Variant Aldehyde Dehydrogenase 2 (ALDH2*2) Is a Risk Factor for Coronary Spasm and ST-Segment Elevation Myocardial Infarction

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Background—Mitochondrial aldehyde dehydrogenase 2 (ALDH2) plays a key role in removing toxic aldehydes. Deficient variant ALDH2*2 genotype is prevalent in up to 40% of the East Asians and reported to be associated with acute myocardial infarction (AMI). To elucidate the mechanisms underlying the association of ALDH2*2 with AMI, we compared the clinical features of AMI patients with ALDH2*2 to those with wild-type ALDH2*1/*1.

Methods and Results—The study subjects consisted of 202 Japanese patients with acute ST-segment elevation myocardial infarction (STEMI) (156 men and 46 women; mean age, 67.3±12.0) who underwent primary percutaneous coronary intervention (PCI). In 85 patients, provocation test for coronary spasm was also done 6 month post-PCI. ALDH2 genotyping was performed by direct application of the TaqMan polymerase chain system. Of the 202 patients, 103 (51.0%) were carriers of ALDH2*2 and 99 (49.0%) those of ALDH2*1/*1. There were no differences in clinical features between ALDH2*2 and ALDH2*1/*1 carrier groups except higher frequencies of coronary spasm and alcohol flush syndrome (AFS) (88.6% vs 56.1%; P=0.001 and 94.3% vs 17.6%; P<0.001), less-frequent alcohol habit (14.6% vs 51.5%; P<0.001), and higher peak plasma creatine phophokinase levels (2224 vs 1617 mg/dL; P=0.002) in the ALDH2*2 than the ALDH2*1/*1 carrier group.

Conclusions—ALDH2*2 is prevalent (51.0%) among Japanese STEMI patients, and those with ALDH2*2 had higher frequencies of coronary spasm and AFS and more-severe myocardial injury compared to those with ALDH2*1/*1. (J Am Heart Assoc. 2016;5: e003247 doi: 10.1161/JAHA.116.003247)

Key Words: acute myocardial infarction • alcohol flushing syndrome • aldehyde dehydrogenase 2 • coronary spasm • coronary spastic angina

The mitochondrial aldehyde dehydrogenase 2 (ALDH2) plays a key role in removal of not only ethanol-derived acetaldehyde, but also other toxic aldehydes such as 4-hydroxy-2-nonenal (4-HNE) derived from lipid peroxidation.1,2 Up to 40% of East Asians carry a variant ALDH2 or ALDH2*2 (Glu504Lys) genotype with deficient activity and suffer from alcohol (ethanol) flushing syndrome (AFS) including facial flushing, headache, nausea, and palpitation, in response to a small amount of alcohol intake attributed to accumulation of acetaldehyde.2–5 Recent studies indicate that carriers of ALDH2*2 genotype have a higher risk for acute myocardial infarction (AMI).6–11 Coronary spasm is not rarely demonstrated in AMI patients in Japan,12,13 and we have reported that ALDH2*2 genotype is associated with coronary spastic angina (CSA).14 ALDH2 protects against myocardial ischemia/reperfusion (I/R) injury by removing toxic aldehydes such as 4-HNE in experimental AMI models.2,15–17 However, the underlying mechanisms linking ALDH2 to AMI in humans remain to be elucidated. In the present study, we examined the clinical features of AMI patients with ALDH2*2 by comparing to those with wild-type ALDH2*1/*1 in acute ST-segment elevation myocardial infarction (STEMI) patients who underwent reperfusion therapy with primary percutaneous coronary intervention (PCI).
Methods

Study Subjects

Two hundred two patients (156 men and 46 women with a mean age of 67.3±12.0) who underwent primary PCI with stent implantation successfully within 12 hours after symptoms and consented to be genotyped for ALDH2 gene polymorphism were the subjects of this study. These patients were recruited from the consecutive 235 Japanese patients admitted and diagnosed as STEMI at our institutions between December 2009 and October 2015. Not included in the study were 26 patients who died during hospitalization (11 with PCI and 15 without PCI attributed to delay of admission), 10 patients with unsuccessful PCI (Thrombolysis In Myocardial Infarction [TIMI] grade <3), 2 patients with emergent coronary artery bypass graft, and 10 patients who did not give informed consent. STEMI was defined as symptoms of myocardial ischemia in association with new persistent electrocardiography (ECG) ST-segment elevation in at least 2 contiguous leads of ≥2 mm (0.2 mV) and a rise and/or fall of biomarkers of myocardial necrosis including cardiac troponin T (cTnT) exceeding the 99th percentile of a normal reference population.18,19 This study was conducted in accord with the Declaration of Helsinki and approved by the ethics committee of our institutions and written informed consent was obtained from each patient.

Genotyping

The details of the method were reported.20 Briefly, single-nucleotide polymorphism genotyping of ALDH2 (Glu504Lys; rs671) was performed using the TaqMan assay on an ABI 7300 Real Time polymerase chain reaction (PCR) System (Applied Biosystems, Foster City, CA) without DNA extraction on whole blood. The mixture was 20 µL and consisted of 10 µL of a Thunderbird Probe qPCR Mix (QPS-101; Toyobo, Osaka, Japan), 0.4 µL of a 50×ROX reference dye (Toyobo), 1 µL of a 20×ALDH2 TaqMan Probe & ALDH2 Primer Mix (C_11703892_10, Applied Biosystems), 2 µL of PCR product, and 6.6 µL of distilled water. Thermal cycling process was performed according to the Applied Biosystems PCR conditions: 2 minutes at 50°C; 10 minutes at 95°C; 40 cycles of denaturation at 95°C for 15 seconds; and annealing and extension at 60°C for 1 minute. Results were analyzed by Applied Biosystems Prism 7300 SDS software. Genotyping was performed with the identification of the study subjects blinded.

Angiographic Documentation of Coronary Spasm

Provocation test for coronary spasm was also performed in 85 of the study patients after obtaining informed consent around 6 months after the attack. Patients with organic stenosis of ≥75% (n=19), 3-vessel organic disease (n=8), restenosis (n=8), left main trunk lesion (n=1), uncontrolled arrhythmias (n=2), heart failure (n=10), resting hypertension >180/110 mm Hg (n=6) acute systemic illness, and hepatic or renal insufficiency or other severe conditions (n=12) were excluded from the study. All vasoactive medications, including calcium-channel blockers, beta-receptor blockers, angiotensin-converting enzyme inhibitors, angiotensin II receptor blockers, and statins, were withdrawn for at least 3 days before angiography except for nitroglycerin used for attacks. Coronary spasm was defined as a transient total or subtotal occlusion or severe diffuse vasoconstriction of an epicardial coronary artery associated with ischemic changes on ECG with or without chest discomfort. The final diagnosis was determined with the consensus of 3 investigators blinded to genotype/flushing phenotype. Coronary spasm was induced by the intracoronary injection of acetylcholine (Ach; Daiichi-Sankyo Co., Tokyo, Japan) after diagnostic catheterization in the morning.14 Details of the provociation test were previously reported.13,14 Briefly, Ach dissolved in 5 mL of warmed 0.9% saline was infused manually in 20 seconds into the left coronary artery (LCA) in incremental doses of 10, 20, 50, and 100 µg and then 10, 20, and 50 µg into the right coronary artery (RCA) depending on the vascular reactivity under continuous monitoring of 12-lead ECG and blood pressure with a temporary pacemaker in place in the morning. Coronary angiography was performed 1 minute after each Ach injection or when ischemic ECG changes appeared. Figure 1 shows a typical case of coronary spasm with stent implantation in the provocation test by Ach 6 months post-AMI.

Coronary spasm induced by this method usually disappeared spontaneously within 1 to 2 minutes and both the LCA and RCA could be examined separately, unless severe spasm occurred in the LCA and necessitated the prompt injection of nitroglycerin (GTN) or isosorbide dinitrate (ISDN) into the artery. Finally, GTN or ISDN was infused to relieve spasm and examine organic lesions. Significant organic coronary stenosis was defined as >50% luminal diameter. The number of study patients needed was calculated based on an uncorrected chi-squared statistic at the 2-tailed test 5% significance level and 80% power, assuming the prevalence of coronary spasm to be 80% in the variant ALDH2*2 MI patient group and 50% in the wild ALDH2*1/*1 MI patient group based on our previous work and others.12–14

Questionnaire Survey

Subjects were asked to fill out a simple questionnaire concerning alcohol flushing on alcohol intake, alcohol drinking habit, and smoking. Habitual drinker was defined as an alcohol drinker more than 5 days a week. Alcohol flushing was defined as a current or a history of facial flushing
immediately after drinking a glass of beer. Smokers were defined as current and past smokers.

**Blood Chemistry Measurements**

Blood samples for measurement of clinical chemistry and other data were collected on admission and repeatedly at least 3 to 4 times later with patients in the supine position. Biochemical and other analyses were done using standard laboratory procedures. Total creatine phosphokinase (CPK) was measured with a standard enzymatic method on a UniCel Dxc800 Multi analyzer 2700 (Beckman Coulter Clinical Diagnostics, Brea, CA). cTnT was assessed by an electrochemoluminescence immunoassay using the Cobas system troponin T kit provided by the manufacturer on a Cobas e 411 disk system analyzer (Roche Diagnostics, Indianapolis, IN). Blood samples for total CPK and lactate dehydrogenase (LDH) were measured on admission and repeated every 4 hours during the first 12 hours and every 12 hours up to 72 hours. cTnT was measured on admission and repeated 3 to 6 hours later and further several times for 1 to 5 days depending on patient conditions.

**Statistical Analysis**

Allele frequencies were determined by direct gene counting, and genotype distributions were checked for departure from Hardy-Weinberg equilibrium using the Pearson chi-square test. Baseline clinical data were expressed as mean±SD or median (25th or 75th percentile) for continuous variables, and within-group differences were evaluated with an unpaired t test or the Mann–Whitney rank-sum test. For discrete variables, data were expressed as counts and percentages and analyzed with the chi-square or Fisher’s exact test. A 2-tailed value of P<0.05 was considered to be statistically significant. Analyses were done using the STATA software program (STATA 11.0; StataCorp, College Station, TX).

**Results**

**Genotype Distribution of ALDH2**

Genotype distributions did not depart from the Hardy-Weinberg equilibrium for ALDH2 genes in the whole group ($\chi^2=0.057$; $P=0.972$). Frequencies of ALDH2*1/*1, ALDH2*1/*2, and ALDH2*2/*2 genotype were 49.0% (99 of 202), 42.3% (86 of 202), and 8.4% (17 of 202), respectively. Frequency of the ALDH2*2 allele was thus 29.7% (120 of 404) in the STEMI patients in this study. This is high, as compared with that of the general population in Japan (23.5% [247 of 1050] in Kumamoto and 24.3% [183 of 752] in Tokyo, Japan).

We have recently reported that frequencies of ALDH2*1/*1, ALDH2*1/*2, and ALDH2*2/*2 genotype were 57.5% (272
of 473), 36.6% (173 of 473), and 5.9% (28 of 473), respectively, and thus frequency of the ALDH2*2 allele was 24.2% (229 of 946) in subjects who had no histories or ECG signs of ischemic heart disease recruited from a health screening program, with age and sex comparable to those of STEMI patients in the present study (age: 68.8±7.6 vs 67.3±12.0; P=0.054 and male ratio: 72.7% [344 of 473] vs 77.2% [156 of 202]; P=0.222).²¹ Frequency of the ALDH2*2 allele was therefore significantly higher in STEMI patients than in those without apparent ischemic heart disease (29.7% [120 of 404] vs 24.2% [229 of 946]; odds ratio [OR]=1.32 [95% CI, 1.01–1.73]; P=0.035). The findings are consistent with those of previous studies⁶⁻¹¹ and indicate that ALDH2*2 is associated with AMI, being randomly assigned at conception independently of the possible confounding factors (Mendelian randomization).²² The study also indicates that the variant ALDH2*2 genotype exists mainly as the heterozygote (ALDH2*1/*2), and we combined heterozygote (ALDH2*1/*2) and homozygote of (ALDH2*2/*2) as a single category of variant ALDH2*2 and compared them with the wild homozygote ALDH2*1/*1 in the following analysis. Accordingly, 51.0% (103 of 202) of STEMI patients (82 men and 21 women; mean age, 67.1±12.2) had variant ALDH2*2 and the remaining 99 (74 men and 25 women; mean age, 67.5±11.8) or 49.0% wild-type ALDH2*1/*1 as shown in Table.

Comparison of Clinical Characteristics Between the ALDH2*2 and ALDH2*1/*1 Groups

Table compares the clinical characteristics of patients between the variant ALDH2*2 group and wild ALDH2*1/*1 group. There were no differences in age, sex, body mass index (BMI), blood pressure, heart rate, cardiac index, pulmonary capillary wedge pressure (PCWP), smoking habit, and plasma levels of low-density lipoprotein (LDL) cholesterol, triglycerides, glucose, C-reactive protein, infarct-related artery, percentage of multivessel disease, and other variables between the two groups. However, the frequencies of AFs and coronary spasm were higher (94.3% vs 17.6%; P<0.001 and 88.6% vs 56.1%; P=0.001, respectively) and alcohol habit lower (14.6% vs 51.5%; P<0.001) in the ALDH2*2 group than in the ALDH2*1/*1 group (Table and Figure 2A). Thus, ALDH2*2 is associated with coronary spasm as well as AFs (OR=6.1; 95% CI [1.8–23.4] and OR=77.8; 95% CI [17.9–441.8], respectively), being randomly assigned at conception independently of the possible confounding factors (Mendelian randomization).²² Accordingly, AFs had 94.3% (50 of 53) sensitivity and 82.4% (42 of 51) specificity for ALDH2*. Conversely, ALDH2*2 had an 84.7% (50 of 59) sensitivity and 93.3% (42 of 45) specificity for AFs and 62.9% (39 of 62) sensitivity and 78.2% (18 of 23) specificity for CSA, respectively. AFS may therefore be a useful clinical marker for ALDH2*2 in the absence of genotyping.

We performed sex-specific analyses to make sure that we did not miss a sex-specific effect. In men, coronary spasm were higher (91.9% vs 59.4%; OR=7.8; 95% CI [1.8–46.3]; P=0.001) in the ALDH2*2 group than in the ALDH2*1/*1 group. However, the number of women was small (n=46) for statistical significance (71.4% vs 44.4%; P=0.28).

Peak plasma levels of total CPK were significantly higher (P=0.002) (Table and Figure 2B) and those of LDH, cTnI, and B-type natriuretic peptide (BNP) tended to be higher and left ventricular ejection fraction (LVEF) tended to lower in the ALDH2*2 than in the ALDH2*1/*1 carrier group (Table). This suggested that myocardial injury may be more severe in AMI patients with ALDH2*2 as compared to those with ALDH2*1/*1.

Discussion

East Asians show rapid, intense AFS after drinking a small amount of alcohol in up to 40% of the population.²⁻⁵ This is caused by the presence of the variant of mitochondrial ALDH2 genotype with a substitution of glutamate to lysine at position 504 (Glu504Lys) or ALDH2*2, which is present only in East Asians but is virtually absent in other populations of the world.²⁻⁵ ALDH2*2 exerts a dominant negative effect over wild-type homozygote ALDH2*1/*1, and heterozygote ALDH2*1/*2 shows a severely reduced and homozygote ALDH2*2/*2 negligible ALDH2 activity.⁵ Carriers of ALDH2*2 thus manifest the characteristic AFS caused by accumulation of ethanol-derived acetaldehyde. ALDH2 is a key enzyme that removes toxic aldehydes such as 4-HNE derived from lipid peroxidation as well as acetaldehyde.¹⁻²

Previous studies reported that ALDH2*2 genotype was associated with AMI in East Asians including Japanese, Koreans, and Chinese.⁶⁻¹⁰ Takeuchi et al. identified the genetic locus of ALDH2*2 (rs671) as the strongest predictor for AMI on a genome-wide association study in Japanese,¹⁰ and their findings were confirmed recently by the study of Hirokawa et al.¹¹

The present study shows that ALDH2*2 genotype is significantly associated with STEMI, and the results are consistent with those of previous studies.⁶⁻¹¹ Because the genotype is assigned randomly at conception independently of the possible confounding factors according to Mendel’s law (Mendelian randomization),²² it is reasonable to think that ALDH2*2 genotype is causally associated with STEMI. The study therefore identifies deficient ALDH2 activity and hence increased reactive aldehydes as a causative risk factor for STEMI.

However, the underlying mechanisms linking ALDH2*2 to STEMI remain to be elucidated. STEMI is assumed to be
triggered by plaque rupture or erosion resulting in coronary thrombotic occlusion.23–25 The present study also shows that ALDH2*2 is causally associated with coronary spasm as well as AFS in patients with STEMI, which is in agreement with our previous study in patients with CSA.14 Coronary spasm is associated with increased reactive oxygen species (ROS),

### Table. Comparison of Clinical Characteristics Between Variant and Wild Type of ALDH2

<table>
<thead>
<tr>
<th>Variables</th>
<th>Total Subjects (n=202)</th>
<th>Variant ALDH2*2 (n=103)</th>
<th>Wild ALDH2*1/*1 (n=99)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y</td>
<td>67.3±12.0</td>
<td>67.1±12.2</td>
<td>67.5±11.8</td>
<td>0.787</td>
</tr>
<tr>
<td>Sex (male), n (%)</td>
<td>156 (77.2)</td>
<td>82 (79.6)</td>
<td>74 (74.7)</td>
<td>0.410</td>
</tr>
<tr>
<td>BMI, kg/m²</td>
<td>24.0±3.3</td>
<td>23.8±2.9</td>
<td>24.1±3.6</td>
<td>0.564</td>
</tr>
<tr>
<td>Systolic BP, mm Hg</td>
<td>127.1±24.1</td>
<td>126.1±22.9</td>
<td>128.2±25.4</td>
<td>0.529</td>
</tr>
<tr>
<td>Diastolic BP, mm Hg</td>
<td>73.5±15.3</td>
<td>72.9±14.8</td>
<td>74.1±15.9</td>
<td>0.588</td>
</tr>
<tr>
<td>Heart rate, beat/min</td>
<td>75 (66, 82)</td>
<td>74 (69, 81)</td>
<td>76 (65, 82)</td>
<td>0.844</td>
</tr>
<tr>
<td>Cardiac index, L/min per m²</td>
<td>2.89 (2.26, 2.95)</td>
<td>2.60 (2.16, 2.79)</td>
<td>3.17 (2.26, 3.07)</td>
<td>0.819</td>
</tr>
<tr>
<td>PCWP, mm Hg</td>
<td>13.3 (9.1, 15.5)</td>
<td>13.0 (9.1, 15.5)</td>
<td>13.5 (9.0, 17.0)</td>
<td>0.957</td>
</tr>
<tr>
<td>hs-CRP, mg/L</td>
<td>0.63 (0.30, 1.9)</td>
<td>0.68 (0.30, 2.20)</td>
<td>0.60 (0.30, 1.70)</td>
<td>0.752</td>
</tr>
<tr>
<td>Glucose, mmol/L</td>
<td>5.92 (5.05, 6.38)</td>
<td>5.74 (5.05, 6.16)</td>
<td>6.09 (5.05, 6.55)</td>
<td>0.130</td>
</tr>
<tr>
<td>Total-C, mmol/L</td>
<td>4.73 (3.98, 5.38)</td>
<td>4.69 (3.98, 5.30)</td>
<td>4.78 (3.93, 5.53)</td>
<td>0.673</td>
</tr>
<tr>
<td>Triglycerides, mmol/L</td>
<td>1.52 (0.91, 1.85)</td>
<td>1.46 (0.93, 1.68)</td>
<td>1.58 (0.89, 1.93)</td>
<td>0.491</td>
</tr>
<tr>
<td>HDL-C, mmol/L</td>
<td>1.23 (0.98, 1.42)</td>
<td>1.21 (0.96, 1.45)</td>
<td>1.24 (1.06, 1.42)</td>
<td>0.106</td>
</tr>
<tr>
<td>LDL-C, mmol/L</td>
<td>2.75 (2.12, 3.34)</td>
<td>2.84 (2.15, 3.34)</td>
<td>2.70 (2.07, 3.34)</td>
<td>0.196</td>
</tr>
<tr>
<td>Uric acid, µmol/L</td>
<td>338 (291, 393)</td>
<td>339 (291, 393)</td>
<td>338 (286, 387)</td>
<td>0.761</td>
</tr>
<tr>
<td>eGFR, mL/min per 1.73 m²</td>
<td>67.8±18.2</td>
<td>66.1±16.4</td>
<td>69.5±19.9</td>
<td>0.234</td>
</tr>
<tr>
<td>Leukocyte, /µL</td>
<td>6466 (5500, 7300)</td>
<td>6500 (5600, 7400)</td>
<td>6300 (5200, 7300)</td>
<td>0.425</td>
</tr>
<tr>
<td>Hemoglobin, g/dL</td>
<td>13±1.8</td>
<td>13.2±1.8</td>
<td>13.2±1.8</td>
<td>0.997</td>
</tr>
<tr>
<td>Platelets, ×10³/µL</td>
<td>22.6±7.5</td>
<td>23.2±7.3</td>
<td>22.0±7.8</td>
<td>0.250</td>
</tr>
<tr>
<td>Smokers, n (%)</td>
<td>129 (63.9)</td>
<td>67 (65.0)</td>
<td>62 (62.6)</td>
<td>0.720</td>
</tr>
<tr>
<td>Current smokers, n (%)</td>
<td>58 (28.7)</td>
<td>29 (28.2)</td>
<td>29 (29.3)</td>
<td>0.858</td>
</tr>
<tr>
<td>Alcohol habit, n (%)</td>
<td>66 (32.7)</td>
<td>15 (14.6)</td>
<td>51 (51.5)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Alcohol flushing, n (%)</td>
<td>59/104 (56.7)</td>
<td>50/53 (49.3)</td>
<td>9/51 (17.6)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>0 Vessel disease, n (%)</td>
<td>3 (1.5)</td>
<td>1 (1.0)</td>
<td>2 (2.0)</td>
<td>0.972</td>
</tr>
<tr>
<td>Multivessels, n (%)</td>
<td>51 (25.2)</td>
<td>25 (24.3)</td>
<td>26 (26.3)</td>
<td>0.745</td>
</tr>
<tr>
<td>Infarct-related artery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LAD, n (%)</td>
<td>93 (46.0)</td>
<td>49 (47.6)</td>
<td>44 (44.4)</td>
<td>0.915</td>
</tr>
<tr>
<td>RCA, n (%)</td>
<td>79 (39.1)</td>
<td>40 (38.8)</td>
<td>39 (39.4)</td>
<td>0.935</td>
</tr>
<tr>
<td>LCX, n (%)</td>
<td>29 (14.4)</td>
<td>14 (13.6)</td>
<td>15 (15.2)</td>
<td>0.752</td>
</tr>
<tr>
<td>LMT, n (%)</td>
<td>1 (0.0)</td>
<td>0 (0.0)</td>
<td>1 (1.0)</td>
<td>0.984</td>
</tr>
<tr>
<td>Coronary spasm, n (%)</td>
<td>62/85 (72.9)</td>
<td>39/44 (88.6)</td>
<td>23/41 (56.1)</td>
<td>0.001</td>
</tr>
<tr>
<td>Peak CPK, IU/L</td>
<td>1995 (1066, 2942)</td>
<td>2224 (1431, 3478)</td>
<td>1617 (850, 2538)</td>
<td>0.002</td>
</tr>
<tr>
<td>Peak LDH, IU/L</td>
<td>581 (426, 779)</td>
<td>606 (447, 1091)</td>
<td>570 (381, 699)</td>
<td>0.079</td>
</tr>
<tr>
<td>cTnT (admission), ng/mL</td>
<td>3.09 (0.93, 7.22)</td>
<td>3.99 (0.86, 7.68)</td>
<td>2.96 (0.93, 5.63)</td>
<td>0.254</td>
</tr>
<tr>
<td>BNP (discharge), pg/mL</td>
<td>162 (33, 170)</td>
<td>181 (42, 200)</td>
<td>141 (29, 156)</td>
<td>0.127</td>
</tr>
<tr>
<td>Echo EF (discharge), %</td>
<td>57.4 (52.6, 64.0)</td>
<td>56.6 (52.0, 62.3)</td>
<td>58.2 (53.6, 65.0)</td>
<td>0.112</td>
</tr>
</tbody>
</table>

AFS indicates alcohol flushing syndrome; ALDH2, aldehyde dehydrogenase type 2; BMI, body mass index; BNP, B-type natriuretic peptide; CPK, creatine phosphokinase; hs-CRP, high sensitivity C-reactive protein; cTnT, cardiac troponin T; DBP, diastolic blood pressure; EF, ejection fraction; eGFR, estimated glomerular filtration rate; HDL-C, high-density lipoprotein-cholesterol; LAD, left anterior descending artery; LCX, left circumflex artery; LDH, lactate dehydrogenase; LDL-C, low-density lipoprotein-cholesterol; LMT, left main trunk; RCA, right coronary artery; SBP, systolic blood pressure; Total-C, total-cholesterol.
morning, which corresponds to that of STEMI.31,32 It is also noted in this connection that coronary spasm has a circadian variation with a peak incidence occurring in the early morning, which corresponds to that of STEMI.31,32 It is therefore likely that coronary spasm may trigger plaque rupture or thrombosis may be distinct from those contributing to coronary atherosclerosis.34

Timely reperfusion by direct PCI is mandatory to salvage ischemic myocardium from infarction, but reperfusion per se paradoxically contributes to myocardial injury.19,35,36 Toxic aldehydes such as 4-HNE are abundantly produced as a result of myocardial I/R injury, and ALDH2 activity protects against I/R injury by eliminating toxic aldehydes in experimental models.2,15,16 In the present study, peak plasma total CPK levels were significantly higher, those of LDH, cTnT, and BNP tended to be higher, and LVEF lower in patients with ALDH2*2 than those with ALDH2*1*1. These findings suggest that the carriers of ALDH2*2 suffer more-severe myocardial injury post-AMI as compared to those of ALDH2*1*1. It is intriguing in this connection to note that the in-hospital mortality rate for AMI is the highest in Japan among the developed countries of the Organization for Economic Coopera- tion and Development (OECD) member nations37 and that the adjusted in-hospital mortality rates for AMI are higher in Asian-Americans than white Americans.38 However, recent studies indicate that 4-HNE may paradoxically evoke hormetic protective effects against oxidative injury in the relatively low concentrations through activating antioxidative systems such as the Nrf2 pathway in experimental models.16,39–42 Thus, further studies are required to determine whether carriers of ALDH2*2 suffer more-severe myocardial injury post-AMI.

**Clinical Implications**

Oxidative degradation of lipid membrane (lipid peroxidation) generates numerous reactive aldehydes and causes oxidative damage in various organs and tissues including the cardiovascular system.1,2,15,16,39–42 ALDH2 removes not only acetaldehyde but also other toxic aldehydes, including 4-HNE and malondialdehyde from lipid peroxidation or acrolein in tobacco smoke, and thereby protects tissues and cells from oxidative damage.1,2 Conversely, ALDH2 activity is suppressed by ROS and/or aldehydes.2,41,42 It is thus likely that carriers of ALDH2*2 have increased reactive aldehydes as risk factors for coronary spasm and AMI. The present study therefore identifies reactive aldehydes as the target to be intervened for the treatment and prevention of coronary spasm and AMI. Using genetically modified ALDH2 models, Ren et al. have shown that ALDH2 also has a cardioprotective role through counteracting cardiac remodeling and myocardial dysfunction after alcohol intake.43 ALDH2 may thus possess important therapeutic potential against alcoholic and other forms of myocardial damage as well.43

The study also indicates that AFS is a sensitive clinical marker for ALDH2*2. These concepts are illustrated in
Figure 3. We thus propose that all patients should be screened for AFS or at least have it documented in the patient’s health records.

ALDH2 also plays an essential role in bioactivation of GTN widely used for treatment of ischemic heart disease.\(^2,44,45\) However, continued administration of GTN leads to tolerance or even cardiac events through inactivation of ALDH2 enzyme and an increased ROS.\(^2,44-46\) Accordingly, carriers of ALDH2*2 genotypes are less responsive to GTN and are also susceptible to GTN tolerance and oxidative damage.\(^2,44-46\)

Calcium-channel blockers are the mainstay in treatment of coronary spasm at present.\(^31,47\) The results of the present study thus imply that calcium-channel blockers also should be considered for treatment of post-AMI patients, particularly those with ALDH2*2.\(^12,13,47\) Recently, Chen et al. showed that a novel small molecule activator of ALDH2, Alda-1, enhanced activity of ALDH2 and effectively restored activity of variant ALDH2*2 to wild-type levels in animal models.\(^2,15\)

Accordingly, it is expected that this class of drug may serve as new therapeutics for AMI and coronary spasm, particularly in those with ALDH2*2 in the future.

**Limitations**

The number of study patients was small because the study included also the invasive intervention. The study subjects were a select population of STEMI who underwent PCI with stent implantation, and this may have altered the relationship with the ALDH2 variant. Thus, the association found in this study needs confirmation in other patient groups. The study subjects were limited to Japanese AMI patients because of the genetic association study,\(^22\) and thus the results of this study may not be necessarily applicable to other populations. Frequency of AFS was assessed on questionnaire survey, and recall subjective biases may have influenced the results.

Aldehydes such as 4-HNE were not measured because aldehydes are highly reactive and large parts of them exist as adducts with proteins, DNA, or lipids in tissues,\(^1,41,42\) and clinically applicable methods are not yet available. In the present study, the patients with severe coronary atherosclerosis and those with severe hypertension were excluded, although the rs671 variant has been reported to associate with both CAD and essential hypertension in the previous studies.\(^9-11,48\) However, the risk factors for, and the predilection sites of, coronary spasm are distinct from those of coronary atherosclerosis and hypertension is not a risk factor for coronary spasm.\(^49,50\) We have shown that stable angina, a prototype of advanced coronary atherosclerosis, is not associated with ALDH2*2 (rs671), but MI is.\(^2,11\)

**Conclusions**

The variant ALDH2*2 genotype was causally associated with coronary spasm and AMI. The study identified deficient ALDH2 activity and hence reactive aldehydes as the risk factors to be targeted and intervened for treatment and
variant of coronary spasm and AMI. AFS is a sensitive clinical marker for ALDH2*2 genotype.

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Disclosures

None.

References


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