Endothelial Dysfunction Precedes Development of Microalbuminuria in IDDM

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In patients with insulin-dependent diabetes mellitus (IDDM), microalbuminuria is a predictor of widespread severe microangiopathy and macroangiopathy. Patients with microalbuminuria show generalized dysfunction of the vascular endothelium, but it is unknown whether endothelial dysfunction precedes the development of microalbuminuria. We examined a cohort of 17 IDDM patients at baseline and on three occasions during a follow-up of (median) 64 months (range 51–89). All had normal (<15 μg/min) urinary albumin excretion (UAE) at the first three examinations. At the fourth examination, 11 patients had normal UAE and 6 had microalbuminuria (median 25.7 μg/min [range 15.3–42.8]). Compared with patients with normal UAE, microalbuminuric patients had significantly higher plasma levels of von Willebrand factor (vWF), a marker of endothelial dysfunction, at the second (200% [118–274] vs. 131% [69–186]), third (208% [188–270] vs. 125% [82–190]), and fourth examinations (231% [202–269] vs. 132% [88–208], P < 0.0001), but not at baseline (128% [98–161] vs. 122%). An increase in vWF preceded the occurrence of microalbuminuria (11). To further investigate whether endothelial dysfunction precedes the occurrence of microalbuminuria. To do this, we followed a group of IDDM patients and measured UAE and plasma vWF concentration at regular intervals (as an estimate of endothelial function).

RESEARCH DESIGN AND METHODS

Cohort study. Between June 1085 and August 1988, 65 IDDM patients (fasting C-peptide levels < 0.01 nmol/l) were recruited and gave informed consent, as previously reported (11,12). Clinical and laboratory data, as detailed below, were obtained at baseline (first examination) and after a median follow-up of 3 years (second examination). This study was completed in 59 patients and showed that the development of microalbuminuria was paralleled by increases in the plasma vWF concentration, but we could not determine whether such increases preceded the occurrence of microalbuminuria. To investigate whether endothelial dysfunction preceded the occurrence of microalbuminuria. To do this, we followed a group of IDDM patients and measured UAE and plasma vWF concentration at regular intervals (as an estimate of endothelial function).

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standard sphygmomanometer with an appropriately sized cuff), insulin dose, current smoking habits, and current medication. After an overnight fast, blood was drawn from an antecubital vein for measurement of glucose (glucose oxidase method), vWF antigen (see below), glycated hemoglobin (spectrophotometric assay; Bio-Rad, Richmond, VA; normal range 3.6–6.6%), serum creatinine concentration (modified Jaffe reaction), and serum total cholesterol (enzymatically; Boehringer Mannheim, Mannheim, Germany). Within 2 months of each examination, data on UAE and retinal status had been collected for all patients (see below).

Main outcome measures

UAE. On the basis of the median UAE in at least three consecutive 4-h (0800–1200) urine collections, patients were classified as having normal (<15 μg/min) or increased UAE. Note that median values are reported, which minimizes the influence of occasional outliers. Microalbuminuria was defined (in advance [11,12]) as UAE of 15–200 μg/min. (We chose 15 μg/min as cutoff because the median UAE in healthy volunteers in our laboratory is 5.7 μg/min, with >95% having an UAE <15 μg/min [11].) Patients were instructed to avoid strenuous exercise and to empty their bladders completely on arising and at noon. Completeness of urine collections was checked by comparing creatinine excretion among samples, whereas absence of infection was ensured by examining urinary sediments; new urine was collected when necessary.

Retinopathy. At the first and second examinations, the ocular fundus was examined by an ophthalmologist after dilatation of the pupils. At the third and fourth examinations, ophthalmoscopy was repeated on each patient by two ophthalmologists. In addition, fluorescein angiograms were obtained after intravenous injection of 5 ml 10% sodium fluorescein.

Endothelial function. Plasma vWF antigen concentration was measured by immunoelectroforesis (11). The intra-assay and interassay variabilities were 4.1 and 8.7%, respectively; the same assay was used throughout the study. Levels of and changes in vWF were expressed as percentages of normal pooled plasma, the antigen level of which is defined as 100% (normal range 50–150; 100% = 1.00 IU/ml). We were careful to avoid increases in vWF associated with hypoglycemia, exercise, smoking, prolonged (>2 min) venous occlusion, and intercurrent illness. In our experience, the within-person day-to-day variability of plasma vWF was thus reduced to ~10%.

The clinical and laboratory data, including UAE and retinal status, were collected without knowledge of the results of the vWF measurements.

Statistical analysis. Data are presented as means ± SD or as medians and ranges, unless otherwise indicated. Patients were divided into two groups according to the absence or presence of increased UAE at the first examination. These groups were then compared with regard to clinical and laboratory characteristics and changes therein at examinations 1–4, using standard parametric and nonparametric testing as indicated. A similar procedure was followed with the absence or presence of retinopathy as the outcome of interest. Finally, correlation analysis was used to study the relationship between (changes in) vWF levels and potential determinants of endothelial injury. All testing was two-sided. P values <0.05 were considered statistically significant.

RESULTS

All 17 patients completed the study, except 1 refused fluorescein angiography at the third examination and another declined both ophthalmoscopy and angiography at the fourth. There was no clinical evidence of macrovascular complications in any patient at the third examination, but at the fourth, one patient (with normal UAE) had had a stroke, confirmed by chart review. There were only two smokers among the patients; this factor was therefore omitted from further analyses. In one patient with persistently normal UAE, antihypertensive medication (a β-receptor antagonist) was started between the third and fourth examinations.

UAE. At the fourth examination, 11 patients had normal UAE (7.2 [3.1–9.9] μg/min) and 6 had microalbuminuria (25.7 [15.3–42.8] μg/min) (Fig. 1). Thus, the cumulative incidence of microalbuminuria was 36%, yielding an incidence density (cases per 100 person-years of follow-up) of 6.3. The main difference between the groups with normal versus increased UAE was the plasma vWF concentration (Table 1 and Fig. 1), which was higher in the microalbuminuric patients at the second (median 200% [range 168–274] vs. 131% [89–180]), third (208% [188–270] vs. 125% [80–190]), and fourth examinations (231% [202–269] vs. 132% [88–208], P < 0.0001 by analysis of variance [ANOVA] and by Student’s t tests), but not at baseline (128% [98–161] vs. 123% [87–210]). UAE at the fourth examination was related to both the plasma vWF level (r = 0.70, P = 0.002) and the change in plasma vWF between examinations 1 and 4 (r = 0.80, P < 0.0001). A plasma vWF level above the upper limit of normal (i.e., 150%) at two or more of the first three examinations predicted the presence of microalbuminuria at the fourth examination with 100% sensitivity (6 of 6) and 82% specificity (9 of 11). These results were not materially altered by exclusion of the patient who received antihypertensive treatment or by exclusion of the two smokers.
TABLE 1
Clinical and laboratory data for patients with IDDM

<table>
<thead>
<tr>
<th></th>
<th>Normal UAE</th>
<th>Microalbuminuria</th>
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</thead>
<tbody>
<tr>
<td>Sex (M/W)</td>
<td>5/6</td>
<td>3/3</td>
</tr>
<tr>
<td>Age (years)</td>
<td>49 ± 13</td>
<td>47 ± 19</td>
</tr>
<tr>
<td>Diabetes duration (years)</td>
<td>16 ± 3</td>
<td>14 ± 9</td>
</tr>
<tr>
<td>Follow-up duration (months)</td>
<td>64 (51–85)</td>
<td>67 (54–89)</td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
<td>24.3 ± 3.2</td>
<td>23.9 ± 2.4</td>
</tr>
<tr>
<td>Smoker (yes/no)</td>
<td>1/10</td>
<td>1/6</td>
</tr>
<tr>
<td>Blood pressure (mmHg)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First examination</td>
<td>139/84 ± 24/6</td>
<td>140/83 ± 28/15</td>
</tr>
<tr>
<td>Second examination</td>
<td>132/81 ± 19/6</td>
<td>142/85 ± 21/10</td>
</tr>
<tr>
<td>Third examination</td>
<td>135/83 ± 15/4</td>
<td>145/85 ± 15/9</td>
</tr>
<tr>
<td>Fourth examination</td>
<td>140/83 ± 25/7</td>
<td>140/83 ± 16/5</td>
</tr>
<tr>
<td>Mean</td>
<td>138/83 ± 19/4</td>
<td>140/84 ± 19/8</td>
</tr>
<tr>
<td>Serum total cholesterol (mmol/l)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First/second examination</td>
<td>6.2 ± 0.8/6.3 ± 0.7</td>
<td>6.0 ± 0.8/6.1 ± 0.7</td>
</tr>
<tr>
<td>Third/fourth examination</td>
<td>6.1 ± 0.7/5.6 ± 1.3</td>
<td>5.9 ± 0.7/5.8 ± 0.8</td>
</tr>
<tr>
<td>Glycated hemoglobin (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First/second examination</td>
<td>8.0 ± 1.0/6.9 ± 0.8</td>
<td>8.4 ± 1.3/6.8 ± 1.3</td>
</tr>
<tr>
<td>Third/fourth examination</td>
<td>6.7 ± 0.8/7.5 ± 1.9</td>
<td>6.7 ± 1.0/6.6 ± 0.7</td>
</tr>
<tr>
<td>Mean</td>
<td>7.2 ± 0.9</td>
<td>7.0 ± 0.9</td>
</tr>
<tr>
<td>Serum creatinine (mmol/l)</td>
<td>80 ± 10</td>
<td>77 ± 8</td>
</tr>
<tr>
<td>Diabetic retinopathy (yes/no)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fundoscopy</td>
<td>4/7</td>
<td>3/2</td>
</tr>
<tr>
<td>Fluorescein angiography</td>
<td>8/3</td>
<td>3/2</td>
</tr>
</tbody>
</table>

Data are number of patients, means ± SD, or medians (ranges) at the fourth examination.

Retinopathy. At the fourth examination, retinopathy was absent on fundoscopy in nine patients and present in seven. When angiography, a more sensitive method, was used as the criterion, retinopathy was absent in 5 patients and present in 11. Retinopathy was mild and consisted of microaneurysms (in nine patients), small hemorrhages (in five patients), and dilated capillaries (in seven patients; angiographic data). No patient had proliferative changes. Patients in whom retinopathy was absent on fundoscopy did not differ from those in whom it was present with regard to follow-up duration, sex distribution, age, diabetes duration, BMI, or serum creatinine at the fourth examination. In addition, ANOVA indicated no differences, at examinations I—4, in UAE, glycated hemoglobin, serum cholesterol, or systolic and diastolic BP. Plasma vWF was also similar (124% [98–210] vs. 122% [87–170], 139% [101–200] vs. 145% [93–274], 140% [102–210] vs. 140% [82–270], and 139% [112–237] vs. 130% [88–209], respectively).

Microalbuminuria reflects an increased transcapillary passage of macromolecules (1), a phase that, in IDDM, is preceded by a clear and persistent increase in vWF levels, as shown by our study. Such data are not available for NIDDM or hypertension, although high vWF levels in NIDDM may similarly increase the risk of development of microalbuminuria and the risk of clinical cardiovascular disease once microalbuminuria is present (17). It is not clear, however, whether the prognostic value of vWF is related to its specific functions, i.e., enhancement of platelet adhesion and factor VIII availability, or whether it is simply a marker of endothelial injury and dysfunction. Nevertheless, both UAE and vWF deserve consideration as clinically useful markers of vascular status.

Determinants of increases in vWF, i.e., of endothelial injury, were not identified. Increases in vWF are nonspecific with respect to the type of injury and can be induced by hypertension, smoking, hypercholesterolemia, hyperglycemia, activation of coagulation, and cytokines (13,18,19). The pathogenesis of microalbuminuria is likely to involve hyperglycemia and an early rise in BP (1,3,20–22). Our study was small and excluded patients with poor glycemic control, thereby limiting the ability to find a relation between UAE or vWF and glycated hemoglobin (11) or BP (20–22). In addition, susceptibility to the development of diabetic nephropathy (and presumably microalbuminuria) is thought to vary.
among individuals (23). Variability among individuals in the susceptibility to injury of the endothelium might play a role, and this would hamper the identification of determinants of endothelial injury in cohort studies. Finally, other factors not assessed in this study may be important, such as insulin resistance, hyperinsulinemia, dyslipidemia, and activation of coagulation (19,24–26).

Are our findings generalizable? Clearly, selection bias cannot be completely excluded in a small study such as this. On the other hand, the patients were not selected on the basis of plasma vWF; therefore, the relationship between UAE and vWF is unlikely to have been affected by selection bias. In addition, the incidence density of microalbuminuria observed (6.3 or 4.2 [4 of 17; Fig. 1] with 20 μg/min [1.3,22] instead of 15 μg/min as cutoff) is within the range reported by others (1.1–8.2 [20–22,27–31]). Finally, the exclusion of patients with poor glycemic control may have increased the within-person stability of plasma vWF levels. Thus, the applicability of our results to patients with poorly controlled diabetes is somewhat uncertain.

Nevertheless, a sustained increase in plasma vWF in patients with IDDM is associated with a high risk of development of microalbuminuria. We suggest that such patients are candidates for intensified treatment of hyperglycemia and of rises in BP (even small ones).

ACKNOWLEDGMENTS

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REFERENCES