HFE C282Y Homozygosity Is Associated With Lower Total and Low-Density Lipoprotein Cholesterol

The Hemochromatosis and Iron Overload Screening Study

Paul C. Adams, MD; James S. Pankow, PhD, MPH; James C. Barton, MD; Ron T. Acton, PhD; Cathie Leendecker-Foster, MS; Gordon D. McLaren, MD; Mark Speechley, PhD; John H. Eckfeldt, MD, PhD

Background—Previous studies have suggested a positive association of coronary heart disease risk and both serum ferritin concentrations and C282Y heterozygosity. Relationships between serum lipids, C282Y homozygosity, and serum ferritin have not been well established.

Methods and Results—The Hemochromatosis and Iron Overload Screening study screened 101 168 participants in primary care from 5 field centers in the United States and Canada with serum ferritin, transferrin saturation, and HFE genotyping for C282Y and H63D mutations. Serum lipids were measured in a subset of 176 C282Y homozygotes (63 male, 113 female whites) without a prior diagnosis of, family history, or treatment for hemochromatosis and a matched sample of participants with normal transferrin saturation and serum ferritin without C282Y or H63D mutations (wild-type, 123 male, 189 female whites). The proportion of subjects who reported using prescription cholesterol-lowering medications was ≈3 times higher in HFE wild-type subjects than C282Y homozygotes among men (22% versus 7%; P<0.02) and, in women, 2 times higher (16% versus 8%; P=0.07). After excluding subjects taking cholesterol medications, C282Y homozygotes had significantly lower mean total and low-density lipoprotein cholesterol concentrations than wild-type subjects, with larger genotypic differences for low-density lipoprotein in men (−0.62 mmol/L; 95% CI, −0.93 to −0.33) than in women (−0.28 mmol/L; 95% CI, −0.52 to −0.08).

Conclusions—Total mean serum cholesterol and low-density lipoprotein levels were lower in C282Y homozygotes than in HFE wild-type participants. Further studies are required to determine whether this is related to iron overload, HFE alleles, or other factors on C282Y-positive chromosome 6p haplotypes. (Circ Cardiovasc Genet. 2009;2:34–37.)

Key Words: hemochromatosis • iron overload • iron

Hemochromatosis associated with homozygosity for the C282Y mutation of the HFE gene is the most common genetic disorder in white populations with a prevalence of ≈1 in 200 to 300 in white persons of northern European descent.1 It has been suggested that there may be a biological advantage to persons carrying mutations of the HFE gene.2 Population studies of elderly subjects have demonstrated no difference in the frequency of HFE mutations compared to younger subjects, suggesting minimal effects of these mutations on longevity.3,4 There have been conflicting reports of the association of iron, serum ferritin (SF), and HFE mutations with coronary heart disease (CHD).5–13 Most studies have reported on associations with C282Y heterozygotes, a group which is very unlikely to have significant iron overload.7 A previous carefully designed population-based study reported lower total cholesterol and low-density lipoprotein (LDL) cholesterol in 48 C282Y homozygotes compared with HFE wild-type subjects.14 In the current study, the relationship between serum lipids, SF, and transferrin saturation (TS) in C282Y homozygotes is reported in a subset of participants from the Hemochromatosis and Iron Overload Screening (HEIRS) study.1

Clinical Perspective see p 37

Methods

The authors had full access to and take full responsibility for the integrity of the data. We have read and agree to the manuscript as written. The multicenter, multiethnic, primary care–based HEIRS study performed initial screening after informed consent on 101 168 participants for hemochromatosis and iron overload using TS and SF measurements and HFE genotyping (C282Y and H63D alleles).1
All C282Y homozygotes identified in the HEIRS study were invited to participate in a post-screening clinical examination that included collection of blood samples for additional testing. In addition, a frequency-matched comparison group was invited to attend the clinical examination from initial screening participants who had the following: (1) HFE genotype wt/wt (wild type); and (2) both TS and SF in the eligible range. Eligible ranges for men were TS 20% to 34% and SF 87 to 247 µL/L. Eligible ranges for women were TS 16% to 28% and SF 19 to 121 µL/L. Variables used for the frequency matching were field center (University of Alabama at Birmingham, University of California at Irvine, Howard University, Kaiser Permanente-Portland and Hawaii, London Health Sciences Centre), age group (24 to 44, 45 to 64, ≥65 years), and date of initial screening visit. Almost all C282Y homozygotes in the HEIRS study were white. Therefore, we restricted the present analysis to subjects who reported that they were white. Medical history including medications was recorded by the examining physician or nurse practitioner.

Total serum cholesterol was measured using the Roche cholesterol oxidase method with the Roche Modular P Chemistry analyzer (Roche Diagnostics Corporation, Indianapolis, Ind). High-density lipoprotein cholesterol was measured in serum using the high-density lipoprotein cholesterol method with the Roche Modular P Chemistry analyzer (Roche Diagnostics Corporation, Indianapolis, Ind). ALT, U/L 36 to 26 10 (3 to 18) 20 23 3 (7 to 2) 0.001 0.24 <0.001

Table 1. Adjusted* Means or Percentages of Iron, Liver, and Lipid Measures by HFE Genotype

<table>
<thead>
<tr>
<th>Measure</th>
<th>C282Y/C282Y</th>
<th>C282Y/C282Y</th>
<th>Difference or Ratio (95% CI)</th>
<th>P&lt;sub&gt;men&lt;/sub&gt;</th>
<th>P&lt;sub&gt;women&lt;/sub&gt;</th>
<th>P&lt;sub&gt;interaction&lt;/sub&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genotype</td>
<td>(n=63)</td>
<td>(n=123)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ferritin, µg/L</td>
<td>1036 135</td>
<td>901 (730 to 1072)</td>
<td></td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
<td>0.11</td>
</tr>
<tr>
<td>ALT, U/L</td>
<td>36 26</td>
<td>10 (3 to 18)</td>
<td></td>
<td>0.001</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>AST, U/L</td>
<td>39 34</td>
<td>4 (0 to 9)</td>
<td></td>
<td>0.02</td>
<td>0.33</td>
<td>0.07</td>
</tr>
<tr>
<td>GGT, U/L</td>
<td>37 35</td>
<td>2 (7 to 9)</td>
<td></td>
<td>0.54</td>
<td>0.45</td>
<td>0.96</td>
</tr>
<tr>
<td>History of liver disease</td>
<td>15 5</td>
<td>2.8 (1.1 to 7.3)</td>
<td></td>
<td>0.03</td>
<td>0.75</td>
<td>0.32</td>
</tr>
<tr>
<td>Lipid-lowering medication, %</td>
<td>7 22</td>
<td>0.30 (0.11 to 0.83)</td>
<td></td>
<td>0.02</td>
<td>0.07</td>
<td>0.57</td>
</tr>
<tr>
<td>Total cholesterol, mmol/L</td>
<td>4.91 5.56</td>
<td>-0.65 (-1.01 to -0.28)</td>
<td></td>
<td>&lt;0.001</td>
<td>0.05</td>
<td>0.27</td>
</tr>
<tr>
<td>LDL cholesterol, mmol/L</td>
<td>2.79 3.41</td>
<td>-0.82 (-0.93 to -0.33)</td>
<td></td>
<td>&lt;0.01</td>
<td>0.01</td>
<td>0.26</td>
</tr>
<tr>
<td>HLD cholesterol, mmol/L</td>
<td>1.22 1.22</td>
<td>0 (0.0 to 0.08)</td>
<td></td>
<td>0.93</td>
<td>0.39</td>
<td>0.61</td>
</tr>
<tr>
<td>Triglycerides, mmol/L</td>
<td>2.15 2.23</td>
<td>-0.08 (-0.08 to 0.72)</td>
<td></td>
<td>0.84</td>
<td>0.70</td>
<td>0.75</td>
</tr>
</tbody>
</table>

1 mmol/L of total, LDL, and HDL cholesterol = 38.67 mg/dL.

ALT indicates alanine aminotransferase; AST, aspartate aminotransferase; GGT, gamma glutamyl transferase; HDL, high-density lipoprotein.

*Adjusted for age and field center.

†Excluding subjects taking lipid-lowering medications.

Results

Age and field center adjusted means or percentages of iron, liver, and lipid measures by HFE genotype are shown in Table 1. The age range in the HEIRS study was 25 to 100 years, with a median age of 51 years. The use of prescription cholesterol-lowering medications was 22% in HFE wild-type men and 16% in HFE wild-type women. In C282Y homozygotes, these medications were used significantly less often in men (7%, P<0.003) and women (8%, P=0.05) than in control subjects. After excluding subjects taking cholesterol medications, C282Y homozygotes had significantly lower mean total and LDL cholesterol concentrations than wild-type subjects, with larger genotypic differences for LDL in men (−0.62 mmol/L; 95% CI, −0.93 to −0.33) than in women (−0.28 mmol/L; 95% CI, −0.52 to −0.08). There was a significant inverse relationship between LDL and SF (r =−0.12, P=0.02) and TS (r =−0.25, P<0.001). Among C282Y homozygotes, the correlation between TS and LDL was −0.16 (P=0.06; n=137). Among wild-type subjects, the correlation between TS and LDL was 0.01 (P=0.90; n=219). Indirect measures of iron status (SF and TS) were markedly higher in both male and female C282Y homozygotes, and there was a statistically significant interaction between ferritin and HFE mutation by gender (P<0.001; Table 1). Because of this strong association, it was difficult to separate the potential contributions of HFE genotype and iron measures to LDL cholesterol levels. LDL cholesterol levels of C282Y homozygotes and wild-type subjects were compared according to TS (Figure). In men, age and center-adjusted prevalence of

Figure. LDL cholesterol in C282Y homozygotes (●) compared with control participants (○), categorized by serum transferrin saturation. Data are expressed as mean with 95% CIs.
hypercholesterolemia was significantly lower in C282Y homozygotes than in wild-type participants (Table 2). This association remained after additional adjustment for history of liver disease, or aspartate aminotransferase, alanine aminotransferase, and γ-glutamyl transferase, but was substantially attenuated when adjusted for TS and SF (Table 2). In women, the association between hypercholesterolemia and HFE genotype was not statistically significant in any of the regression models (Table 2). We performed age stratification (<55 and ≥55) and found the LDL effect was larger in younger subjects (0.44 mmol/L) than in older subjects (0.21 mmol/L). A formal test of genotype × age interaction was not significant.

**Discussion**

CHD has not been reported commonly in long-term studies of C282Y homozygotes, despite its being the most common cause of death in most Western countries. In this study, we have determined that C282Y homozygotes have a significantly lower total and LDL cholesterol. The direction and magnitude of the effect are very similar to those in a previous study regarding the relationship of serum iron measures and CHD morbidity or type counterparts. Several large population-based studies have not demonstrated any differences in CHD morbidity or mortality events across all HFE genotypes, but it is unlikely that these studies were large enough to detect modest reductions in risk for C282Y homozygotes.

Differences in serum cholesterol concentrations could result from long-term liver damage due to iron overload in C282Y homozygotes. It seems unlikely to be related to liver disease with decreased cholesterol synthesis because most participants had relatively mild iron overload. Liver biopsies were infrequently performed in the HEIRS study and cirrhosis was a rare observation. Among patients with chronic hepatitis C, total cholesterol levels were 0.31 to 0.41 mmol/L (12 to 16 mg/dL) lower among those with significant liver fibrosis than in those with no significant fibrosis.

It is important to establish whether the observations in this study regarding the relationship of serum iron measures and cholesterol and LDL cholesterol values apply to patients without HFE mutations. The magnitude of the differences in cholesterol would have public health significance if they could be extrapolated to the general population. The effects of oral iron supplements on serum lipids have not been clearly established, and many multivitamin preparations that claim to lower cholesterol contain iron. Experimental iron overload in rats has been found to lower LDL and raise high-density lipoprotein. Excess iron could affect cholesterol metabolism due to increased intracellular oxidative stress, membrane peroxidation, and altered activity of liver enzymes involved in cholesterol metabolism and lipoprotein formation. Patients with hemochromatosis typically have low levels of hepcidin that increase ferroportin expression on macrophages, which decrease intracellular iron. Foam cells in the arterial wall are deteriorated macrophages and may have decreased iron and less oxidative damage.

It is important to recognize that elevated SF may be associated with CHD because SF may be a marker of obesity, the metabolic syndrome, diabetes, and inflammation. In this study, the selection of controls with a normal SF reduced the chance of including wild-type participants with metabolic syndrome, and therefore the differences observed here may be more marked than in the general population.

An unresolved question arising from these studies is whether the decreased cholesterol in C282Y homozygotes is related to excess iron, or a genetic effect of the HFE gene itself or other genes in close proximity such as those in the HLA region which are in linkage disequilibrium with the **H locus**. The HEIRS study design resulted in a subset of C282Y homozygotes with a broad range of SF levels and included nonexpressing patients with a normal SF. Further studies should include the study of serum lipids in C282Y homozygotes before and after phlebotomy therapy. In conclusion, we have confirmed the previous observation, that C282Y homozygotes have a lower total and LDL cholesterol than matched controls without HFE mutations. This may be a factor in the reportedly normal life expectancy that has been reported in patients in population studies and an elucidation of the underlying basis for these observations could be relevant to population health.

**Acknowledgments**

The authors acknowledge the assistance of all the HEIRS study investigators and its participants for making this study possible.

**Sources of Funding**

The HEIRS Study was initiated and funded by the National Heart, Lung, and Blood Institute in conjunction with the National Human...
Genome Research Institute. The study was supported by contracts N01-HC05185 (University of Minnesota); N01-HC05186, N01-CM-07003-74, and the Minority Community Clinical Oncology Program (Howard University); N01-HC05188 (University of Alabama at Birmingham); N01-C05189 (Kaiser Permanente Center for Health Research); N01-HC05190 (University of California, Irvine); N01-HC05191 (London Health Sciences Centre); and N01-C05192 (Wake Forest University). Additional support was provided by University of Alabama at Birmingham General Clinical Research Center grant M01-RR00032; Howard University General Clinical Research grant M01-RR10284; University of California, Irvine/University of Alabama at Birmingham General Clinical Research Center grant M01-RR00827, sponsored by the National Center for Research Resources, National Institutes of Health; Howard University Research Scientist Award UH1-01-20379-05 from the National Heart, Lung, and Blood Institute and the Office of Research on Minority Health (to V.R.G.); the National Institutes of Health; Howard University Research Scientist Award UH1-01-20379-05 from the National Heart, Lung, and Blood Institute and the Office of Research on Minority Health (to V.R.G.); and the Southern Iron Disorders Center (to J.C.B., R.T.A.).

Disclosures

None.

References


3. Ellervik C, de Craen AJ, Gussekloo J, Moghaddam P, Vandenbrouke JP. Increased risk of acute myocardial infarction in carriers of the hemo-


**CLINICAL PERSPECTIVE**

Total cholesterol and LDL were found to be significantly lower in patients that were homozygous for the C282Y mutation of the hemochromatosis (HFE) gene in the Hemochromatosis and Iron Overload Screening (HEIRS) Study. The HEIRS study was a multi-ethnic North American study that screened 99,711 participants for iron overload and HFE mutations. Mechanisms for this potential inverse association are unknown.
HFE C282Y Homozygosity Is Associated With Lower Total and Low-Density Lipoprotein Cholesterol: The Hemochromatosis and Iron Overload Screening Study
Paul C. Adams, James S. Pankow, James C. Barton, Ron T. Acton, Cathie Leiendecker-Foster, Gordon D. McLaren, Mark Speechley and John H. Eckfeldt

Circ Cardiovasc Genet. 2009;2:34-37; originally published online January 23, 2009;
doi: 10.1161/CIRCGENETICS.108.813089
Circulation: Cardiovascular Genetics is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2009 American Heart Association, Inc. All rights reserved.
Print ISSN: 1942-325X. Online ISSN: 1942-3268

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://circgenetics.ahajournals.org/content/2/1/34

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Circulation: Cardiovascular Genetics can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Circulation: Cardiovascular Genetics is online at:
http://circgenetics.ahajournals.org//subscriptions/