Is hyperhomocysteinaemia a risk factor for recurrent venous thrombosis?


Summary
Several studies have shown a relation between hyperhomocysteinaemia and arterial vascular disease. We looked at the association between hyperhomocysteinaemia and venous thrombosis which could be clinically important as hyperhomocysteinaemia is easily corrected by vitamin supplementation.

We studied 185 patients with a history of recurrent venous thrombosis and 220 controls from the general population. Homocysteine concentrations were measured before and 6 h after oral methionine loading. We defined hyperhomocysteinaemia as the homocysteine concentration above the fasting or the postmethionine concentration above the 90th percentile of the controls (unadjusted odds ratio 3.1 [1.8-5.5]). After adjustment for age, sex, and menopausal status the odds ratio was 3.1 [1.8-5.5]). Hyperhomocysteinaemia is a common risk factor for recurrent venous thrombosis and can lead to a two-fold or three-fold increase in risk.

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Is hyperhomocysteinaemia a risk factor for recurrent venous thrombosis?

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Introduction
Hyperhomocysteinaemia is a disorder of methionine metabolism. Several studies have shown a relation between mild hyperhomocysteinaemia and vascular disease. However, little attention has been directed towards venous thrombosis, which is surprising because of the high frequency of venous thrombosis among patients with classical homocysteinuria. We present the results of a study on the relation between mild hyperhomocysteinaemia and venous thrombosis in patients with recurrent venous thrombosis.

Patients and methods
Patients were selected from the files of the anticoagulant clinic of The Hague. In the Netherlands, virtually all patients with a history of recurrent venous thrombosis have long-term coumarin therapy and are registered at an anticoagulant clinic. All patients between 20 and 90 years who had had two or more episodes of venous thrombosis were invited to take part. Pregnancy was the only exclusion criterion. Of the 473 patients approached, 185 participated (39%).

We recruited the control group through a general practice in The Hague. We invited 220 people aged 20-90 from this practice to take part in a health survey of risk factors for cardiovascular disease. 532 people agreed to participate and the first 220 formed the control group.

We obtained a short medical history of all patients by interview and all controls by questionnaire. A methionine-loading test was done on all subjects. This test consisted of a basal homocysteine measurement (after overnight fasting) and a second homocysteine measurement 6 h after oral methionine loading (0.1 g L-methionine per kg bodyweight in 200 mL orange juice), A diet poor in protein was given to the patients during the tests. We obtained blood samples from the antecubital vein in 5 mL Vacutainer tubes and 4-5 mL EDTA vacuum glass tubes for determination of the homocysteine and vitamin concentrations and routine laboratory measurements (creatinine, aspartate aminotransferase, alanine aminotransferase, gammaglutamyl...
transpeptidase, alkaline phosphatase, and a whole blood count. The EDTA-samples for homocysteine measurement were immediately placed on ice and centrifuged at 3500 g for 5 min within 2 h. The plasma was separated and stored at ~20°C until analysis.

Routine laboratory tests were done with a Kodak Ektachem Processor. Vitamin B12 and folic acid concentrations were measured in serum samples stored at ~70°C with the Dalcount SPNB (solid phase no boil) Radiosay (Diagnostic Product Corporation, Los Angeles, USA). The total homocysteine concentration in plasma was measured in the laboratory of Paediatrics and Neurology of the Nijmegen University Hospital. Vitamin B12 and folic acid concentrations were calculated for the three higher levels and compared them with the lowest reference level. We also calculated a logistic regression model, which represented the proportion of all cases of recurrent thrombosis attributable to hyperhomocysteinemia, provided that the relation between hyperhomocysteinemia and thrombosis is a causal one.

The study protocol was approved by the ethics committee of the Leyenburg Hospital.

**Results**

The mean age of the patient group invited was 67 (range 20–97) years old. For patients who took part mean age was 61 (range 23–88) years compared with 51 (21–84) years in controls. The ratio between pulmonary embolism and deep venous thrombosis as main diagnosis was 1/1·6 in the group of patients invited and 1/1·5 in patients taking part in the study. The median time between the first episode of thrombosis and the study was 17 (range 1–58) years; the median time between the last episode of thrombosis and the study was 7 (range 1–30) years.

The figure shows the individual homocysteine fasting and post-methionine values. The cut-off point was defined as the 90th percentile of the distribution among the control subjects (18·6 μmol/L for the fasting value and 58·8 μmol/L for the post-methionine value). These cut-off points are comparable to the reference values (mean ± 2 SD) obtained from healthy, younger volunteers in the laboratory of Nijmegen with values of 18, 15, and 19 μmol/L for the fasting homocysteine concentration and 54, 51, and 69 μmol/L for the post-methionine homocysteine concentration for men, premenopausal women, and postmenopausal women, respectively.

Among the patients with thrombosis, 46 (25%) had fasting homocysteine concentrations above the cut-off

Table 1: Homocysteine concentrations and risk of recurrent venous thrombosis

<table>
<thead>
<tr>
<th>Fasting homocysteine concentrations</th>
<th>Cases 105</th>
<th>Controls 220</th>
<th>Odds ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;90th percentile (18·6 μmol/L)</td>
<td>46</td>
<td>21</td>
<td>3·1 (1·8–5·5)</td>
</tr>
<tr>
<td>≤90th percentile (18·6 μmol/L)</td>
<td>139</td>
<td>199</td>
<td>1·0 (0·5–2·3)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Post-methionine homocysteine concentrations</th>
<th>Cases 105</th>
<th>Controls 220</th>
<th>Odds ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;90th percentile (58·8 μmol/L)</td>
<td>44</td>
<td>20</td>
<td>3·1 (1·7–5·5)</td>
</tr>
<tr>
<td>≤90th percentile (58·8 μmol/L)</td>
<td>141</td>
<td>200</td>
<td>1·0 (0·5–2·3)</td>
</tr>
</tbody>
</table>

Table 2: Thrombosis risk for different cut-off points of homocysteine concentrations

We calculated crude odds ratios as estimates of the relative risk and used Miettinen's test-based 95% CI. Adjusted odds ratios were calculated with a logistic regression model. These odds ratios reflected the risk of recurrent thrombosis for people with hyperhomocysteinemia compared with normal individuals when the data were adjusted for age, sex, and menopausal status. To find a dose-response relation we stratified the homocysteine concentrations of both cases and controls into quartiles and calculated the odds ratios for the three higher levels and compared them with the lowest reference level. We also calculated an aetiological fraction, which represented the proportion of all cases of recurrent thrombosis attributable to hyperhomocysteinemia, provided that the relation between hyperhomocysteinemia and thrombosis is a causal one.
The importance of hyperhomocysteinaemia as a risk factor for venous thrombosis is a function of the odds ratio and the prevalence in the general population. This is reflected by the aetiologic fraction. For the fasting value we calculated an aetiologic fraction of 0.17 (CI 0.08-0.23) for the post-methionine value at the 90th percentile of the control group.

We stratified the homocysteine measurements of both patients and controls into quartiles and calculated the odds ratios for the three highest levels and compared them with the lowest (Table 3). For fasting and post-methionine values the odds ratio increased with homocysteine concentration.

Discussion

Our study shows that hyperhomocysteinaemia is a risk factor for recurrent venous thrombosis. Because the enrolment of incident cases with recurrent venous thrombosis would have taken a long time, we invited patients from an anti-coagulant clinic who were registered with a history of recurrent venous thrombosis.

This implicates a concession to diagnostic accuracy. So it is possible that some patients might not have had recurrent venous thrombosis according to present criteria of objective testing. However, if this is the case our results will only be diluted, and the real association between hyperhomocysteinaemia will be stronger. Furthermore, in 100 patients we were able to trace medical records and found a positive objective test for venous thrombosis. In this subgroup we came to the same conclusion.

Up to now there is no consensus about reference values for plasma homocysteine concentrations. Most clinical studies on hyperhomocysteinaemia refer to laboratory reference values, usually obtained from healthy young volunteers. However, we found it more suitable to use a control group from the general population, i.e., the population where the patients came from. First we analysed our data at different cut-off points. A cut-off point at the 90th percentile of the control group is quite similar to the reference value based on a laboratory staff control group, which is younger and might have less comorbidity. This means that, with respect to these laboratory reference values hyperhomocysteinaemia is quite common in our control group, which is recruited from a general population.

We also found an increasing odds ratio with an increasing homocysteine concentration. This finding implies that there is no certain sharp cut-off point at all.

Table 3: Thrombosis risk for strata of homocysteine concentrations

<table>
<thead>
<tr>
<th>Fasting homocysteine concentrations</th>
<th>Cases (n=85)</th>
<th>Controls (n=220)</th>
<th>Total (n=305)</th>
<th>Odds ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st quartile &lt;10-0 μmol/L</td>
<td>26</td>
<td>68</td>
<td>104</td>
<td>1.0</td>
</tr>
<tr>
<td>2nd quartile 11-0-14-0 μmol/L</td>
<td>35</td>
<td>66</td>
<td>101</td>
<td>1.0 (0.9-1.1)</td>
</tr>
<tr>
<td>3rd quartile 14-0-17-0 μmol/L</td>
<td>51</td>
<td>49</td>
<td>100</td>
<td>2.0 (1.3-3.6)</td>
</tr>
<tr>
<td>4th quartile &gt;17-0 μmol/L</td>
<td>63</td>
<td>37</td>
<td>100</td>
<td>3.2 (1.8-5.5)</td>
</tr>
</tbody>
</table>

| Post-loading homocysteine concentrations | | | |
|-----------------------------------------| | | |
| 1st quartile <35-5 μmol/L              | 24          | 77              | 101           | 1.0                |
| 2nd quartile 35-5-43-0 μmol/L          | 47          | 59              | 106           | 2.7 (1.5-5.0)      |
| 3rd quartile 43-0-64-0 μmol/L          | 50          | 52              | 102           | 3.3 (1.7-5.7)      |
| 4th quartile >64-0 μmol/L              | 64          | 35              | 100           | 5.1 (3.1-8.3)      |

*Reference category: odds ratio=1. Test for trend, p<0.001.
Battstrom et al reported no significant difference between patients with venous thrombosis and controls that might have been because of the small sample size (42 cases and 42 controls). From their data we were able to calculate an odds ratio for primary thrombosis of 3.1 (0.40-27.7). Falcon et al found a high percentage of hyperhomocysteinemia (18.8%) in patients with one or more events of venous thrombosis before 40 years. Our study shows that for recurrent thrombosis this observation might have been because of the small sample size between patients with venous thrombosis and controls unknown. There is some evidence that homocysteine hyperhomocysteaemia can provoke thrombosis is Battstrom et al reported no significant difference from our data. The underlying mechanism by which hyperhomocysteinemia may cause thrombosis is unknown. There is some evidence that homocysteine contributes to endothelial damage in the arterial vessel wall, but it is not clear whether this mechanism has a role in venous thrombosis. Another mechanism has been postulated by Rodgers et al who found an in vitro effect of homocysteine on factor V activation and inhibition of thrombomodulin-dependent protein C activation. Moreover, an effect of homocysteine on thrombocyte aggregation has been reported.

Hyperhomocysteinemia may be the result of a hereditary defect in the enzymes involved in methionine metabolism or it might be acquired as a result of vitamin deficiency. It is not known whether the two types confer a similar risk of thrombosis. However, we did not find lower folate acid and vitamin B12 concentrations in patients than in controls. In fact we found higher homocysteine concentration at a given folate acid concentration in patients than in controls (data not shown.) This finding may suggest that some form of decreased enzyme activity and not vitamin deficiency leads to thrombosis. Several studies have shown that hyperhomocysteinemia can be corrected by vitamin supplementation. Whether vitamin supplementation for those with high levels of homocysteine will be beneficial with respect to prevention of (recurrent) venous thrombosis has to be further studied.

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