Familial Combined Hyperlipidemia Is Associated With Alterations in the Cholesterol Synthesis Pathway
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Arterioscler Thromb Vasc Biol. 2010;30:113-120; originally published online October 15, 2009; doi: 10.1161/ATVBAHA.109.196550

Arteriosclerosis, Thrombosis, and Vascular Biology is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 1079-5642. Online ISSN: 1524-4636

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Clinical and Population Studies

Familial Combined Hyperlipidemia Is Associated With Alterations in the Cholesterol Synthesis Pathway


Objectives—Familial combined hyperlipidemia (FCH) is a common familial lipid disorder characterized by increases in plasma total cholesterol, triglyceride, and apolipoprotein B-100 levels. In light of prior metabolic and genetic research, our purpose was to ascertain whether FCH cases had significant abnormalities of plasma markers of cholesterol synthesis and absorption as compared to unaffected kindred members.

Methods and Results—Plasma levels of squalene, desmosterol, and lathosterol (cholesterol synthesis markers) and campesterol, sitosterol, and cholestanol (cholesterol absorption markers) were measured by gas-liquid chromatography in 103 FCH patients and 240 normolipidemic relatives (NLR). Squalene, desmosterol, and lathosterol levels were 6% (0.078), 31% (P<0.001) and 51% (P<0.001) higher in FCH as compared to NLR, and these differences were especially pronounced in women. An interaction with obesity was also noted for a subset of these markers. We did not observe any apparent differences for the cholesterol absorption markers among FCH patients and NLR.

Conclusions—Our data indicate that both men and women with FCH have alterations in the cholesterol synthesis pathway, resulting in 51% higher levels of lathosterol (and additionally desmosterol in women). Plasma levels of the cholesterol precursor sterol squalene were only slightly increased (6%), suggesting enhanced conversion of squalene to lathosterol in this disorder. (Arterioscler Thromb Vasc Biol. 2010;30:113-120.)

Key words: cholesterol ■ lipids ■ sterols ■ familial combined hyperlipidemia
whereas the plant sterols campesterol and sitosterol (both derived from the diet), and the bile acid residue cholesta-
ol, are all absorbed in very low quantities in the intestine and their plasma levels have been demonstrated to serve as markers of fractional cholesterol absorption. In support, treatment with cholesterol synthesis and absorption inhibitors (ie, statins and ezetemibe) not only lower total cholesterol levels, they also specifically lower plasma levels of these (ie, apoB48 particles, and remnant lipoprotein cholesterol (RLPC), of which apoB-48 is a specific marker of intestinal lipid transport.

For the current study we measured squalene, desmos-
terol, lathosterol (markers of synthesis) and campesterol, and sitosterol and cholesterol (markers of absorption) in a population of FCH patients and their normolipidemic relatives (NLR). In addition, we also performed an extensive characterization of the lipid profiles in these FCH families, measuring total cholesterol, triglycerides, LDL-C, HDL-C and VLDL-C, sdLDL-C, total apoB levels, apoB48 particles, and remnant lipoprotein cholesterol (RLPC), which of apoB-48 is a specific marker of intestinal lipid transport.

Methods

Study Population

The study population consisted of 343 subjects, 103 FCH patients and 240 NLR, from 32 well-defined FCH families. The diagnosis of FCH was based on a previously established nomogram. Briefly, plasma triglycerides and total cholesterol levels, adjusted for age and gender, and absolute apoB levels were included in a nomogram to calculate the likelihood of having FCH. A subject was defined as being affected with FCH if the probability was above 60%, provided that the diagnostic phenotype was also present in at least 1 first-degree relative and premature CVD (ie, before the age of 60) was present in at least 1 individual in the family. Families were excluded when a secondary cause of the hyperlipidemia was diagnosed in the proband (ie, diabetes mellitus, hypothyroidism, and hepatic or renal impairment). Before the start of the study all participants withdrew from using lipid-lowering medication for at least 4 weeks. Blood was drawn after an overnight fast for laboratory analyses and the isolation of DNA. The ethics committee of the Radboud University Nijmegen Medical Center approved the study protocol and all subjects gave informed consent.

Laboratory Measurements

Plasma total cholesterol, triglycerides, LDL-C, VLDL-C, HDL-C, apoB, and glucose concentrations in all subjects were determined using routine laboratory procedures as previously described. Insulin was measured directly by an immunoassay obtained from the Otsuka Corporation. Small dense (sd) LDL-C was measured using kits obtained from the Denka Seiken Company. RLPC was measured using kits obtained from the Kyowa Medex Corporation, and plasma apoB48 was measured by an enzyme linked immunoassay obtained from the Shibayagi Company as previously described. All assays had within and between run coefficients of variation of less than 5%, and the nonroutine assays were only performed on a subset of subjects because of limited sample availability (see footnote to Table 1).

Statistical Analyses

All continuous variables were checked for their distribution and expressed as means±SD, or in the case of nonlinear distributions,
Table 2. Correlations of the Cholesterol Synthesis and Absorption Markers With BMI, WHR, Glucose, and Insulin in All Subjects (n=343)

<table>
<thead>
<tr>
<th></th>
<th>BMI</th>
<th>WHR</th>
<th>Glucose</th>
<th>Insulin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Squalene</td>
<td>0.062</td>
<td>0.059</td>
<td>−0.013</td>
<td>−0.011</td>
</tr>
<tr>
<td>Lathosterol</td>
<td>0.482*</td>
<td>0.471*</td>
<td>0.389*</td>
<td>0.336*</td>
</tr>
<tr>
<td>Desmosterol</td>
<td>0.337*</td>
<td>0.320*</td>
<td>0.360*</td>
<td>0.304*</td>
</tr>
<tr>
<td>Campesterol</td>
<td>−0.082</td>
<td>0.081</td>
<td>0.076</td>
<td>−0.074</td>
</tr>
<tr>
<td>Sitosterol</td>
<td>−0.128†</td>
<td>0.030</td>
<td>0.074</td>
<td>−0.148†</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>−0.063</td>
<td>0.032</td>
<td>−0.013</td>
<td>−0.110</td>
</tr>
</tbody>
</table>

Values represent Spearman Rank correlation coefficients. *P<0.001 and †P<0.05.

Results

The characteristics of the 103 patients with FCH and the 240 NLR are presented in the study population at large, as well as stratified by gender (Table 1). There was no difference in the gender distribution among FCH patients and those of the NLR, although the FCH group was significantly older and had higher BMIs and WHRs (P<0.05 for all comparisons). FCH patients had higher glucose (P<0.01) and insulin (P<0.001) levels and as expected, higher levels of total cholesterol, triglycerides, non-HDL-C, VLDL-C, and VLDL-TG (P<0.001, for all parameters) and HDL-C levels were significantly lower. In addition, RLPC, apoB and apoB48 (the intestinal apoB), were significantly higher (P<0.001, for all comparisons) in FCH as compared to the NLR. There were interesting gender differences among FCH patients and the NLR. In women, FCH was associated with 33% higher LDL-C levels and 100% higher sdLDL-C levels (P<0.001, for both comparisons), whereas these differences were not observed in the men. As mentioned above, apoB48 levels were higher in the FCH group when compared to the NLR, however the percentile difference observed in men was almost twice as high as the difference seen in women (250% higher versus +13%).

Individual correlations between markers cholesterol synthesis and absorption in relation to markers of obesity and insulin resistance are presented in Table 2. In the combined study groups, lathosterol and desmosterol levels correlated (all at P<0.001) with BMI and WHR and with glucose and insulin levels. In addition, there was a small inverse correlation for sitosterol with BMI and insulin levels (both P<0.05, Table 2). Supplemental Table I (available online at http://atvb.ahajournals.org) provides data showing a better correlation for lathosterol and desmosterol with glucose levels and a less pronounced correlation with insulin levels in the FCH patients compared to the NLR. The nature of these correlations remained the same in gender subgroups (data not shown).

We observed a strong correlation between both lathosterol and desmosterol in relation to apoB, triglycerides, and LDL-C (P<0.001 for all), which appeared to be stronger in women than in men (supplemental Table II). In addition, apoB and LDL-C correlated with campesterol and sitosterol in both men and women and with cholesterol in men only (supplemental Table II).

The FCH phenotype was associated with increased markers of cholesterol synthesis (Table 3). Lathosterol levels were elevated by 51% (P<0.001) in FCH, squalene tended to be higher in FCH (+6%, P=0.125), however, this effect was observed in women only (+15%, P<0.001) and not in men. In addition, desmosterol levels were 54% higher in female FCH patients (P<0.001) and only 11% higher in male FCH patients (P=0.069) when compared to their NLR counterparts. To account for the fact that plasma sterols are mainly transported in the LDL and HDL particles,34 values were also presented as ratio to total cholesterol (/C). Although squalene concentrations were increased in female FCH patients 15% (P=0.001), squalene/C levels were actually reduced in both male and female FCH patients by −21% (P=0.010) and −14% (P=0.050), respectively, independent of BMI. Desmosterol/C and lathosterol/C overall remained comparable to the unadjusted values, desmosterol/C being elevated in women by 24% (P=0.002) and lathosterol/C in both men and women by 17% (P=0.013) and 22% (P<0.001), respectively. Adjusting the lathosterol and desmosterol associations for BMI did not affect the level of significance of the sterol markers when expressed in absolute terms, however the associations were no longer significant when using the sterol values normalized to total cholesterol.

Markers of cholesterol absorption in FCH patients and NLR are presented in Table 4. With regard to these markers there was evidence for a gender interaction. In men with FCH, absolute concentrations of campesterol and sitosterol tended to be elevated by 21% (P=0.065), while remaining constant in women. After adjusting for BMI, the differences were significant (P=0.012 and P=0.027). Normalized to total cholesterol, campesterol/C and sitosterol/C were no longer elevated in men and significantly lower in women with FCH (−26%, P=0.003 and −25%, P=0.004, respectively). Absolute cholesterol concentrations were not different in FCH, but cholesterol/C was 16% lower (P<0.001) in both men and women with FCH and independent of BMI.

Although we did not observe correlations between the markers of synthesis and absorption when expressed in absolute terms (data not show), there was a negative correlation between lathosterol/C and campesterol/C in the NLR (r=−0.271, P<0.001) not observed in the FCH patients (r=−0.156, P=0.120). Furthermore, the lathosterol/campesterol ratio was 37% higher in FCH patients than in NLR, and this was predominantly attributable to the elevations observed in women (66%) rather than in men (19%) (Table 5).
Discussion

Since the description and characterization of the FCH phenotype more than 30 years ago,1 many studies have been undertaken to uncover the mechanisms causing FCH. Both the results of biochemical investigations as well as the results from candidate gene studies and genome wide scan studies have been of great interest, but the actual cause of the elevated total cholesterol, triglycerides, and apoB levels as well as the underlying genetic defect has not yet been elucidated. This study shows that both men and women with FCH have higher levels of the cholesterol precursor lathosterol when compared to their NLR. Based on these findings we hypothesize that patients with FCH have an underlying defect in sterol metabolism resulting in overproduction of lathosterol and cholesterol.

Although we found marginally higher levels of plasma squalene (6%), this effect was predominantly attributable to increased squalene levels in women (15%). When the squalene levels were expressed as a ratio over total cholesterol, we found them to be lower in both men and women. The cholesterol precursor lathosterol was elevated in men and women with FCH (both in absolute terms as well as adjusted for total cholesterol), suggesting that there is either enhanced conversion of squalene to lathosterol or increased direct production of lathosterol in these patients. Although a limitation of our study is that the design is cross-sectional and does not establish causation, in FCH we find increased levels of lathosterol which correlate with apoB, triglycerides and LDL-C, suggesting that FCH is (partly) the result of an imbalance in the cholesterol synthesis pathway and future research should focus on regulators within this pathway.

In contrast to the markers of cholesterol synthesis, the differences among FCH and NLR regarding the markers of cholesterol absorption are less clear. Both campesterol and sitosterol tended to be higher in FCH patients, but these...
findings were restricted to men and were only significant when taking into account BMI. When the absorption markers were expressed relative to total cholesterol, we found significantly lower levels in women for campesterol/C and sitosterol/C. Cholestanol/C was lower in both men and women. The question remains however whether the association of FCH with lower values for the absorption markers over cholesterol is a true effect (ie, the result of lower cholesterol absorption), or whether it is the result of dividing a constant concentration of absorption markers by a higher total cholesterol concentration caused by increased cholesterol synthesis. Furthermore, it is known that dietary intake of plant sterols can affect plasma concentrations of campesterol and sitosterol. Because no dietary information was collected, we cannot rule out that FCH patients were consuming greater amounts of dietary

Table 4. Cholesterol Absorption Markers, Expressed in Absolute Concentrations as Well as Normalized to Total Cholesterol, in the Normolipidemic Relatives (NLR) and Patients With Familial Combined Hyperlipidemia (FCH)

<table>
<thead>
<tr>
<th>Sterols expressed in µmol/L</th>
<th>NLR</th>
<th>FCH</th>
<th>% Difference FCH vs NLR</th>
<th>P Value†</th>
<th>BMI Adj. P Value‡</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Campesterol</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>9.7 (7.1, 13.2)</td>
<td>11.0 (7.8, 15.3)</td>
<td>13</td>
<td>0.191</td>
<td>0.022</td>
</tr>
<tr>
<td>Men</td>
<td>10.2 (7.7, 14.2)</td>
<td>12.3 (9.7, 17.3)</td>
<td>21</td>
<td>0.065</td>
<td>0.012</td>
</tr>
<tr>
<td>Women</td>
<td>9.1 (6.8, 12.3)*</td>
<td>9.5 (7.1, 13.0)*</td>
<td>4</td>
<td>0.726</td>
<td>0.243</td>
</tr>
<tr>
<td><strong>Sitosterol</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6.2 (4.7, 8.1)</td>
<td>7.1 (4.7, 10.1)</td>
<td>15</td>
<td>0.167</td>
<td>0.006</td>
</tr>
<tr>
<td>Men</td>
<td>6.2 (4.9, 8.3)</td>
<td>7.5 (5.5, 10.4)</td>
<td>21</td>
<td>0.131</td>
<td>0.027</td>
</tr>
<tr>
<td>Women</td>
<td>6.2 (4.6, 8.0)</td>
<td>6.1 (4.5, 9.5)</td>
<td>−2</td>
<td>0.571</td>
<td>0.068</td>
</tr>
<tr>
<td><strong>Cholestanol</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>7.8 (2.8)</td>
<td>8.1 (3.0)</td>
<td>4</td>
<td>0.387</td>
<td>0.303</td>
</tr>
<tr>
<td>Men</td>
<td>8.3 (3.1)</td>
<td>8.3 (2.3)</td>
<td>0</td>
<td>0.912</td>
<td>0.887</td>
</tr>
<tr>
<td>Women</td>
<td>7.3 (2.4)*</td>
<td>7.9 (3.4)</td>
<td>8</td>
<td>0.180</td>
<td>0.125</td>
</tr>
</tbody>
</table>

Sterols expressed as 10^2 mmol/mol cholesterol

<table>
<thead>
<tr>
<th>Sterols expressed as 10^2 mmol/mol cholesterol</th>
<th>NLR</th>
<th>FCH</th>
<th>% Difference FCH vs NLR</th>
<th>P Value†</th>
<th>BMI Adj. P Value‡</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Campesterol/C</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>203 (155, 264)</td>
<td>169 (135, 241)</td>
<td>−17</td>
<td>0.011</td>
<td>0.302</td>
</tr>
<tr>
<td>Men</td>
<td>200 (152, 286)</td>
<td>181 (158, 273)</td>
<td>−10</td>
<td>0.839</td>
<td>0.369</td>
</tr>
<tr>
<td>Women</td>
<td>207 (158, 259)</td>
<td>154 (113, 211)†</td>
<td>−26</td>
<td>0.003</td>
<td>0.052</td>
</tr>
<tr>
<td><strong>Sitosterol/C</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>128 (98, 165)</td>
<td>109 (82, 152)</td>
<td>−15</td>
<td>0.004</td>
<td>0.396</td>
</tr>
<tr>
<td>Men</td>
<td>121 (96, 157)</td>
<td>119 (86, 163)</td>
<td>−2</td>
<td>0.347</td>
<td>0.710</td>
</tr>
<tr>
<td>Women</td>
<td>135 (100, 170)</td>
<td>101 (78, 148)</td>
<td>−25</td>
<td>0.004</td>
<td>0.164</td>
</tr>
<tr>
<td><strong>Cholestanol/C</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>160 (53)</td>
<td>134 (48)</td>
<td>−16</td>
<td>0.001</td>
<td>0.010</td>
</tr>
<tr>
<td>Men</td>
<td>162 (56)</td>
<td>135 (40)</td>
<td>−17</td>
<td>0.030</td>
<td>0.067</td>
</tr>
<tr>
<td>Women</td>
<td>158 (50)</td>
<td>133 (53)</td>
<td>−16</td>
<td>0.015</td>
<td>0.059</td>
</tr>
</tbody>
</table>

*Significantly different from men at P<0.05 within the subgroup. †P values adjusted for age and family structure. ‡P values adjusted for age and family structure and BMI.

Table 5. Ratios of Lathosterol Over Campesterol in the Normolipidemic Relatives (NLR) and Patients With Familial Combined Hyperlipidemia (FCH)

<table>
<thead>
<tr>
<th>Lathosterol/campesterol ratio</th>
<th>NLR</th>
<th>FCH</th>
<th>% Difference FCH vs NLR</th>
<th>P Value†</th>
<th>BMI Adj. P Value‡</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>0.71 (0.43, 1.11)</td>
<td>0.97 (0.67, 1.42)</td>
<td>37</td>
<td>&lt;0.001</td>
<td>0.194</td>
</tr>
<tr>
<td>Men</td>
<td>0.77 (0.39, 1.27)</td>
<td>0.92 (0.71, 1.18)</td>
<td>19</td>
<td>0.097</td>
<td>0.305</td>
</tr>
<tr>
<td>Women</td>
<td>0.62 (0.44, 1.01)*</td>
<td>1.03 (0.66, 1.71)*</td>
<td>66</td>
<td>&lt;0.001</td>
<td>0.018</td>
</tr>
</tbody>
</table>

*Significantly different from men at P<0.05 within the subgroup. †P values adjusted for age and family structure. ‡P values adjusted for age and family structure and BMI.
plant sterol margarines and other sterols as compared to controls. Finally, even though we noted elevated levels of apoB48 in FCH patients, these elevations are likely a reflection of delayed clearance of intestinal remnant lipoproteins as previously described in FCH, rather than attributable to increased absorption, and overall, these findings suggest that FCH is not associated with altered cholesterol absorption.

Previous studies suggest a central role for fat mass in the onset of FCH. In agreement with this concept, we found associations indicating that there is an interaction between plasma sterols and BMI which may play a central role in the onset of FCH. The relationship between obesity and cholesterol production is not straightforward because more fat mass does not always cause excess cholesterol production. This concept was illustrated by a recent study from the laboratory in 19 severely obese women undergoing bypass surgery, showing a markedly reduction in fat mass without a significant reduction in total cholesterol levels. A possible mechanism linking plasma sterols to fat metabolism may come from the demonstration that sterol intermediates from the cholesterol synthesis pathway, especially desmosterol, act as liver x receptor (LXR) ligands. LXR stimulates hepatic triglyceride synthesis and fat storage and has been described as a master regulator of fat metabolism. Further studies are necessary to determine a possible interaction between LXR, desmosterol and the other plasma sterols in cases with FCH versus controls.

We have performed extensive characterization of the lipid and apolipoprotein profiles in FCH patients and their NLR, as well as in subgroups of men and women, and found that within the FCH group LDL-C and sdLDL-C were elevated in women only. This may suggest that in female FCH patients there is even greater cholesterol synthesis than in male FCH patients. In agreement, the cholesterol synthesis data also suggest that there are gender specific mechanisms associated with FCH. Although lathosterol was elevated in both male and female FCH patients, the effect seemed to be more prominent in women than in men (62% versus 42%). The other cholesterol precursors, squalene and desmosterol, were significantly higher (15% and 54%, respectively) in FCH women while remaining constant in men. These increases observed in FCH women were attributable to the fact that in the NLR group the women had lower sterol levels than the men. This was especially true for desmosterol. In women, desmosterol levels were higher in the FCH compared to the NLR group, but similar to the levels seen in the FCH men. To speculate on a possible underlying mechanism, recent studies demonstrate that the enzyme responsible for the conversion of desmosterol to cholesterol (ie, 24-dehydrocholesterol reductase, DHCR24 also known as Seladin-1), is activated by estrogens. In theory the activation of the DHCR24 by estrogens may be reduced in postmenopausal women when compared to premenopausal women (57% higher, P<0.001).

To our knowledge this is the second study to measure synthesis and absorption markers in FCH patients. Previously, Garcia-Otin and colleagues measured cholesterol synthesis and absorption markers among autosomal dominant hypercholesterolemia (ADH) patients, including 31 patients with familial hypercholesterolemia and 38 patients with FCH. In contrast to our study, which was designed to gain insight into the mechanism underlying FCH, the primary objective of the Garcia-Otin group was to use these markers to differentiate between the different forms of ADH. They noted that the campesterol/C and sitosterol/C ratios were lower in the FCH patients when compared to controls, which is in line with our cholesterol adjusted ratios were lower in the FCH patients when compared to controls, but they observed no differences for the lathosterol/C ratio, suggesting that alterations in absorption markers were associated with FCH. Their study, however, was conducted in a FCH group consisting of predominantly men (27 versus 11 women), and limited numbers prevented them from analyzing subgroups. Because this is the second study to measure synthesis and absorption markers in a FCH population, replication of these findings is necessary in different study populations, preferably using the same standardized diagnostic criteria for FCH.

Finally, we would like to speculate on possible novel candidate genes, taking into account our findings that the FCH phenotype was associated with elevated cholesterol synthesis markers. USF1 has been suggested to be the most important candidate gene for FCH. However, in these families USF1 was not a major gene for FCH, but rather a modifier gene contributing to related lipid traits. Recently, a whole genome study mapped all the target regions of USF1 and identified multiple regions involved in the
lipid metabolism, including a number of vital genes in
the synthesis of cholesterol summarized in supplemental
Table III. Of these genes, sterol-C5-desaturase-like
(SC5DL) plays a crucial role in the formation of choles-
terol from lathosterol and the (earlier mentioned) DHCR24
is involved in many steps of the synthesis of cholesterol,
one of which is the conversion of desmosterol to choles-
terol. Our findings of elevated lathosterol in both men and
women with FCH, and the association of lathosterol with
LDL-C, triglycerides, and apoB in our entire study popu-
lation, raises the possibility that the SC5DL gene is a
candidate gene for FCH. In addition, when the chromo-
some 1 data were reanalyzed in the Dutch population, it
revealed that 1p31 was strongly linked to elevated apoB
levels. The authors hypothesized that the nearby leptin
receptor (LEPR) gene was involved, but the data proved to
be negative. Although speculative, the DHCR24 gene is
also located in this region (Table 4) and based on our
findings of increased desmosterol in women and the
association of desmosterol with apoB levels, we hypothe-
size that alterations in this gene may cause elevated apoB
rather than the LEPR gene. Future studies, sequencing the
SC5DL as well as the DHCR24 genes in FCH patients,
appear to be warranted.

In conclusion, our study indicates that FCH patients have
alterations in the cholesterol synthesis pathway, resulting in
higher levels of lathosterol (and additionally desmosterol in
women). In the cholesterol synthesis pathway there are 2
enzymes that warrant further investigation: SC5DL and
DHCR24. The genes for these enzymes are located in exactly
those chromosomal regions previous linked to FCH in gene
wide scans, and code for the key enzymes involved in the
metabolism of lathosterol and desmosterol, the sterols we
found to be elevated in FCH patients. Our data indicate that
FCH patients appear to have enhanced conversion of
squalene to lathosterol, and further examination of the
SC5DL and DHCR24 genes and their gene products appear to
be justified and may ultimately lead us to a precise under-
standing of the defects underlying FCH.

Sources of Funding
T.M.v.H. was supported by the Ruth L. Kirschstein National
Research Service Award, training grant no. DK07651, and a research
grant from Unilever Food and Health Research Institute, Unilever
R&D, Vlaardingen, The Netherlands. S.O. and M.A. were supported
by research fellowships from Kyowa Medex Co, Tokyo Japan and
Denka Seiken Co, Tokyo Japan, respectively. E.J.S. was supported by
grants RO1 HL-60935, HL-74753, and P50HL083813 from the National
Institutes of Health and contract 53-3K-06 from the United
Department of Agriculture Research Service.

Disclosures
None.

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17. Aouizerat BE, Allayee H, Cantor RM, Davis RC, Lanning CD, Wen PZ,
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plasma LDL: A reevaluation of the LDL receptor paradigm. Atherosclerosis.
Supplemental Table I. Correlations of the cholesterol synthesis and absorption markers with Glucose and Insulin in NRL and FCH patients.

<table>
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<tr>
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<th>NLR</th>
<th></th>
<th>FCH</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Glucose</td>
<td>Insulin</td>
<td>Glucose</td>
<td>Insulin</td>
</tr>
<tr>
<td>Squalene</td>
<td>0.060</td>
<td>-0.031</td>
<td>-0.152</td>
<td>-0.049</td>
</tr>
<tr>
<td>Lathosterol</td>
<td>0.261*</td>
<td>0.217†</td>
<td>0.456*</td>
<td>0.112</td>
</tr>
<tr>
<td>Desmosterol</td>
<td>0.269*</td>
<td>0.239†</td>
<td>0.382*</td>
<td>0.187</td>
</tr>
<tr>
<td>Campesterol</td>
<td>-0.001</td>
<td>-0.150‡</td>
<td>0.087</td>
<td>-0.145</td>
</tr>
<tr>
<td>Sitosterol</td>
<td>0.026</td>
<td>-0.225†</td>
<td>0.008</td>
<td>-0.241‡</td>
</tr>
<tr>
<td>Cholestanol</td>
<td>0.010</td>
<td>-0.132</td>
<td>-0.067</td>
<td>0.070</td>
</tr>
</tbody>
</table>

Values represent Spearman Rank correlation coefficients. *p<0.001, †p<0.01 and ‡p<0.05.
Supplemental Table II. Correlations of the cholesterol synthesis and absorption markers with apoB, triglycerides and LDL-C in all subjects (n=343) and by gender.

<table>
<thead>
<tr>
<th></th>
<th>ApoB</th>
<th>Triglycerides</th>
<th>LDL-C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Squalene</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>0.001</td>
<td>-0.010</td>
<td>0.038</td>
</tr>
<tr>
<td>Men</td>
<td>-0.003</td>
<td>-0.151</td>
<td>0.126</td>
</tr>
<tr>
<td>Women</td>
<td>-0.038</td>
<td>0.046</td>
<td>-0.042</td>
</tr>
<tr>
<td><strong>Lathosterol</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>0.577*</td>
<td>0.534*</td>
<td>0.385*</td>
</tr>
<tr>
<td>Men</td>
<td>0.484*</td>
<td>0.514*</td>
<td>0.209†</td>
</tr>
<tr>
<td>Women</td>
<td>0.610*</td>
<td>0.498*</td>
<td>0.505*</td>
</tr>
<tr>
<td><strong>Desmosterol</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>0.452*</td>
<td>0.383*</td>
<td>0.407*</td>
</tr>
<tr>
<td>Men</td>
<td>0.236†</td>
<td>0.236†</td>
<td>0.231†</td>
</tr>
<tr>
<td>Women</td>
<td>0.550*</td>
<td>0.430*</td>
<td>0.530*</td>
</tr>
<tr>
<td><strong>Campesterol</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>0.270*</td>
<td>0.010</td>
<td>0.248*</td>
</tr>
<tr>
<td>Men</td>
<td>0.326*</td>
<td>0.000</td>
<td>0.276*</td>
</tr>
<tr>
<td>Women</td>
<td>0.201†</td>
<td>-0.005</td>
<td>0.230†</td>
</tr>
<tr>
<td><strong>Sitosterol</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>0.275*</td>
<td>-0.038</td>
<td>0.267*</td>
</tr>
<tr>
<td>Men</td>
<td>0.393*</td>
<td>0.000</td>
<td>0.334*</td>
</tr>
<tr>
<td>Women</td>
<td>0.172†</td>
<td>-0.098</td>
<td>0.212†</td>
</tr>
<tr>
<td><strong>Cholestanol</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>0.153†</td>
<td>-0.040</td>
<td>0.192*</td>
</tr>
<tr>
<td>Men</td>
<td>0.212†</td>
<td>-0.055</td>
<td>0.265†</td>
</tr>
<tr>
<td>Women</td>
<td>0.066</td>
<td>-0.086</td>
<td>0.127</td>
</tr>
</tbody>
</table>

Values represent Spearman Rank correlation coefficients. *p<0.001, †p<0.01 and ‡p<0.05.
Supplemental Table III. Key enzymes in the cholesterol metabolism pathway of which the genes posses a USF1 binding site

<table>
<thead>
<tr>
<th>Gene</th>
<th>Chromosome</th>
<th>Protein</th>
<th>Metabolic Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>MVK</td>
<td>12q24</td>
<td>mevalonate kinase</td>
<td>Converts Mevalonic acid into mevalonate 5-phosphate.</td>
</tr>
<tr>
<td>PMVK</td>
<td>1q22</td>
<td>phosphomevalonate kinase</td>
<td>Converts mevalonate 5-phosphate into mevalonate 5-diphosphate.</td>
</tr>
<tr>
<td>SC5DL</td>
<td>11q23.3</td>
<td>sterol-C5-desaturase-like</td>
<td>Converts of lathosterol into 7-dehydrocholesterol.</td>
</tr>
<tr>
<td>DHCR24</td>
<td>1p33-p31.1</td>
<td>24-dehydrocholesterol reductase (also known as Seladin-1)</td>
<td>Catalyzes the reduction of the delta-24 double bond of sterol intermediates during cholesterol biosynthesis.</td>
</tr>
</tbody>
</table>