Homocysteine: Update on a new risk factor

In the past few years, considerable advances have been made in our understanding of the relationship between homocysteine and vascular disorders. This review focuses on important recent findings in:

- The clinical epidemiology of hyperhomocysteinemia and vascular disorders.
- The potential mechanism of vascular damage in hyperhomocysteinemia.
- The causes of high homocysteine levels in patients with vascular disease.
- The elevated homocysteine concentrations in patients with end-stage renal disease, organ transplants, and recurrent deep venous thrombosis.
- The effect of supplementation with B vitamins on homocysteine concentrations in patients with vascular disorders.

What is homocysteine?

Homocysteine, a sulfur-containing amino acid derived from methionine, is essential for a number of vital biochemical processes. It is metabolized by two pathways: remethylation and transsulfuration.

Remethylation

The body conserves adequate quantities of methionine through remethylation of homocysteine (Figure 1). This process requires a number of enzymes and an adequate supply of folic acid and vitamin B₁₂.

Transsulfuration

Breakdown of homocysteine by the transsulfuration pathway requires both cystathionine β-synthase and vitamin B₆ and results in

Abstract

A high fasting plasma homocysteine level is an independent risk factor for atherosclerosis and venous thrombosis. Vitamin therapy can lower homocysteine levels, but no benefit has yet been demonstrated; studies using clinical outcomes as endpoints are now in progress.

Key points

The normal range for plasma homocysteine is 5 to 15 μmol/L, although the upper limit of normal may need to be lowered.

Plasma homocysteine concentrations increase with age and in a number of congenital and acquired conditions, notably renal failure and vitamin deficiency.

Several studies have shown high plasma homocysteine levels to be a strong, independent risk factor for cardiovascular disease. There is now broad agreement that a high plasma homocysteine concentration is also a risk factor for venous thrombosis.

Folic acid supplements reduce elevated homocysteine levels; the dosage should be higher for patients with renal insufficiency than for patients with normal renal function.
How Homocysteine is Produced and Metabolized

Demethylation
converts methionine to homocysteine; conversion is increased by a diet rich in methionine.

Remethylation pathway
converts homocysteine into methionine. The process requires:
- Vitamin B₁₂
- Folate
- Methionine synthase
- 5,10-methylenetetrahydrofolate reductase.

Transsulfuration pathway
converts homocysteine into cysteine and products that are excreted in the urine. The process requires:
- Vitamin B₆
- Cystathionine β-synthase.

Homocysteine levels tend to rise with age

- CAUSES OF HIGH PLASMA HOMOCYSTEINE LEVELS

Plasma levels of homocysteine tend to rise with age, possibly due to inadequate intake of B vitamins, renal insufficiency, and perhaps also due to decreases in the activity of enzymes necessary for homocysteine metabolism; Table 1 shows the principal causes of high homocysteine levels.

Enzymatic defects
High plasma homocysteine levels may be seen with enzymatic defects in the transsulfuration and the remethylation pathways.

Transsulfuration enzyme disorders are rare and unlikely to account for the hyperho-
mocysteinemia frequently seen in patients with vascular disorders.

Remethylation enzyme disorders. A number of mutations of methylenetetrahydrofolate reductase have been reported. Most are rare, but a thermolabile variant caused by a single amino acid substitution (alanine to valine) due to a C-to-T point mutation at position 677 has an allele frequency of 30% to 45% in the general population. This variant, which may result in decreased enzyme activity in vivo, is associated with modest elevations in homocysteine concentrations and has been cited as a risk factor for coronary artery disease, although not consistently. Folic acid supplements may lower the high homocysteine levels seen in this disorder.

Vitamin deficiency
Because folic acid and vitamin B₁₂ are essential for the remethylation pathway, and vitamin B₆ is essential for the transsulfuration pathway, a lack of these vitamins can cause impaired metabolism of homocysteine.

### CLINICAL EPIDEMIOLOGY OF HOMOCYSTEINE AND VASCULAR DISORDERS

The normal total plasma homocysteine level ranges from 5 to 15 μmol/L. However, the upper limit of normal may need to be lowered, because the risk of vascular disease appears to begin increasing with plasma homocysteine levels well within the normal range (Figure 2).

**High homocysteine levels are a risk factor for coronary artery disease**
Several studies have shown high plasma homocysteine levels to be an independent risk factor for cardiovascular disease. This association was first suspected from studies of the natural history of homocystinuria, a rare inborn error of metabolism complicated by occlusive arterial disease and thromboembolism. This autosomal recessive disease is caused by cystathionine β-synthase deficiency and is characterized by extremely high homocysteine concentrations (> 100 μmol/L). Subsequent studies revealed more modestly elevated homocysteine levels (>15 to 20 μmol/L) in patients with coronary artery disease, stroke, and peripheral vascular disease.

Folate, vitamin B₆ levels are lower in patients with coronary artery disease
A growing body of epidemiologic evidence shows that low levels of both folic acid and vitamin B₆ may be risk factors for vascular disorders. In 1994, Panchanuriti et al showed an association between lower folate levels and angiographic evidence of coronary artery disease. Recently, Morrison et al reported that persons with lower folate levels had a higher 15-year coronary mortality rate. In a large European case-control study of 750 patients and 800 controls, homocysteine correlated negatively with folate and vitamin B₆ levels. Low folate status was associated with an increased risk of vascular disease. In the folate, vitamin B₆ levels are lower in patients with coronary artery disease.

### CAUSES OF HYPERHOMOCYSTEINEMIA

#### Inherited causes
- Disorders of transsulfuration
  - Cystathionine β-synthase deficiency
- Disorders of remethylation
  - Defective vitamin B₁₂ transport
  - Defective vitamin B₁₂ coenzyme synthesis
  - Defective methionine synthase
  - 5,10-methylenetetrahydrofolate reductase deficiency (rare) and a thermolabile variant (common in most populations)

#### Acquired causes
- Diseases
  - Chronic renal failure
  - Acute lymphoblastic leukemia
  - Psoriasis
- Vitamin deficiencies
  - Vitamin B₁₂
  - Folate
  - Vitamin B₆
- Drugs
  - Methotrexate (an inhibitor of dihydrofolate reductase)
  - Phenyltoin and carbamazepine (antagonists of folate)
  - Nitrous oxide (an inactivator of methionine synthase)
  - Theophylline (an antagonist of vitamin B₆)
  - 6-azauridine triacetate (an antagonist of vitamin B₆)

Higher doses of folic acid are needed to lower homocysteine in renal failure.
Homocysteine levels are high in end-stage renal disease
The kidney is an important organ in homocysteine metabolism, and end-stage renal disease is associated with greatly increased homocysteine levels and possibly lower levels of B vitamins. Recent studies showed that a high homocysteine concentration in patients with renal failure is an independent risk factor for vascular complications and that this risk rises with increasing plasma homocysteine levels.

Homocysteine levels are high after organ transplantation
Centers in Europe and North America have reported that homocysteine levels increase after organ transplantation—and transplant recipients have a high risk of vascular events. In patients at the Mayo Clinic, homocysteine concentrations increased by 70% after cardiac transplantation and remained elevated 12 months later. Vitamin B12 and folate levels decreased, as did the glomerular filtration rate.

At the Cleveland Clinic, homocysteine concentrations were higher in 189 heart transplant recipients than in controls. Folate and pyridoxal 5'-phosphate levels were lower, and deficiencies of these vitamins were seen in 10% to 20% of transplant recipients. Hyperhomocysteinemia was seen more often in patients with vascular complications following transplantation than in those without.

Homocysteine levels are also higher in recipients of transplanted kidneys, lungs, and
livers. The role, if any, of homocysteine in the genesis of the vascular complications that occur in these patients requires further study.

**High homocysteine increases the risk of deep venous thrombosis**

In a pooling study of 629 patients with homocystinuria, Mudd et al. found that deep venous thrombosis was the most frequent thrombotic complication, accounting for approximately 50% of all such events. Several recent studies have therefore examined the relationship between high homocysteine concentration and venous thromboembolism.

A study by den Heijer et al. measured the plasma homocysteine concentrations of patients with recurrent venous thrombosis, and also administered a methionine loading test. (This is a test similar to a glucose tolerance test, in which patients receive a standardized dose of methionine. Homocysteine concentrations are measured at intervals afterward; this test is sometimes used to expose a tendency to high homocysteine levels in patients in whom fasting values are normal).

The researchers found that 25% of patients with thrombosis had fasting homocysteine concentrations greater than the 95th percentile for values in normal controls; these high concentrations carried an odds ratio of 3.1 for thrombosis. A similar relationship was seen for abnormal results on the methionine loading test.

In 60 patients with unexplained thrombotic episodes studied at the Cleveland Clinic, hyperhomocysteinemia was the only abnormality detected on a hypercoagulation profile. In general, there is now broad agreement that a high plasma homocysteine concentration is also a risk factor for venous thrombosis.

**TABLE 2**

**HOMOCYSTEINE AND ATHEROTHROMBOSIS: POSSIBLE MECHANISMS**

<table>
<thead>
<tr>
<th>Effects on vascular endothelium</th>
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<tr>
<td>Cytotoxic damage at high doses</td>
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<td>Abnormal prostacyclin synthesis</td>
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<td>Altered chemokine production</td>
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<td>Changes mediated through adhesion molecules</td>
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<th>Effects on platelets and clotting factors</th>
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<tr>
<td>Increased synthesis of thromboxane B2 and other eicosanoids</td>
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<td>Increased levels of platelet-derived thromboxane A2</td>
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<td>Increased platelet adhesion and aggregation</td>
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<td>Decreased platelet survival</td>
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<td>Activation of factor XII</td>
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<td>Decreased antithrombin III levels</td>
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<td>Factor V activation</td>
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<td>Decreased activation of protein C</td>
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<td>Inactivation of thrombomodulin production or activity</td>
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<td>Increased affinity of Lp(a) for plasmin-modified fibrin</td>
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<td>Inhibition of von Willebrand factor processing and secretion</td>
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<td>Blocking of t-PA binding to endothelial cells</td>
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**Endothelial damage**

Current studies mostly focus on the endothelium as the site where vascular damage starts, rather than on platelets or clotting factors. A number of pathogenetic mechanisms, such as reduced activity of essential enzymes or nutrients, could lead to high homocysteine levels within endothelial cells. For example, we have been unable to demonstrate the presence of cystathionine ß-synthase activity in cultured human aortic endothelial cells and in human cardiovascular tissue extracts. This finding implies that endothelial cells cannot metabolize homocysteine by the transsulfuration pathway. If this is true, any increase in plasma homocysteine concentrations could then disrupt endothelial function. Decreased DNA synthesis was demonstrated in a recent in vitro study, in which endothelial cells exposed to homocysteine and adenosine showed reduced proliferation. The effect was dose-dependent and was observed at concentrations as low as 10 µmol/L. In addition, this effect was specific for homocysteine and was not observed with folic acid.

**We give 0.4 mg of folic acid a day, and recheck the homocysteine level after 4 to 6 weeks.**
cysteine. Very low levels of homocysteine (10 to 50 μmol/L) also enhance the expression of monocyte chemotractant protein 1 (MCP-1) in human aortic endothelial cells.\textsuperscript{27}

Vascular smooth muscle cells may also be adversely affected by homocysteine. Homocysteine can stimulate proliferation of smooth muscle cells grown in culture.\textsuperscript{28} Hydrogen peroxide, formed by oxidation of homocysteine, may cause oxidant stress and play an important role in smooth muscle cell damage before overt vascular disease develops.\textsuperscript{29} Recently, homocysteine exposure was shown to decrease the ratio between the intracellular concentrations of reduced and oxidized glutathione, the most important intracellular redox buffer.\textsuperscript{29}

Consequences of endothelial damage
Once initiated, endothelial damage may be expressed in various ways, including inhibited synthesis of prostacyclin, decreased platelet survival, increased factor V expression, inactivation of endothelial anticoagulant protein C, or disruption of the processing and secretion of von Willebrand factor. In monkeys, diet-induced hyperhomocysteinemia is associated with altered endothelial-dependent vascular function,\textsuperscript{30} and a recent clinical study in humans\textsuperscript{31} documented that homocysteine may also inhibit endothelium-dependent flow-mediated dilation, perhaps by inhibiting nitric oxide.

**VITAMIN THERAPY FOR PATIENTS WITH VASCULAR DISEASE OR RENAL FAILURE AND HIGH HOMOCYSTEINE**

Folic acid lowers homocysteine concentrations in normal subjects, patients with vascular disease, and patients with established renal failure.\textsuperscript{6-8} It can be used alone or in combination with vitamins B₆ and B₁₂. The treatment is rapid and is effective after only 2 weeks.

The dose and combination of vitamins that should be used remains unclear, although levels of 1 mg or even less may be useful in patients with coronary artery disease. Naurath et al\textsuperscript{12} used a regimen of 1.1 mg of folic acid, 1 mg of vitamin B₁₂, and 5 mg of vitamin B₆ and normalized elevated homocysteine levels. At the Cleveland Clinic, we recently completed a placebo-controlled study of approximately 100 patients with coronary artery disease. Patients were given folic acid 0.4, 1.0, or 5 mg daily for 3 months. Homocysteine concentrations fell by approximately 30% in all treatment groups but remained unchanged in the placebo group.\textsuperscript{33} Thus, doses of folic acid as low as those found in multivitamin pills may be of use in lowering homocysteine levels in patients with coronary artery disease.

Much higher doses of folic acid are needed to lower homocysteine concentrations in patients with renal failure—as high as 15 mg/day or more.\textsuperscript{34}

**Recommendations**
Although folic acid supplementation may lower homocysteine concentrations, there is no evidence that it improves clinical outcomes. Nevertheless, if homocysteine levels are high, and no other risk factors for vascular disease are present, or if episodes of thrombosis are recurrent, vitamin therapy may be a reasonable addition to usual treatment. In such patients, we currently use 0.4 mg folic acid daily and recheck the homocysteine concentration after 4 to 6 weeks. This therapy is innocuous and inexpensive.

In patients taking folic acid, it is prudent to check vitamin B₁₂ levels before starting treatment, and perhaps also during follow-up, to ensure that vitamin B₁₂ deficiency is not present. Oral or parenteral vitamin B₁₂ supplements may be given if necessary. Intervention studies using folic acid supplements in patients with cerebrovascular disease are now in progress to assess the role of vitamin therapy in patients with atherosclerosis.

**Food fortification with folic acid**
Beginning in January 1998, products made with cereal grain or flour will be fortified by the addition of 140 μg of folic acid per 100 g of flour. This measure is intended to reduce the incidence of neural tube defects, but it may also reduce homocysteine concentrations and decrease the risk of atherosclerosis in the general population, although substantially higher levels of folate may be needed to achieve desirable effects in many subgroups.
REFERENCES


