Lipoprotein-associated phospholipase A2 (Lp-PLA₂): A novel and promising biomarker for cardiovascular risks assessment

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Abstract. Atherosclerosis and its manifestations namely cardiovascular diseases (CVD) are still the leading cause of morbidity and mortality worldwide. Although intensified interventions have been applied, the residual cardiovascular (CV) risks are still very high. Lipoprotein-associated phospholipase A2 (Lp-PLA₂) is a novel and unique biomarker highly specific for vascular inflammation and atherosclerosis. Both pro-atherogenic property of Lp-PLA₂ and positive correlation with CV events have already been demonstrated by a large number of scientific and clinical studies. Currently, in the Adult Treatment Panel III (ATP III) guideline, Lp-PLA₂ has been recommended as an adjunct to traditional risk factors in assessing future CV risks. Encouragingly, darapladib, an orally Lp-PLA₂ specific inhibitor, has been tested in basic research and preclinical trials and the outcomes are quite striking. Additionally, there are two phase III ongoing clinical trials in evaluating the efficacy and safety of darapladib on cardiovascular outcomes. With regard to the potential values of Lp-PLA₂ in risk stratification, therapeutic regimen establishment and prognosis evaluation in patients with moderate or high risk, our present review is going to summarize the relevant data about the bio-chemical characteristics of Lp-PLA₂, the actions of Lp-PLA₂ on atherosclerosis and the results of Lp-PLA₂ in scientific research and clinical studies.

Keywords: Lipoprotein-associated phospholipase A2, cardiovascular diseases, inflammatory biomarker

1. Introduction

Despite great advances in terms of screening, diagnosis, treatment and prevention have been achieved in the past decades, cardiovascular diseases (CVD) are still the leading cause of morbidity and mortality worldwide [1]. It has been well documented that the initiation and progress of CVD is largely associated with the severity of atherosclerosis. Literally, atherosclerosis is recognized as a chronic and dynamic status of vascular inflammation, and usually has already existed for years or decades before cardiovascular (CV) events occurring [2–4]. Therefore, quantitatively and accurately evaluating the severity of atherosclerosis will be helpful and beneficial to identify an individual at high risk for CV events. A variety of approaches (e.g., Framingham risk criteria and Reynolds risk scoring) have been used to effectively evaluate CV risk in population with risk factors. Furthermore, promotion of risk stratification would not only raise concerns for potential CV risk but also directly improve prognosis. However, there are still some deficiencies, including complexity and inaccuracy, especially when applied these risk estimating systems to individuals with moderate risk, which is defined as equal or more than 2 risk factors or the 10 years Framingham CV risk is 10–20% [5]. Consequently,
AHA/CDC incorporates high sensitivity C-reactive protein (Hs-CRP) into traditional risk factors for further enhancing the sensitivity and accuracy of risk estimating systems [6]. Nonetheless, Hs-CRP is an indicator of general inflammation, rather than exclusive to vascular inflammation [7]. Hence, the analysis of Hs-CRP elevation sometimes can be confounded by other conditions such as infection, adiposity, or rheumatic disease [8]. Lipoprotein-associated phospholipase A2 (Lp-PLA2) is a novel and unique biomarker, highly specific for vascular inflammation and atherosclerosis [7,8], and pro-atherogenesis and positive correlation with CV events have been sufficiently demonstrated by a large number of scientific and clinical studies [9–13]. Currently, in the Adult Treatment Panel III (ATP III) guideline, Lp-PLA2 has been recommended as an adjunct to traditional risk factors in the process of CV risk assessment [14]. Moreover, results from clinical studies indicate that the combination of Lp-PLA2 and Hs-CRP would be much better than Hs-CRP alone for reclassifying CV risk [15,16]. Encouragingly, dazabladil, an oral Lp-PLA2 specific inhibitor, has been tested in basic research and preclinical trials and the outcomes are quite striking [17–20]. With regard to the potential values of Lp-PLA2 in risk stratification, therapeutic regimen establishment and prognosis evaluation in patients with moderate or high CV risk, our present review is going to summarize the relevant data about the bio-chemical characteristics of Lp-PLA2, the actions of Lp-PLA2 on atherosclerosis and the results of Lp-PLA2 in scientific research and clinical studies.

2. Atherosclerosis initiation and development

It’s well known that vascular inflammation, hallmark of the beginning of atherosclerosis, is primarily incurred by endothelial dysfunction. Accordingly [21, 22], after exposed to traditional risk factors for a certain period, such as obesity, smoking, hypertension, dyslipidemia and diabetes mellitus, endothelial cells gradually become dysfunction and the natural barrier built among endothelia is impaired. Subsequently, lipids begin accumulating in sub-endothelial spaces [23]. Macrophages infiltrate and engulf lipids and turn into foam cells, and concomitantly produce inflammatory cytokines, reactive oxygen species and chemotactic factors, which are largely derived from oxidized low density lipoprotein (oxLDL) hydrolysis. Afterward, more leukocytes infiltrate and accumulate, lipid oxidation aggravates, endothelial cells deteriorate, and consequently vascular inflammation propagates. With numerous vicious cycles, atherosclerotic plaque, featured by necrotic lipid core, inflammatory cells and fibrous cap, is gradually established, which directly lead to the risk of CV events significantly increase. Basically, the occurrence of CV events largely depends on the stability of atherosclerotic plaque, and many characteristics have been identified to evaluate the plaque stability. For example, compared with other phenotypes, plaque with thinner fibrous cap and larger volume of necrotic lipid core is more vulnerable and easier to rupture. Therefore, identifying a prone-rupture plaque would be beneficial and helpful to prevent CV events. Currently, however, the risk assessment algorithms could not provide reliable evidences to identify a potential prone-rupture plaque [24]. Intravascular ultrasound (IVUS) and carotid magnetic resonance imaging have been used to successfully assess the component of atherosclerotic plaques in few studies. Nevertheless, these approaches are neither invasive nor inexpensive and simple, which hampers its broad application. Intriguingly, many studies reveal that comparing to stable plaque with small lipid core and thick fibrous cap, the activity of Lp-PLA2 in the prone-rupture plaque is much higher [25,26]. Moreover, the distribution of Lp-PLA2 is found predominantly adjacent to areas with massive macrophages aggregation and oxLDL accumulation [9,27], indicating that Lp-PLA2 activity or mass is significantly related to the plaque stability and Lp-PLA2 may be useful and reliable to identify vulnerable plaques and to evaluate future CV risks.

3. Bio-chemical characteristics of Lp-PLA2

Lp-PLA2, also known as platelet-activating factor acetylhydrolase or type VIIA PLA2, is encoded by PLA2G7 gene and composed of 441 amino acids. Lp-PLA2 is a Ca²⁺-independent phospholipase which belongs to phospholipase A2 superfamily [28]. There are two kinds of Lp-PLA2, namely secreted Lp-PLA2 in circulating system and Lp-PLA2 within atherosclerotic plaque. After mainly produced by macrophages in atherosclerotic plaque, Lp-PLA2 enters into circulating system and turns to be secreted Lp-PLA2 [8, 29]. Approximately 70% of secreted Lp-PLA2 binds to LDL-C and the residual 30% binds to HDL-C and other lipoproteins [30]. Biologically, secreted Lp-PLA2 mainly binds to ApoB portion of LDL and hydrolyzes LDL into lysophosphatidylcholine (Lyso-
PC) and arachidonic acid. While in the atherosclerotic plaque, Lp-PLA$_2$ hydrolyzes oxLDL into Lyso-PC and oxidized non-esterified fatty acids (oxNEFAs), both of which play important and multiple roles on atherogenesis [31–33]. Since secreted Lp-PLA$_2$ is derived from atherosclerotic plaque and with regard to its properties of high specificity and low bio-variability [34], measurement of secreted Lp-PLA$_2$ can accurately and quantitatively reflect the degree of inflammatory reaction within atherosclerotic plaque. Nowadays, secreted Lp-PLA$_2$ measurement can be classified into enzyme activity and enzyme mass [35]. Although activity and mass is significantly correlative [36,37], only Lp-PLA$_2$ mass measurement has already been approved by US Food and Drug Administration for clinical use [38]. Additionally, some studies recently report that the correlation of mass and activity may not be as high as previously expected, which necessitates further investigation. At the very beginning, based on the 50$^{th}$ percentile serum level in healthy population, $>235$ ng/mL of Lp-PLA$_2$ is defined as the cut-point for risk stratification [39]. Afterward, many studies reveal that comparing to those with Lp-PLA$_2$ level less than 200 ng/mL, patients with Lp-PLA$_2$ level more than 200 ng/mL has higher CV risk [10,12,40–42]. With respect to the definition and function of biomarker [43], in terms of enhancing risk assessment and increasing diagnostic and prognostic values, to our knowledge, it may be more appropriate to set Lp-PLA$_2$ $>200$ ng/mL as the cut-point, so as to find out truly high risk patients and carry out more specific therapy. In addition, one issue needed to be addressed here is that currently setting this cut-point is for better discriminating moderate or high risk patients rather than as a therapeutic target for treatment [5]. Recently, one meta-analysis shows that by contrast with the cut-point, roughly linear correlation between Lp-PLA$_2$ and CV risk and mortality is observed [37]. However, to our knowledge, appropriately specify Lp-PLA$_2$ therapeutic target for each patient with different risk stratification would be essential in the future when convincing and solid evidences, regarding lowering Lp-PLA$_2$ serum level with specific inhibitor could safely and significantly reduce CV events, can be achieved from ongoing phase III clinical trials [44,45].

4. Effects of Lp-PLA$_2$ on atherosclerosis

Currently, Lp-PLA$_2$ is recognized as a pro-atherogenic enzyme responsible for regulating lipid metabolism and inflammatory respond. However, at the very beginning, there are some controversies regarding the dual anti- and pro-atherogenic effects of Lp-PLA$_2$ on atherosclerosis. Lp-PLA$_2$ is primarily recognized as anti-atherogenic enzyme because of its capability of hydrolyzing platelet activating factor (PAF) and LDL-C, both of which are considered detrimental to vessel wall [9,46]. Some scientific research in different animal models also shows that increase serum level of Lp-PLA$_2$ could mitigate vascular inflammation and attenuate atherosclerosis. On the contrary, reduction of Lp-PLA$_2$ due to missense mutation could lead to CV risk profoundly increase [9,47,48]. Intriguingly, a substantial amount of studies gradually report that the activity or mass of Lp-PLA$_2$ positively associates with the severity of atherosclerosis and CV risk [49–51]. The two detrimental substrates, namely Lyso-PC and oxNEFAs, degraded by Lp-PLA$_2$ play crucial roles on the development and progress of atherosclerosis [52,53]. Both Lyso-PC and oxNEFAs are capable of recruiting leukocytes, up-regulating inflammatory cytokine, amplifying oxidation, enhancing matrix metalloproteinase expression, and finally expanding necrotic lipid core and thinning fibrous cap [53–55]. Emerging evidences have also consistently shown that comparing to healthy individuals, activity or mass of Lp-PLA$_2$ is significantly increased in patients with CVD. Histologically, in prone-rupture plaques, the activity or mass of Lp-PLA$_2$ is also much higher than that in the relatively stable plaques. Furthermore, after the activity or mass of Lp-PLA$_2$ is decreased by darapladib or statins, the volume of necrotic lipid core and the number of macrophages and foam cells are profoundly reduced when compared with control group. Encouragingly, many published studies and meta-analyses have also consistently demonstrated that after fully adjusted for traditional risk factors, elevated Lp-PLA$_2$ is associated with increased risk of CVD. Recently, one meta-analysis shows that Lp-PLA$_2$ activity is positively correlated with non-HDL-C ($r = 0.49$, 95% IC 0.45–0.52), LDL-C ($r = 0.48$, 0.41–0.55), apo-lipoprotein B ($r = 0.45$, 0.38–0.51), and log$_e$ triglycerides ($r = 0.22, 0.19–0.26$), while inversely correlated with HDL-C ($r = −0.24, −0.29 to −0.19$) and apo-lipoprotein A1 ($r = −0.15, −0.23 to −0.05$) [37], indicating that the atherogenic effect of Lp-PLA$_2$ is largely associated with conventional atherogenic-lipids. Collectively, the adverse effects, regarding pro-atherogenesis, Lp-PLA$_2$ imposes on cardiovascular system is outweighed the so-call anti-atherogenesis as evidenced by a large number of scientific and clinical research.
Table 1  
Epidemiological studies in evaluating the associations of Lp-PLA2 and primary outcomes

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Study population</th>
<th>Cardiovascular end-point</th>
<th>Study major findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>WOSCOPS [7]</td>
<td>2000</td>
<td>580 CVD cases</td>
<td>CHD</td>
<td>The highest quintile of Lp-PLA2 was a doubling risk for CHD as compared with the lowest quintile</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1160 controls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WHI [75]</td>
<td>2001</td>
<td>123 cases</td>
<td>CHD, non-fatal MI and stroke</td>
<td>Lp-PLA2 was not a strong predictor of future cardiovascular risk among unselected women</td>
</tr>
<tr>
<td></td>
<td></td>
<td>123 controls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ARIC [15]</td>
<td>2004</td>
<td>608 cases</td>
<td>CHD</td>
<td>Lp-PLA2 and CRP might be complementary in identifying individuals at high CHD risk in whom LDL-C &lt;130 mg/dL</td>
</tr>
<tr>
<td></td>
<td></td>
<td>740 controls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Rotterdam Study [76]</td>
<td>2005</td>
<td>308 CHD cases</td>
<td>CHD and ischemic stroke</td>
<td>Lp-PLA2 activity was an independent predictor of CHD and ischemic stroke in the general population</td>
</tr>
<tr>
<td></td>
<td></td>
<td>110 strokes and1820 controls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malmo [77]</td>
<td>2007</td>
<td>131 strokes</td>
<td>CVD</td>
<td>Higher plasma level of Lp-PLA2 increased incident CVD risk</td>
</tr>
<tr>
<td></td>
<td></td>
<td>131 MIs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Rancho Bernardo Study [78]</td>
<td>2008</td>
<td>1077 community men and women</td>
<td>CHD</td>
<td>Elevated Lp-PLA2 levels predict CHD events in apparently healthy older adults</td>
</tr>
<tr>
<td>The Bruneck Study [79]</td>
<td>2009</td>
<td>765 subjects</td>
<td>CVD</td>
<td>Increased Lp-PLA2 activity was associated with incident fatal and non-fatal CVD</td>
</tr>
<tr>
<td>The Cardiovascular Health Study [80]</td>
<td>2010</td>
<td>508 MIs</td>
<td>CVD</td>
<td>Lp-PLA2 mass and activity were associated with incident CVD events in older adults</td>
</tr>
<tr>
<td></td>
<td></td>
<td>565 Strokes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>665 CVD death</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2  
Epidemiological studies in evaluating the associations of Lp-PLA2 and secondary outcomes

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Study population</th>
<th>Cardiovascular end-point</th>
<th>Study major findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Association of Lp-PLA2 with CAD and the major adverse events [81]</td>
<td>2005</td>
<td>504 consecutive CAD patients</td>
<td>CAD and major adverse events</td>
<td>Higher Lp-PLA2 levels were associated with a higher incidence of major adverse events</td>
</tr>
<tr>
<td>The HELICOR study [82]</td>
<td>2005</td>
<td>312 patients with CAD and 479 controls</td>
<td>CAD</td>
<td>Elevated Lp-PLA2 concentrations were associated with the presence of stable CAD</td>
</tr>
<tr>
<td>The PROVE IT-TIMI [22]</td>
<td>2006</td>
<td>3648 ACS patients</td>
<td>CV events</td>
<td>Lp-PLA2 activity was associated with an increased risk of CV events</td>
</tr>
<tr>
<td>The KAROLA study [83]</td>
<td>2006</td>
<td>1051 patients with CHD</td>
<td>CHD</td>
<td>Increased concentrations of Lp-PLA2 predict future cardiovascular events in patients with manifest CHD</td>
</tr>
<tr>
<td>The PEACE trial [13]</td>
<td>2007</td>
<td>3766 stable CAD patients</td>
<td>CV events</td>
<td>In stable CAD, an elevated level of Lp-PLA2 was a significant predictor of nonfatal adverse CV outcomes</td>
</tr>
<tr>
<td>The Veterans Affairs HDL Intervention Trial [84]</td>
<td>2008</td>
<td>1451 men</td>
<td>CV events</td>
<td>High Lp-PLA2 independently predicted CV events</td>
</tr>
<tr>
<td>Expression of Lp-PLA2 in carotid artery plaques predicts cardiac outcome [26]</td>
<td>2009</td>
<td>162 consecutive patients</td>
<td>CV events</td>
<td>Lp-PLA2 expression in carotid artery plaques is a predictor of long-term cardiac outcome</td>
</tr>
</tbody>
</table>

5. Basic and clinical research of Lp-PLA2

As aforementioned, Lp-PLA2 is firstly recognized as an anti-atherogenic enzyme. The efficacies of Lp-PLA2 over-expression have been tested in different animal models. The first study to document the anti-inflammatory effect of Lp-PLA2 is performed by Tjoelker and co-workers in 1995 [56]. Thereafter, Morgan and colleagues report that in rabbit with myocardial ischemia-reperfusion injury, infusion of recombinant Lp-PLA2 decreases leukocyte infiltration and reduces myocardial necrosis when compared to control group [57]. In the mice model with apo-lipoprotein E deficiency, adenoviral gene transfer of human Lp-PLA2 diminishes macrophages infiltration and reactive oxygen species production [58]. In another study carried out by Noto H and colleagues [59], they find that Lp-PLA2 has potential to ameliorate lipid oxidation and concomitantly reduce serum level of pro-atherogenic lipoproteins. However, in addition to anti-atherogenic evidences, a substantial amount of studies from scientific to clinical ranges also consistently show that Lp-PLA2 not only involves in the initiation and progress of atherosclerosis, but also relates to plaque rupture and CV events occurring. For instance, in the swine model with diabetes mellitus and hyper-
lipidemia, inhibiting Lp-PLA₂ activity effectively prevents coronary artery lesions progress [20]. In the mice model with apo-lipoprotein E deficiency, attenuating Lp-PLA₂ profoundly ameliorates inflammatory reaction and deters plaque formation [19]. Since the first report of WOSCOPS in 2000 [7], many epidemiological studies and meta-analyses have also been conducted to further investigate and clarify the associations between Lp-PLA₂ and the prognosis of patients with CVD. In the clinical trial of WOSCOPS [7], results indicate that Lp-PLA₂ elevation appears to be a risk factor for coronary heart disease (CHD), which strongly implicates the effects of Lp-PLA₂ on atherogenesis and CV risk assessment. Garza CA and colleagues report that after adjusted for traditional risk factors, Lp-PLA₂ is still significantly associated with CV risk and Lp-PLA₂ measurement is helpful and beneficial for risk stratification [38]. In a cross-section study conducted by Blankenberg and co-workers [60], they observe that participants with the highest quartile of Lp-PLA₂ activity have a 1.8-fold increase risk of CHD when compared to those in the first quartile after fully adjusted for other clinical and metabolic factors. In 2008, Marshall A. Corson and colleagues conducted a meta-analysis and they included 25 clinical trials in evaluating the relationship between Lp-PLA₂ and CV risk [8]. Of these, ten of 11 primary studies and 12 of 13 recurrent CV events studies consistently demonstrate the positive correlation between Lp-PLA₂ and future CV risk. Another 6 studies also observe the positive correlation between Lp-PLA₂ and ischemic stroke. Recently, a meta-analysis includes 32 clinical studies in evaluating the relationship of circulating Lp-PLA₂ mass or activity with future risk of CHD, ischemic stroke, and mortality [37]. Notably, after adjusted for conventional risk factors, relative risks with Lp-PLA₂ elevation significantly increase for CHD [1.11 (95% CI 1.07–1.16) and 1.10 (1.05–1.16)], ischemic stroke [1.14 (1.02–1.27) and 1.08 (0.97–1.20)], vascular mortality [1.13 (1.05–1.22) and 1.16 (1.09–1.24)] and non-vascular mortality [1.10 (1.03–1.18) and 1.10 (1.04–1.17)], strongly supporting the notion that Lp-PLA₂ is a reliable indicator for the evaluation of future CV risk. Furthermore, this meta-analysis also shows that the risk of Lp-PLA₂ for CVD is comparable in magnitude to that with non-HDL cholesterol and systolic blood pressure, further indicating that the novel biomarker Lp-PLA₂ may be as valuable and significant as conventional risk factors. Finally, other epidemiological studies in investigating the correlation between Lp-PLA₂ and the primary or secondary outcomes of CVD are also summarized in Tables 1 and 2 respectively.

6. Lp-PLA₂ gene polymorphism and CVD

It is worth to be noted that the activity or mass of Lp-PLA₂ is variable among different ethnic groups, and the variants of Lp-PLA₂ encoding gene (PLA2G7), which locates on chromosome 6p21-p12, predominantly contributes to this phenomenon. Furthermore, many studies on the single nucleotide polymorphism (SNP) of PLA2G7 reveal that the biological functions of similar variant are quite contrary in different ethnic groups [61–64]. For example, in the Chinese Han population, Li and co-workers find that there is significant association between V279F variant (PLA2G7, rs16874954) and CVD, indicating that carrier of rare allele F increases the risk of CV events [65], which is consistent to the Japanese population as reported by Yamada [66] and Shimokata [67]. Nevertheless, in the South Korean population, V279F variant results in an unexpectedly opposite outcome [68], A379V variant (PLA2G7, rs1051931), in which alanine is substituted by valine, leads to the modification of Lp-PLA₂ function and consequently enhance the anti-atherogenic effects as reported by Ninio E and co-workers [69]. Intriguingly, in the study conducted by Liu and colleagues [70], the outcome is quite contradictory. They find that in the Chinese Taiwan Han population, A379V variant is significantly associated with Lp-PLA₂ activity and the severity of coronary atherosclerosis. Recently, a meta-analysis including a total of 12 studies shows that in the populations from European ancestry, among the 7 SNPs, A379V variant shows the strongest association with Lp-PLA₂ activity, however, no significant correlation is found between PLA2G7 variants and cardiovascular risk markers, coronary atheroma, or CHD [71]. To our knowledge, these disparities among different studies may be at least partially ascribed to the following mechanisms. First of all, the prime differences of ethnicity. Secondly, the clinical characteristics of subjects between each study are not always comparable, therefore, the outcome relates to the same PLA2G7 variant may be quite contrary. Thirdly, the different frequencies of PLA2G7 variant among studied subjects may also contribute to the discrepancy. Last but not the least, genetic variants other than PLA2G7 per se may also influence Lp-PLA₂ activity or mass. Although it is still uncertain about the relationship of PLA2G7 variants with Lp-PLA₂ activity or mass and prognosis among different ethnic groups, we consider that the two ongoing clinical trials (STABILITY and SOLID-TIMI 52) which involve different ethnic groups will finally demonstrate the effects of Lp-PLA₂ reduction on the outcomes of patients with CVD irrespective of PLA2G7 variants.
7. Further perspective

Nowadays, although intensified interventions have been applied, a significant residual CV risk is still observed when takes Lp-PLA₂ into account for risk assessment [51,72] indicating that incorporation of Lp-PLA₂ would be more accurate and reliable to identify patients with different degree of CV risk. Currently, Lp-PLA₂ measurement has only been reserved to patients with moderate or high CV risk, rather than unselectively applied to apparently healthy population or low risk patients, since the values of Lp-PLA₂ in these population groups are insignificant. For example, in the ARIC study [15], the investigators recruit an apparently healthy middle-aged population, and the result suggests that c-statistic improvement is obtained when incorporating Lp-PLA₂ to traditional risk factors, however, this effect is quite modest. In another Women’s Health Study [73], the authors enroll 28,263 apparently healthy middle-aged women for assessing the relationship of baseline Lp-PLA₂ level and the mortality risk of CVD over a mean follow-up of three years. They conclude that in the healthy women, Lp-PLA₂ is not a strong predictor for future CV risk. In summary, both of the studies indicate that on the basis of current evidences, Lp-PLA₂ should not be routinely used in low-risk or apparently healthy populations.

As mentioned before, traditional risk estimating models are neither reliable nor simple. Incorporation of a highly specific and sensitive biomarker endorsed by consensus panel would absolutely facilitate clinicians to easily and accurately recognize patients at high risk for CV events [5]. Moreover, since previous risk assessment models could not identify a prone-rupture plaque [74], Lp-PLA₂ incorporation not only would be helpful to identify patients who are at high risk for CV events, but also could raise awareness so as to perform more intensified interventions. Due to lack of large, prospective and randomized clinical trials to support darapladib application in clinical practices at present time, it is recommended that patients with higher level or activity of Lp-PLA₂, serum LDL-C level should be lowered by additional 30 mg/dL.

8. Conclusion

In summary, based on present scientific and clinical evidences, Lp-PLA₂ appears to be a valuable biomarker for better discriminating patients with moderate or high CV risks. In spite of intensified interventions, a majority of patients are still with high residual CV risk, Lp-PLA₂ incorporation could provide additive values to traditional risk factors in identifying a prone-rupture plaque and assessing future CV risks. Last but not least, to our knowledge, if the two ongoing phase III clinical trials finally are able to demonstrate the efficacy and safety of Lp-PLA₂ specific inhibitor darapladib, the future strategies will be significantly shifted and the outcomes will definitely be overwhelmingly improved.

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Conflict of interest

All authors declare that there is no conflict interest.

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