (2–6). Despite this discrepancy, evidence is now emerging in favor of the more pathologic form, Aβ1-42 being elevated at the stage of mild cognitive impairment or an even earlier prodromal stage of AD, possibly owing to increased production (2,5,7). These findings suggest that increased risk of AD associated with family history may be mediated in part through the enrichment of individuals with vascular risk factors and may be reflective of presymptomatic AD pathology. It remains to be determined, however, whether association of Aβ with medication used to treat vascular risk factors is indicative of prevention or amelioration of AD. Nonetheless, this exploratory study, which provides baseline data, and longitudinal evaluation of peripheral Aβ will provide a better understanding of the significance of this association in AD etiology.

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DISCLOSURE
We declare that the authors have no competing interests as defined by Molec-

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