Association of the APOLIPOPROTEIN A1/C3/A4/A5 Gene Cluster With Triglyceride Levels and LDL Particle Size in Familial Combined Hyperlipidemia

Rebecca Mar, Päivi Pajukanta, Hooman Allayee, Martine Groenendijk, Geesje Dallinga-Thie, Ronald M. Krauss, Janet S. Sinsheimer, Rita M. Cantor, Tjerk W.A. de Bruin, Aldons J. Lusis

Abstract—The APOLIPOPROTEIN (APO) A1/C3/A4/A5 gene cluster on chromosome 11 has been hypothesized to be a modifier of plasma triglycerides in FCH. In the present study, we extended previous association analyses of the gene cluster to include APOA5, a newly discovered member of the cluster. Eight SNPs across the APOA1/C3/A4/A5 gene region were analyzed in 78 FCH probands and their normolipidemic spouses as well as in 27 Dutch FCH families. Of the individual SNPs tested in the case-control panel, the strongest evidence of association was obtained with SNPs in APOA1 (P=0.001) and APOA5 (P=0.001). A single haplotype defined by a missense mutation in APOA5 was enriched 3-fold in FCH probands when compared with the normolipidemic spouses (P=0.001) and a second haplotype was significantly enriched in the spouses (P=0.001). Family-based tests also indicated significant association of triglyceride levels and LDL particle size with the investigated SNPs of APOC3 and APOA5. These findings suggest that genetic variation in the APOA1/C3/A4/A5 gene cluster acts as a modifier of plasma triglyceride levels and LDL particle size within FCH families and furthermore indicate that a number of haplotypes may contribute to FCH. (Circ Res. 2004;94: 1115–1122.)

Key Words: genetics ■ coronary artery disease ■ apolipoproteins

Familial combined hyperlipidemia (FCH; see Mendelian Inheritance in Man [MIM-144250], which can be accessed online [OMIM] at http://www.ncbi.nlm.nih.gov/Omim/) is a complex lipid disorder characterized by elevated plasma triglyceride and cholesterol levels. The prevalence of FCH is about 1% to 2% in Western societies, whereas in survivors of myocardial infarction under 60 years of age, it is enriched about 10-fold, indicating an important role in coronary artery disease. FCH is often accompanied by an overproduction of apolipoprotein (apo) B-100–containing lipoproteins, accumulation of small, dense low-density lipoprotein (LDL) particles, and reduced concentrations of high-density lipoproteins (HDL). Although the disorder was first recognized about 30 years ago, the underlying genetic abnormalities in FCH remain unknown.

In a landmark study, Pennacchio and colleagues identified APOA5, a new member of the APOA1/C3/A4 gene cluster that modulates plasma triglycerides in mice as well as in humans. Two distinct alleles of APOA5 were shown to be independently associated with ~30% increase in plasma triglyceride levels in two independent populations. Several additional studies have confirmed the association of APOA5 SNPs with increased plasma triglyceride levels in the general population and in dyslipidemic populations.

Strong linkage between the APOA1/C3/A4 gene cluster and FCH was first reported in 1991 by Wojciechowski and colleagues. We have previously reported modest evidence for linkage to FCH, although these results have not been confirmed by other studies. Furthermore, association of the locus with FCH has been observed in cohorts where there was no evidence for linkage. The differences in the results among these studies may be explained by the complex nature of FCH in which multiple genes and environmental factors are thought to play a role. Population-based differences as well as differences in ascertainment and diagnosis of FCH between studies could also explain the conflicting results.

To test whether variation in the APOA1/C3/A4/A5 gene cluster is associated with FCH and its associated lipid parameters, we used both a case-control and family-based...
TABLE 1. Clinical Characteristics of Probands and Spouses

<table>
<thead>
<tr>
<th>Trait</th>
<th>FCH Probands</th>
<th>Spouses</th>
<th>TG Probands</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male/female, n</td>
<td>51/31</td>
<td>50/74</td>
<td>24/27</td>
</tr>
<tr>
<td>Age, years</td>
<td>52±11</td>
<td>51±11</td>
<td>49±12</td>
</tr>
<tr>
<td>Total cholesterol, mmol/L</td>
<td>7.10±2.66</td>
<td>5.54±1.02</td>
<td>7.25±3.04</td>
</tr>
<tr>
<td>Triglycerides, mmol/L</td>
<td>4.63±8.99</td>
<td>1.33±0.61</td>
<td>6.10±10.94</td>
</tr>
<tr>
<td>HDL-C, mmol/L</td>
<td>0.92±0.26</td>
<td>1.22±0.39</td>
<td>0.92±0.28</td>
</tr>
<tr>
<td>LDL-C, mmol/L</td>
<td>4.39±1.62</td>
<td>3.72±0.92</td>
<td>3.98±1.47</td>
</tr>
<tr>
<td>apoB, g/L</td>
<td>1.39±0.34</td>
<td>1.00±0.25</td>
<td>1.36±0.35</td>
</tr>
<tr>
<td>Body mass index, kg/m²</td>
<td>27.62±3.57</td>
<td>25.37±3.83</td>
<td>28.00±4.10</td>
</tr>
<tr>
<td>Waist-to-hip ratio</td>
<td>0.94±0.08</td>
<td>0.86±0.09</td>
<td>0.94±0.09</td>
</tr>
</tbody>
</table>

Values are expressed as mean±SD.

TABLE 2. Clinical Characteristics of the FCH Family Members

<table>
<thead>
<tr>
<th>Trait</th>
<th>Hyperlipidemic Individuals</th>
<th>Normolipidemic Individuals</th>
<th>Spouse Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male/female, n</td>
<td>173/125</td>
<td>144/151</td>
<td>87/121</td>
</tr>
<tr>
<td>Age, years</td>
<td>48±16</td>
<td>34±16</td>
<td>48±15</td>
</tr>
<tr>
<td>Total cholesterol, mmol/L</td>
<td>7.37±2.37</td>
<td>4.95±0.81</td>
<td>5.70±1.06</td>
</tr>
<tr>
<td>Triglycerides, mmol/L</td>
<td>3.57±6.78</td>
<td>1.27±0.41</td>
<td>1.64±1.04</td>
</tr>
<tr>
<td>HDL-C, mmol/L</td>
<td>1.14±0.32</td>
<td>1.21±0.32</td>
<td>1.25±0.34</td>
</tr>
<tr>
<td>LDL-C, mmol/L</td>
<td>4.66±1.36</td>
<td>3.13±0.74</td>
<td>3.73±0.99</td>
</tr>
<tr>
<td>apoB, g/L</td>
<td>1.32±0.30</td>
<td>0.83±0.21</td>
<td>1.02±0.28</td>
</tr>
<tr>
<td>PPDP (Å)</td>
<td>265.21±10.91</td>
<td>274.42±6.91</td>
<td>273.44±7.19</td>
</tr>
<tr>
<td>Body mass index, kg/m²</td>
<td>26.14±3.57</td>
<td>23.09±3.16</td>
<td>25.33±3.76</td>
</tr>
<tr>
<td>Waist-to-hip ratio</td>
<td>0.89±0.09</td>
<td>0.82±0.08</td>
<td>0.85±0.10</td>
</tr>
</tbody>
</table>

*Peak LDL particle size.
Values are expressed as mean±SD.

approach. In the present study, we provide evidence confirming the association of the APOA1/C3/A4/A5 gene cluster with FCH and report the novel finding of an association of the cluster with LDL particle size. The results demonstrate that the APOA1/C3/A4/A5 gene cluster is an important genetic determinant of plasma triglyceride levels and LDL particle size in FCH.

Materials and Methods

Subjects

The 82 FCH probands and 124 spouses were recruited through the Lipid Clinics of the Utrecht and Maastricht University Hospitals, the Netherlands. The clinical characteristics of the study populations are listed in Tables 1 and 2. Twenty-seven FCH families from Utrecht were ascertained through probands as previously described and in the expanded Materials and Methods section in the online data supplement available at http://circres.ahajournals.org. All subjects gave informed consent, and the study protocol was approved by the Institutional Review Committees of the University Hospitals of Utrecht and Maastricht, the Netherlands, and the University of California, Los Angeles.

Biochemical Analyses

Venous blood was drawn after an overnight fast, and plasma was prepared by immediate centrifugation. Lipids and apolipoproteins were quantified by methods as described. LDL particle diameters were measured as described. Proband and hyperlipidemic relatives who used lipid-lowering drugs were studied after their lipid-lowering treatment was withheld for 3 weeks.

Dichotomization of Triglyceride Status

Triglyceride levels are age- and sex-dependent. Therefore, the triglyceride trait of the FCH probands and family members was dichotomized based on the 90th age- and sex-specific population percentiles for triglyceride levels. Because no triglyceride percentiles for the Dutch population are publicly available, we used Finnish population percentiles for this qualitative approach. This method of reclassification of Dutch FCH individuals is identical to the criteria reported elsewhere. Because the Finnish triglyceride levels are, on average, somewhat higher than the Dutch, the Finnish population percentiles can be considered to be a more stringent criteria than if population averages from the Netherlands were used. Using these criteria, there were 152 affected individuals and 671 unaffected individuals in the family study sample.

Genotyping

The Xmn I, Msp I, Sau I, and the Hin I polymorphisms were genotyped as described. APOA5 SNPs 1, 2, and 4 were genotyped by pyrosequencing using the PSQ96 instrument and the SNP Reagent kit (Pyrosequencing AB). APOA5 SNP3 was genotyped as described. Primer design information and accession numbers for the SNPs are given in the online data supplement.

Statistical Analyses

Pairwise linkage disequilibrium (LD) was estimated using the Genetic Equilibrium option of the MENDEL 5.0 program. Statistical analyses of association in probands and spouses were performed using the SAS computer program. One-sided Fisher’s exact probability values are reported because association of the investigated genotypes was observed in other studies (see reviews). A Bonferroni correction was used to account for multiple testing. SNPs in strong LD with each other were not considered as independent groups of SNPs in complete LD. ANOVA was used to initially assess genotypic differences in mean triglyceride levels across the three genotypic groups. However, due to a low number of homozygotes, individuals who were either heterozygous or homozygous for the minor allele were grouped together. Unpaired t tests were then used to assess genotypic differences in the spouse and proband groups separately. Triglyceride values of the spouses and probands were not adjusted for age and sex because these factors were accounted for only a small part of the variation in triglyceride levels (R²<0.05).

For spouses and probands from the 27 FCH families, SNP haplotypes were constructed using the GENEHUNTER program.
When using pedigree data, Mendelian errors were identified with the PedCheck program. For haplotype construction, APOA5 SNPs were chosen as the representative marker for APOA5 SNPs 1, 2, and 4 due to extensive LD; however, for clarity, all three SNPs are shown in Figure 2B. The haplotypes identified in the 27 families were then used to assign the haplotypes in the spouses and probands. Haplotypes present in fewer than 10 individuals were binned. Fisher’s exact test was used to compare the haplotype distributions of FCH probands and spouse controls and to test for enrichment of each haplotype versus all other haplotypes.

The SNPs were tested for linkage or association in the FCH families through use of the gamete competition test and the haplotype-based haplotype relative risk test (HHRR). The gamete competition test was performed using OPTION 8 of MENDEL 5.04 and the HHRR analysis was performed using the HRRLAMB program. The gamete competition method provides a parametric extension of the transmission/disequilibrium test (TDT) and views transmission of marker alleles from heterozygous parents to affected children as a contest between the alleles, making effective use of full pedigree data. The gamete competition method is not merely a test of association, because the null hypothesis is no association and no linkage, and thus, linkage could result in a significant probability value. Using the gamete competition test, the SNPs were tested for association or linkage with FCH and a binary triglyceride trait as well as with the following quantitative traits: triglyceride levels, total cholesterol, BMI, WHR, LDL levels, HDL levels, LDL particle size, apoA-I levels, apoB levels, and apoC-III levels. Due to nonnormality, triglycerides were log transformed before all analyses. The HHRR is an extension of the TDT, which includes one affected individual per pedigree when there is no linkage to the region, yet it is also able to incorporate data from triads in which the parents are either homozygous or have missing genotypes. All genotyped SNPs were tested for association with FCH and a binary triglyceride trait using this method.

Results

Pairwise Linkage Disequilibrium

Setting a criterion of \( P<0.001 \), the observed pattern of LD was the same in spouses and probands (online Tables I and II, available at http://cicles.ahajournals.org, in the online data supplement). APOA5 SNPs 1, 2, and 4 were found to be in strong LD with each other and with the SstI polymorphism of APOC3. Both of the APOA1 polymorphisms, XmnI and MspI, were in LD with each other and with APOA5 SNP3. HindII was not in significant LD with any of the polymorphisms studied (online Tables I and II).

Case-Control Association Studies With Individual SNPs

The allele frequencies of the eight polymorphisms in APOA1/C3/A4/A5 were compared between FCH probands and their spouses (Figure 1). The XmnI, MspI, SstI, and HindII polymorphisms were chosen on the basis of previously reported associations with FCH. The studied APOA5 SNPs were chosen on the basis of reported associations with triglyceride levels (SNPs 1 and 4) and the likelihood of altering the level of expression or function of apoAV (SNPs 2 and 3). APOA5 SNP2 is located in the putative Kozak sequence of APOA5 and thus, may alter the level of APOA5 expression. APOA5 SNP3 results in a nonsynonymous substitution of serine to tryptophan and therefore may alter apoAV function. With the exception of HindII, the minor alleles were about 2-fold increased in the probands over controls, although only XmnI, MspI, SstI, and APOA5 SNP3 reached statistical significance (corrected \( P=0.001, P=0.001, P=0.01, \) and \( P=0.001, \) respectively). The minor alleles of XmnI, MspI, and APOA5 SNP3 were associated with higher triglyceride levels in FCH probands, although only XmnI reached statistical significance (4.47±3.5 versus 3.25±2.3 mmol/L; \( P=0.02 \) for carriers versus noncarriers; data not shown). The four FCH probands that were homozygous for the minor allele of APOA5 SNP3 exhibited a marked increase in plasma triglycerides over probands homozygous for the major allele (7.46±5.7 versus 4.45±1.3 mmol/L, respectively), although due to a small number of homozygotes, statistical significance was not reached. In contrast to the other polymorphisms studied, the frequency of the minor allele of HindII was significantly increased in spouse controls (\( P=0.004 \)). Within FCH probands, carriers of the minor allele of HindII exhibited lower plasma triglycerides (3.15±1.40 versus 5.12±10.7 mmol/L, for carriers versus noncarriers), although this decrease was not significant (\( P=0.39 \)).

In a subset of 40 hypertriglyceridemic probands (see Materials and Methods), the frequency of the rare alleles of XmnI, MspI, and APOA5 SNP3 were three times more frequent in probands than in spouse controls (\( P=0.000003, P=0.0001, \) and \( P=0.0001, \) respectively); however, no associations with SstI, HindII, or APOA5 SNPs 1, 2, or 4 were observed.

Haplotype Distributions in FCH Cases and Controls

The locations of the SNPs used to define each haplotype are shown in Figure 2A. The six haplotypes shown in Figure 2B represent 95% of those observed in spouses and probands.
The haplotype distribution of the probands was significantly different from that of the spouse controls \((P=0.0001)\). Of the six haplotypes, there was significant association of haplotypes 3 and 6 with FCH (Figure 2B). When compared with the spouse controls, the frequency of haplotype 3, which carries the minor alleles of \(XmnI\), \(MspI\), and \(APOA5\) SNP3, was 3-fold enriched in the probands \((P=0.001)\). Interestingly, no difference in the frequency of haplotype 4, which carries the minor alleles of \(XmnI\) and \(MspI\) but not of \(APOA5\) SNP3, was observed between the spouses and the probands \((P=0.4)\).

Consistent with the increased frequency of the minor allele of \(HinI\) in normolipidemic spouses, the frequency of the haplotype that carries this allele was also significantly increased in spouses \((P=0.001)\).

**Haplotype-Based Haplotype Relative Risk Test**

Next, we investigated the associations of the eight SNPs and their haplotypes on the 27 Dutch FCH families, which avoids some potential problems with population association. Suggestive evidence of association of the \(XmnI\) polymorphism with FCH was observed \((P=0.03)\). For the binary triglyceride trait, evidence of association was observed with \(HinI\) \((P=0.04)\) and \(APOA5\) SNP3 \((P=0.001)\). Interestingly, no difference in the frequency of the minor allele of \(SstI\) in normolipidemic spouses, the frequency of the haplotype that carries this allele was also significantly increased in spouses \((P=0.001)\).

**Gamete Competition Test**

The gamete competition test was also used to investigate the contribution of this locus to FCH. Significant evidence of preferential transmission of the minor alleles of \(SstI\) \((P=0.001)\), \(APOA5\) SNPs 2 and 4 \((P=0.002\) and \(P=0.004\), respectively), and the major allele of \(HinI\) \((P=0.003)\) was observed. Similar results were obtained with quantitative triglyceride levels (Table 3, right). \(SstI\) and \(APOA5\) SNPs 1, 2, and 4 were also strongly associated with LDL particle size \((P=0.004, P=0.005, P=0.0001, P=0.0004\), respectively). Because a number of studies have demonstrated that waist-to-hip ratio (WHR) is strongly correlated with LDL particle size, we tested for

**TABLE 3. Family-Based Association of Polymorphisms in the APOA1/C3/A4/A5 Gene Cluster With FCH, Triglycerides, and LDL Particle Size**

<table>
<thead>
<tr>
<th>Haplotype-Based Haplotype Relative Risk</th>
<th>Gamete Competition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Haplotype</td>
<td>FCH</td>
</tr>
<tr>
<td>------------</td>
<td>-----</td>
</tr>
<tr>
<td>(XmnI)</td>
<td>0.03*</td>
</tr>
<tr>
<td>(MspI)</td>
<td>0.3</td>
</tr>
<tr>
<td>(SstI)</td>
<td>0.9</td>
</tr>
<tr>
<td>(HinI)</td>
<td>0.6</td>
</tr>
<tr>
<td>A5snp1</td>
<td>0.7</td>
</tr>
<tr>
<td>A5snp2</td>
<td>0.10</td>
</tr>
<tr>
<td>A5snp3</td>
<td>0.6</td>
</tr>
<tr>
<td>A5snp4</td>
<td>0.3</td>
</tr>
</tbody>
</table>

*\(P=0.05, **P=0.005,†\)Age- and sex-dependent binary triglyceride trait; ‡Quantitative triglyceride levels; §Peak LDL particle diameter.
association of the SNPs with WHR. Only the minor allele of Sxrl showed evidence of preferential transmission to individuals with a high WHR (\(P=0.01\), data not shown). There was also evidence of association of APOA5 SNP2 and SNP4 with HDL levels (\(P=0.008\) and \(P=0.02\), but no evidence of association was observed with total cholesterol, LDL, apoA-I, apoB, or apoC-III levels (data not shown).

Discussion

Our results indicate that variation in the APOAI/C3/A4/A5 gene cluster is associated with a difference in both plasma triglyceride levels and LDL particle size in FCH. This study is of particular importance because linkage and association results of the APOAI/C3/A4 gene cluster in FCH have not always been consistent. Although we and others have previously reported both linkage and association of this locus with FCH, several other studies have not observed the same results. The discrepancies among studies regarding the involvement of this gene cluster in FCH may be explained both by the complexity of its contribution to FCH as well as the potential genetic heterogeneity underlying the disease.

Although the association of APOA5 SNPs with triglyceride levels has been firmly established, no direct effect on LDL particle size has previously been reported, although it has been associated with WHR, a strong predictor of LDL particle size. By using a quantitative gamete competition test, we were able to investigate the effects of APOAI/C3/A4/A5 variation on several lipid parameters within FCH families. The presence of sdLDL particles, which often accompanies the FCH phenotype, has been postulated to be a consequence of VLDL overproduction, and has been associated with CAD. Indeed, it has been shown that the most consistent lipid abnormality among FCH patients is the persistence of sdLDL. Therefore, genes influencing LDL particle size might be key factors contributing to the development of FCH, and by extension, the development of coronary artery disease (CAD). It has been shown that the minor allele of the Sxrl polymorphism may help to predict coronary artery disease within FCH families. Additionally, we have previously reported evidence that the APOAI/C3/A4 gene cluster is a shared genetic determinant of LDL particle size in FCH families and families enriched for CAD.

Consistent with this finding, polymorphisms within APOC3 as well as APOA5 were significantly associated with LDL particle size (\(P=0.004\) and \(P=0.0001\), respectively) (Table 3), providing evidence that these genes could contribute to the production and/or development of sdLDL, and thereby may be significant risk factors for the development of CAD.

The gamete competition test provided only modest results with the combined hyperlipidemia trait (\(P=0.01\) for Sxrl) and with a binary triglyceride trait (\(P=0.001\)). This result is comparable to that obtained in a similar study of 115 FCH families in which the minor allele of Sxrl (alternatively named APOC3) was associated with combined hyperlipidemia (\(P=0.014\)) and with a binary triglyceride trait (\(P=0.049\)). However, in that study, the minor allele of APOA5 SNP3 (alternatively named APOA5) was significantly associated with FCH (\(P=0.003\)), whereas in the present study, this SNP was not significantly associated with FCH in our family study sample (\(P=0.6\)). The differences in these results are most likely due to differences in FCH diagnostic criteria, because when an age- and sex-adjusted criterion is applied to the triglyceride trait, a significant association is observed for this SNP (\(P=0.05\)).

In the case-control study, the investigated SNPs were associated with FCH, and with binary and quantitative triglyceride traits within FCH probands. APOA5 SNP1 has been associated with increased VLDL-cholesterol in a population of 627 dyslipidemic individuals and with increased VLDL-apoB in 16 FCH families. Although these traits were not available for analysis in the present study, no significant differences in total cholesterol, LDL-cholesterol, HDL-cholesterol, or plasma apoB were observed between carriers and noncarriers in the case-control sample. However, these negative results could be due to the limited size of our case-control data set.

It has been postulated that additional genetic factors are necessary for expression of the triglyceride-raising effect of APOA5 variants. Consistent with this hypothesis, an increase in plasma triglyceride levels was observed only in FCH probands who carried the minor allele of APOA5 SNP3, whereas spouse controls who carried the minor allele did not exhibit increased triglyceride levels, suggesting that the dyslipidemic background present in FCH individuals augments the triglyceride-raising effect of this allele. A similar result was observed in a study by Ribalta et al in which proband carriers of the APOA5 SNP3 (alternatively named \(1131^{\text{T}}\)) allele exhibited higher plasma triglyceride levels than that of noncarrier probands (2.52 ± 1.34 versus 1.76 ± 0.90 mmol/L), whereas this effect on triglyceride levels was not observed in normal lipidemic relatives (0.82 ± 0.47 versus 0.94 ± 0.44 mmol/L, for carriers versus noncarriers, respectively). Therefore, analysis of multilocus associations with other FCH candidate genes may help to elucidate possible gene-gene interactions that affect plasma triglyceride levels within FCH individuals. One such possible candidate is the gene encoding the peroxisome proliferator-activated receptor alpha (PPARA). PPARA gene expression has been shown to affect the expression of APOA1, APOC3, and APOA5. Indeed, variation near the PPARA locus has been shown to have a modifying effect on plasma concentrations of apoC-III in FCH subjects, raising the possibility of an additional effect on plasma apoAV, which could subsequently influence triglyceride levels.

Lastly, we were also able to place APOA5 within the context of a previously defined FCH susceptibility haplotype at this locus. Previously, we reported the identification of two possible susceptibility haplotypes, one which carries the minor alleles of XmnI and Mspl (X2M2S1) and the other which carries the minor allele of Sxrl (X1M1S2). With the addition of APOA5 SNP3, the X2M2S1 haplotype has now been dichotomized into two haplotypes, indicated by haplotypes 3 and 4 in Figure 2B. In the present study, only the haplotype carrying the minor allele of APOA5 SNP3 (haplotype 3) was enriched in FCH probands, suggesting that the previous association with the X2M2S1 haplotype was due to LD with APOA5 SNP3. This finding indicates that it may be the presence of APOA5 SNP3 (S19W) that is important in the
development of FCH rather than the XmnI and MspI polymorphisms. This hypothesis is further supported by the findings of Eichenbaum-Voline et al.\textsuperscript{12} who reported a significant preferential transmission of the APOA5 SNP3 minor allele to FCH individuals. With the inclusion of APOA5 SNPs, the second susceptibility haplotype, the X1M1S2 haplotype, is also now dichotomized into two haplotypes: haplotype 5, which carries the SaxI minor allele as well as the minor alleles of APOA5 SNPs 1, 2, and 4, and haplotype 6, which carries the SaxI minor allele and common alleles at all other loci (Figure 2B). Both haplotypes 5 and 6 are enriched in FCH probands, although the low frequency of these haplotypes in our data sample limits our ability to detect a statistically significant association.

Although the primary purpose of this study was to investigate the role of APOA5 in FCH, the contribution of APOC3 cannot be overlooked. The SaxI polymorphism has been shown to be significantly associated with a decrease in LDL particle size in men and has been consistently associated with increased plasma triglyceride levels in several populations.\textsuperscript{19,47}–\textsuperscript{51} The SaxI polymorphism of APOC3 was associated with FCH in our case-control and family study samples, and with LDL particle size in FCH families. The SaxI minor allele also exhibited preferential transmission to affected individuals in British FCH families.\textsuperscript{12} Taken together, these data strongly suggest that APOC3 contributes significantly to FCH, and in particular, to LDL particle size.

In conclusion, although it is likely that variation within the APOA1/C3/A4/A5 gene region primarily affects triglyceride levels, the novel association with LDL particle size provides additional evidence of the contribution of this locus to FCH. The data also demonstrate the existence of a specific haplotype that is associated with FCH and further support the notion that APOA5 acts as a modifier of FCH. Thus, incorporation of these data into a multilocus genome scan approach may enhance the signals of existing FCH loci and may also lead to the identification of other novel loci that contribute to FCH.

Acknowledgments

This study was supported by NIH grant HL-28481 (to R.M.C., A.J.L., and P.P.). R.M. was supported by the Netherlands Organization for Scientific Research (NOW) grant 900-95-297. H.A. was supported by a Post-Doctoral Fellowship in Medical Genetics through NIH Scientific Research (NOW) grant 900-95-297. H.A. was supported by a Training Grant 5-T32-GM08243-15. R.M.K. was supported by NIH and A.J.L., and P.P.). R.M. was supported by the National Human Genome Research Institute (NHGRI) of NIH grant T32 HG02536. T.W.A.D.B. was supported by the Netherlands Organization for Scientific Research (NOW) grant 900-95-297. H.A. was supported by a Post-Doctoral Fellowship in Medical Genetics through NIH Training Grant 5-T32-GM0243-15. R.M.K. was supported by NIH grants HL-18574, HL-66091, and HL-07975. J.S.S. was supported by National Institute of Mental Health grant MH59490. We would like to thank the patients and relatives who participated in this study.

References


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Circ Res. published online March 4, 2004;
Circulation Research is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 0009-7330. Online ISSN: 1524-4571

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Data Supplement (unedited) at:
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Expanded Material and Methods

Detailed Ascertainment Criteria

The probands met the following criteria: (1) a primary combined hyperlipidemia with varying phenotypic expression, including a fasting plasma cholesterol > 6.5 mmol/l, or > 90th percentile for age, defined according to tables from the Lipid Research Clinics, and fasting plasma triglycerides >2.3 mmol/l; (2) at least one first degree relative with a different hyperlipidemic phenotype; (3) a positive family history of premature CAD defined as a myocardial infarction or cardiovascular disease before 60 years of age. Additional singleton FCH probands in the case-control study sample were single individuals diagnosed as FCH when the following criteria were met: (1) evidence of documented premature coronary artery disease in the family or in the patient and (2) documented evidence of multiple lipoprotein phenotype present among first-degree relatives. Exclusion criteria for the probands included diabetes, obesity (BMI > 30), tendon xanthomas indicative of familial hypercholesterolemia, or type III hyperlipidemia (apoE2/E2). Relatives were assigned the FCH phenotype when they met the following criteria: fasting plasma cholesterol > 6.5 mmol/l, and/or fasting plasma triglycerides > 2.3 mmol/l. Using these criteria, there were 275 affected individuals and 548 unaffected relatives in the study sample. The spouses (n=208) represent a population-, environment-, nutrition-, and age-matched control group for the probands and their hyperlipidemic relatives. Additional normolipidemic spouses of FCH family members were included in the control study sample.

SNP Primer Information and Accession Numbers

Primers for PCR were designed using the Primer3 program, available at the Whitehead Institute for Biomedical Research Web site. Detection primers for pyrosequencing were
designed through the use of the SNP primer Design Software, version 1.01 (Pyrosequencing AB). Oligo Analyzer 2.5, available at the Integrated DNA Technologies Web site, was used to calculate the melting temperature of the primers and to check all the primers for primer dimers and hairpins to prevent possible background signals in the SNP genotyping. \( APOA5 \) SNPS 1, 2, 3 and 4 were previously identified and are available at the dbSNP home page under accession numbers ss3199915, ss4383596, ss4383597, and ss3199914, respectively.
Supplementary Tables

Table I. Pairwise Linkage Disequilibrium in Normolipidemic Spouses.

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Table II. Pairwise Linkage Disequilibrium in FCH probands.

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</table>

Pairwise linkage disequilibrium between SNPs was estimated using the Genetic Equilibrium option of MENDEL 5.0. Fisher’s exact P-values are shown above (spouses) and below (probands) the gray boxes. NS = not significant

\(^a\text{APOA1} -2500\text{C>T}\\
\(^b\text{APOA1} -75\text{G>A}\\
\(^c\text{APOC3} 3238\text{G>C}\\
\(^d\text{APOA4} 347\text{A>T}\\
\(^e\text{APOA5} -1131\text{T>C}\\
\(^f\text{APOA5} -3\text{A>G}\\
\(^g\text{APOA5} \text{S19W}\\
\(^h\text{APOA5} \text{exon3+476G>A}
References for Online Data Supplements


Electronic Database Information

URLs for data presented herein are as follows:

Integrated DNA Technologies, http://www.idtdna.com/ (for Oligo Analyzer 2.5)

Whitehead Institute for Biomedical Research, http://www-genome.wi.mit.edu/genome_software/other/primer3.html (for the Primer3 program)