Relationship Between Measures of Adiposity, Arterial Inflammation, and Subsequent Cardiovascular Events

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Background—The objective of this study was to evaluate how different measures of adiposity are related to both arterial inflammation and the risk of subsequent cardiovascular events.

Methods and Results—We included individuals who underwent 18F-fluorodeoxyglucose positron emission tomography/computed tomography imaging for oncological evaluation. Subcutaneous adipose tissue (SAT) volume, visceral adipose tissue (VAT) volume, and VAT/SAT ratio were determined. Additionally, body mass index, metabolic syndrome, and aortic 18F-fluorodeoxyglucose uptake (a measure of arterial inflammation) were determined. Subsequent development of cardiovascular disease (CVD) events was adjudicated. The analysis included 415 patients with a median age of 55 (P25–P75: 45–65) and a median body mass index of 26.4 (P25–P75: 23.4–30.9) kg/m². VAT and SAT volume were significantly higher in obese individuals. VAT volume (r=0.290; P<0.001) and VAT/SAT ratio (r=0.208; P<0.001) were positively correlated with arterial inflammation. Thirty-two subjects experienced a CVD event during a median follow-up of 4 years. Cox proportional hazard models showed that VAT volume and VAT/SAT ratio were associated with CVD events (hazard ratio [95% confidence interval]: 1.15 [1.06–1.25]; P<0.001; 3.60 [1.88–6.92]; P<0.001, respectively). Body mass index, metabolic syndrome, and SAT were not predictive of CVD events.

Conclusions—Measures of visceral fat are positively related to arterial inflammation and are independent predictors of subsequent CVD events. Individuals with higher measures of visceral fat as well as elevated arterial inflammation are at highest risk for subsequent CVD events. The findings suggest that arterial inflammation may explain some of the CVD risk associated with adiposity. 

Key Words: adipose tissue ■ atherosclerosis ■ cardiovascular events ■ obesity ■ positron emission tomography

The increasing prevalence of obesity and the associated complications are a major health concern.12 Obesity has been linked to cardiovascular disease (CVD) morbidity and mortality.3–5 However, clinical studies demonstrated that not all obese individuals are at high risk for CVD, and it has been postulated that a subpopulation of obese but metabolically healthy individuals have a reduced risk for CVD.6,7 The metabolic syndrome (MetS) represents a cluster of metabolic abnormalities that are associated with a substantially increased risk of CVD.5,8,9 Traditionally, obesity is determined based on body mass index (BMI) which represents an important predictor of CVD. However, imaging measures of visceral adipose tissue (VAT) explain a greater part of the variation in metabolic risk factors and are more strongly associated with abnormal metabolic profile beyond BMI.10 One potential biological link between VAT and atherosclerosis relates to immune regulation.11,12 Adipocytes and adipocyte-related macrophages release inflammatory cytokines, which induce insulin resistance, endothelial dysfunction, and hypercoagulability, all of which promote atherosclerosis.13–15 Consistent with the proposed inflammatory link, several studies have identified an association between VAT volume and elevated levels of circulating inflammatory biomarkers.16–18 In addition, the ratio between VAT and subcutaneous adipose tissue (SAT), a measure of relative body fat composition, has been associated with increased cardiometabolic risk.19

See Editorial by Dweck and Hyafil
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18F-fluorodeoxyglucose positron emission tomography (FDG-PET) allows for noninvasive evaluation of aortic
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wall inflammation, which predicts future CVD events.20–23 Accordingly, aortic FDG uptake acts as an imaging biomarker for atherosclerotic plaque inflammation. The aim of this study was to evaluate how different measures of adiposity are related to both arterial inflammation and the risk of subsequent cardiovascular events.

Methods

Study Population
A total of 415 subjects who underwent 18F-FDG-PET and computed tomography (CT) imaging for oncological evaluation at the Massachusetts General Hospital between 2005 and 2008 were retrospectively identified and included in the final analysis if clinical follow-up information was available for at least 3 electronic medical records of 1 year apart (Figure 1). Predefined inclusion criteria included (1) >30 years of age, (2) absence of prior cancer diagnosis or remission from cancer at the time of PET imaging and throughout the follow-up period, and (3) absence of CVD or acute or chronic inflammatory or autoimmune disease at time of imaging. Detailed inclusion and exclusion criteria for this population have been previously published.24 The study protocol was approved by the local human research committee.

Data Collection
Review of medical records within Partners HealthCare was performed to extract patient data. Height and weight at the time of FDG-PET imaging were used to calculate BMI (kg/m²). Traditional CVD risk factors, such as age, sex, hypertension, hyperlipidemia, type 2 diabetes mellitus, and statin therapy, were collected. High- and low-density lipoprotein, triglycerides, and total cholesterol were recorded. Additionally, fasting glucose (within 6 months of PET imaging) was noted. Framingham Risk Score for 10-year general CVD risk was calculated.24 MetS was defined based on the presence of ≥3 of the following characteristics: (1) BMI>26.7 kg/m², (2) elevated triglycerides ≥150 mg/dL; (3) reduced HDL: men <40 mg/dL and women <50 mg/dL; (4) elevated blood pressure ≥130/85 mmHg; (5) elevated fasting glucose ≥100 mg/dL., as adapted from the Adult Treatment Panel III25 using the method of Ridker et al.26

Outcome Data
CVD outcomes were defined similar to the Framingham Heart Study.24 Two cardiologists, who were blinded to all imaging data, used clinically available records to adjudicate events as follows: incident stroke or transient ischemic attack, acute coronary syndrome (unstable angina, non-ST-segment–elevation myocardial infarction, and ST-segment–elevation myocardial infarction), revascularization (coronary, carotid, or peripheral), new-onset angina, peripheral arterial disease, heart failure, or CVD death. Follow-up was measured from the subjects’ index FDG-PET imaging to the development of a CVD event or until the latest clinical follow-up recorded as of May 8, 2012.

PET/CT Imaging Protocol
FDG-PET imaging was performed using a Biograph 64 (Siemens, Forchheim, Germany) as per clinical protocol after intravenous administration of ~10 mCi of FDG, with patients imaged in the supine position over 15 to 20 minutes. PET images were acquired ~60 minutes after FDG administration. Before PET imaging, a nongated, noncontrast-enhanced CT (120 kV, 50 mAs) was acquired.

Imaging Measures of Adipose Tissue Volume and Metabolism
Fat volumes were measured by an investigator (M.H. MacNabb) who was blinded to the clinical data and arterial measurements. Abdominal VAT and SAT volumes were measured as previously described using CT scans, which takes an average of 5 minutes per scan to quantify and demonstrated excellent inter- and intrareader reproducibility (intraclass correlation coefficient =0.99).27 Patients were not analyzed if the abdomen was outside the scan range. Briefly, VAT and SAT volumes were measured using a dedicated offline workstation (Siemens Medical Solutions, Forchheim, Germany), and VAT/SAT ratio was calculated. Adipose tissue was identified using a threshold between −195 and −45 Hounsfield units (HU). The abdominal muscular wall was used as a boundary to separate VAT and SAT volumes. The volume was measured across all axial slices and was expressed as cm³.

An assessment of VAT activity (VAT FDG uptake) was performed to derive the metabolic activity within VAT. However, measurement of FDG uptake adjacent to the intestines was not feasible because of substantial spillover of activity from the intestines. Accordingly, the

Table 1. Baseline Characteristics of Study Subjects

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Full Cohort (n=415)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y</td>
<td>55 (45–65)</td>
</tr>
<tr>
<td>Male, %</td>
<td>177 (42.7)</td>
</tr>
<tr>
<td>BMI, kg/m²</td>
<td>26.4 (23.4–30.9)</td>
</tr>
<tr>
<td>MetS*</td>
<td>63 (30.6)</td>
</tr>
<tr>
<td>Current smoker, %</td>
<td>42 (10.1)</td>
</tr>
<tr>
<td>Diabetes mellitus, %</td>
<td>35 (8.4)</td>
</tr>
<tr>
<td>Dyslipidemia, %</td>
<td>113 (27.2)</td>
</tr>
<tr>
<td>Statin use, %</td>
<td>78 (18.8)</td>
</tr>
<tr>
<td>Hypertension, %</td>
<td>142 (34.2)</td>
</tr>
<tr>
<td>Prior history of cancer</td>
<td>357 (86.0)</td>
</tr>
<tr>
<td>Cardiovascular event, %</td>
<td>32 (7.7)</td>
</tr>
<tr>
<td>Framingham risk score†</td>
<td></td>
</tr>
<tr>
<td>Low (10-y risk &lt;10%)</td>
<td>109 (51.7)</td>
</tr>
<tr>
<td>Medium (10-y risk 10% to 20%)</td>
<td>51 (24.2)</td>
</tr>
<tr>
<td>High (10-y risk &gt;20%)</td>
<td>44 (20.9)</td>
</tr>
</tbody>
</table>

Values are mean (SD), median (P25–P75), or n (%). BMI denotes body mass index; MetS, metabolic syndrome.

*Available in 206 patient.
†Available in 211 patients.

Figure 1. Flowchart of study design. CT indicates computed tomography; CVD, cardiovascular disease; and PET, positron emission tomography.
Table 2. Pearson Correlation Between Arterial Inflammation and Adiposity Measures

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Aortic TBR</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI</td>
<td>0.313</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>SAT volume</td>
<td>0.162</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>VAT volume</td>
<td>0.290</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>VAT/SAT ratio</td>
<td>0.208</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>VAT&lt;sub&gt;spo&lt;/sub&gt;</td>
<td>0.180</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

SAT indicates subcutaneous adipose tissue; VAT, visceral adipose tissue; and VAT<sub>spo</sub>, VAT activity–volume product.

Table 3. Differences in Clinical Parameters Between Subjects With and Without a CVD Event

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Full Cohort (n=415)</th>
<th>No CVD Event (N=383)</th>
<th>CVD Event (N=32)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI</td>
<td>27.5±5.5</td>
<td>27.5±5.5</td>
<td>27.6±4.8</td>
<td>0.863</td>
</tr>
<tr>
<td>SAT volume</td>
<td>104.2±55.4</td>
<td>104.3±55.6</td>
<td>102.7±53.4</td>
<td>0.870</td>
</tr>
<tr>
<td>VAT volume</td>
<td>56.9±37.5</td>
<td>55.2±36.9</td>
<td>76.5±39.8</td>
<td>0.002</td>
</tr>
<tr>
<td>VAT/SAT ratio</td>
<td>0.52 (0.33–0.74)</td>
<td>0.50 (0.31–0.72)</td>
<td>0.69 (0.50–1.16)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>VAT&lt;sub&gt;spo&lt;/sub&gt;</td>
<td>31.3 (20.8–49.1)</td>
<td>29.6 (20.4–46.4)</td>
<td>45.8 (33.2–64.6)</td>
<td>0.002</td>
</tr>
<tr>
<td>Aortic TBR</td>
<td>2.0±0.3</td>
<td>2.0±0.3</td>
<td>2.2±0.3</td>
<td>0.001</td>
</tr>
</tbody>
</table>

Data are presented as mean±SD. BMI indicates body mass index; SAT, subcutaneous adipose tissue; TBR, target-to-background ratio; VAT, visceral adipose tissue; and VAT<sub>spo</sub>, VAT activity–volume product.
VAT Activity

VAT was greater in obese individuals (43.5 [29.5–63.6] versus 22.1 [14.1–30.2], obese versus nonobese individuals; *P*<0.001) and in individuals with MetS (50.7 [31.8–65.7] versus 27.4 [16.1–41.0], with versus without MetS; *P*<0.001). There was a strong correlation between BMI and VAT (r=0.639; *P*<0.001) and weaker one between aortic TBR and VAT (r=0.180; *P*<0.001). VAT was more strongly associated with VAT volume (r=0.878; *P*<0.001) than to SAT (r=−0.234; *P*<0.001).

CVD Events

A total of 32 patients experienced CVD events over a median follow-up of 4 years. Ten patients developed acute coronary syndrome (8 acute myocardial infarctions and 2 unstable angina pectoris), 4 underwent percutaneous coronary revascularization, 7 had a stroke, 1 experienced a transient ischemic attack, 1 underwent carotid revascularization, 5 had new-onset angina pectoris, 3 were diagnosed with peripheral artery disease and underwent peripheral revascularization, and 1 cardiovascular death. Differences in BMI, VAT, SAT volume, VAT/SAT, VAT activity–volume product, and aortic TBR between subjects with and without a CVD event are displayed in Table 3. Receiver operating characteristic curve analysis also showed that VAT volume, VAT/SAT ratio, and VAT activity–volume product were the strongest discriminators (Figure 2). VAT activity–volume product was found not to contain incremental prognostic information with a univariate hazard ratio of 1.10 (95% CI 0.22–5.64) and an area under the curve of 0.51. However, Cox proportional hazard models revealed that VAT volume, VAT/SAT ratio, and VAT activity–volume product were significant predictors of subsequent CVD events (HR [95% CI]: 1.15 [1.06–1.25], *P*<0.001; 3.60 [1.88–6.92], *P*<0.001; 2.38 [1.39–4.10], *P*<0.001, respectively). This remained significant after correcting for age, BMI, and aortic TBR (all *P*<0.05; Table 4). However, neither SAT volume, BMI, nor the presence of MetS predicted CVD (Table 4 and Figure 3). Adjusting for prior history of cancer did not have an effect on the significance of the HRs.

In this study, as previously noted, aortic inflammation (as TBR) was a potent predictor of CVD risk (Table 4). When...
evaluating both VAT volume and VAT/SAT ratio in a Cox proportional hazard model, only VAT/SAT ratio was found to be significant (HR [95% CI]: 2.88 [1.30–6.40]; P = 0.005). Moreover, we observed that the combination of arterial inflammation and VAT/SAT ratio provided incremental risk discrimination. When individuals were classified according to high versus low VAT/SAT ratio (dichotomized above or below median values) as well as high versus low arterial

Figure 3. KM plot displaying proportion free of cardiovascular disease (CVD) events stratified by BMI (A; median=26.4 kg/m²), MetS (B), SAT volume (C; median=95.0 cm³), VAT volume (D; median=48.4 cm³), VAT/SAT ratio (E; median=0.52), and VAT Activity–Volume Product (median=31.3; F). BMI indicates body mass index; MetS, metabolic syndrome; SAT, subcutaneous adipose tissue; VAT, visceral adipose tissue; and VATAVP, VAT activity–volume product.
inflammation (also dichotomized above or below median values), the subgroup with both high VAT/SAT ratio and high arterial inflammation did substantially worse than the others (Figure 4). Also when evaluating both VAT_{AVP} and VAT/SAT ratio in a Cox proportional hazard model, only VAT/SAT ratio was found to be significant (HR [95% CI]: 2.62 [1.25–5.51]; \( P = 0.011 \)).

**Discussion**

To our knowledge, this study is the first to evaluate the association between measures of VAT, arterial inflammation, and subsequent CVD events. VAT volume, VAT/SAT ratio, and VAT_{AVP} correlated moderately with arterial inflammation, an independent predictor for CVD events. Moreover, we observed that VAT volume, VAT/SAT ratio, and VAT_{AVP} were predictors for the occurrence of CVD events, independent of BMI or arterial inflammation. In addition, the observed link between VAT volume and arterial inflammation may explain some but not all of VAT’s association with CVD events.

The relationship of VAT to metabolic complications is independent of the variation in total body fat, and as such, the assessment of CVD risk solely by measurement of BMI may be inadequate. In our study, BMI was not found to be an independent predictor of CVD events. The potential reasons for this are multifocal and may be related to the distinct types of fat that might contribute to increased body mass. VAT compared with SAT is more metabolically active and regarded as pathogenic. VAT secretes proinflammatory mediators, including IL-6, IL-8, MCP-1, RANTES, MIP-1α, and PAI-1. Fontana et al detected higher IL-6 levels in the portal vein compared with peripheral artery and also observed a correlation between portal vein IL-6 concentrations and systemic C-reactive protein concentrations, thus, providing evidence for a potential mechanistic link between VAT and systemic inflammation which plays an crucial role in the development of atherosclerosis. Though VAT_{AVP} was associated with events, it was not found to be independent of VAT/SAT ratio. This finding raises the possibility that the volume of VAT may be more important a predictor of VAT-associated diseases than the activity of VAT. However, it is also worth noting that in this study, VAT activity was measured in only a small region of interest (technical limitations because of spillover of FDG activity from adjacent gut tissue made it infeasible to measure VAT activity throughout the entire VAT volume).

Buccerius et al observed a significant correlation between adipose tissue FDG uptake and arterial FDG uptake in 173 patients with atherosclerosis. Further, Christen et al demonstrated higher FDG uptake in VAT compared with SAT in humans. In a mouse model exploring the underlying mechanism, they observed higher FDG uptake in stromal tissue, which contain inflammatory cells. In concert with the proinflammatory nature of VAT, we found a moderate correlation between VAT volume and arterial inflammation (aortic TBR). Furthermore, in the current study, we found incremental prognostic value in VAT volume even after correcting for aortic TBR, thus suggesting that VAT tissue might predispose to CVD events via mechanisms that extend beyond its link to arterial inflammation.

We furthermore evaluated the relationship between VAT/SAT, arterial inflammation, and CVD events. VAT/SAT ratio reflects the propensity to store fat viscerally relative to subcutaneously. One possible theory is that excess energy is primarily stored in SAT; however, when this depot is dysfunctional, energy can alternatively be stored in VAT. In the Framingham Heart Study, VAT/SAT ratio was found to significantly correlate with cardiometabolic risk factors, beyond associations with BMI and VAT. In our study, we observed that VAT/SAT ratio had a stronger correlation with VAT than SAT volume. Moreover, we found that VAT/SAT ratio also correlates with arterial inflammation and remained a significant predictor after correcting for Framingham Risk Score, beyond VAT volume.

Several limitations of the study should be noted. First, generalizability might be limited because of the highly selected nature of this patient population (primarily patients who had a prior history of treated cancer) and the relative small number of events. Though, in a previous study, we found that aortic TBR contained prognostic information in both cancer survivors, as well as cancer-naive individuals. Second, event adjudication was limited to information contained in the medical records; thus, the possibility of event misclassification exists. Third, prior research demonstrated the optimal time point for the evaluation of FDG uptake in the vascular wall is beyond 60 minutes, and the arterial wall signals may be somewhat suboptimal for assessment of arterial inflammation. Nonetheless, we and others have previously shown that circulation times, such as those used in this population, still result in tissue FDG uptake that provides an independent predictive value for subsequent CVD events. Fourth, the data needed to calculate Framingham Risk Score and MetS were available for only half of the population; hence, power to assess associations in that smaller group may have been constrained. However, despite this limitation, VAT/SAT remained a predictor of CVD events.

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**Figure 4.** KM plot displaying proportion free of cardiovascular disease (CVD) events stratified by the combination of median TBR (median=2.0) and median VAT/SAT ratio (median=0.52). Pairwise log rank comparison showed that only the combination of high VAT/SAT and high aortic TBR was different from the other groups (using low aortic TBR and low VAT/SAT volume as the reference group, \( P = 0.129 \), \( P = 0.147 \), \( P = 0.002 \)). SAT indicates subcutaneous adipose tissue; TBR, target-to-background ratio; and VAT, visceral adipose tissue.
even in the smaller group who had the available data. Finally, the retrospective and observational design of this study does not allow us to infer causal relations.

In conclusion, we observed that measures of visceral fat mass and metabolism associate with arterial inflammation and predict future CVD events. These findings provide additional evidence for VAT volume and VAT/SAT ratio as imaging biomarkers for CVD risk. Further, the findings suggest that their association with arterial inflammation may explain some of the CVD risk associated with adiposity.

Disclosures
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References
Obesity is a major health concern because of increased risk of cardiovascular disease. However, not all obese individuals are at high risk for cardiovascular events. Possibly, a subpopulation of obese and metabolically diseased individuals is at highest risk for events, and accurate identification of these patients could allow for better medical management (eg, by reclassification of statin eligibility). In our study, we observed that visceral adipose tissue volume and visceral adipose tissue/subcutaneous adipose tissue ratio both were predictors for the occurrence of CVD events, independent of BMI or arterial inflammation. In addition, a link was observed between visceral adipose tissue volume and arterial inflammation, which could explain part of visceral adipose tissue’s association with cardiovascular events.
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