Association between Nonalcoholic Fatty Liver Disease and Carotid Atherosclerosis

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Abstract

Aim/Background: Nonalcoholic fatty liver disease (NAFLD) frequently accompanies to the criteria of Metabolic Syndrome (MetS) like obesity, diabetes, and dyslipidemia. It is recently approved as a liver attaint of MetS. While MetS is a highly atherogenic condition we examined whether NAFLD was associated with atherosclerosis, as measured by ultrasound in the carotid arteries.

Methods: Carotid intima-media thickness and cardiovascular risk factors were evaluated in 64 patients with an ultrasound diagnosis of primary NAFLD and 64 matched population controls. Metabolic syndrome was established according to WHO and ATP-III criteria. IMT values were evaluated according to protocols of standard measurements of carotid artery.

Results: The metabolic syndrome and all its individual features were significantly (P<0.001) more frequent in NAFLD patients than in control subjects. Patients with NAFLD and controls had similar mean intima-media thickness (IMT) of 1,06±0,71 mm and 0,96±0,66 mm respectively, but plaque prevalence was significantly higher in patients with NAFLD than in controls (18,7% and 9,37%, respectively). Conversely, C-reactive protein levels were elevated in control group comparing to patient group.

Conclusion: In the present study NAFLD did not have increased IMT but had high prevalance of carotid plaque. The presence of MetS did not affect the prevalence of increased IMT and carotid plaque formation. The clinical implication of this study is that patients with NAFLD and control group are at similar risk of CVD. Studies in large NAFLD patient population comparing to control goups should be performed. How be it, patients with NAFLD should undergo periodic cardiovascular risk assessment.

Keywords: NAFLD; Carotid atherosclerosis

Introduction

Nonalcoholic fatty liver disease is described with fat accumulation in the liver without significant amount of alcohol consumption and has a spectrum ranging from simple steatosis to steatohepatitis, cirrhosis and liver failure [1-2]. NAFLD frequently has a relation to the components of metabolic syndrome like diabetes, dyslipidemia, obesity and hypertension [3-4].

Because of associated metabolic disturbances, NAFLD is regarded to have much atherogenic condition and so carries potential high cardiovascular risk [5-6]. Early detection of atherogenesis and the cardiovascular risk related to NAFLD has not been widely researched [7-8]. In this case-control study, we investigated the relation of NAFLD with atherosclerosis by measuring carotid intima-media thickness (IMT) and plaque to detect increased cardiovascular risk.

Materials and Methods

Subjects

We examined all subjects addressed for diagnostic abdominal ultrasound to the Radiology Division of Bursa High-
Clinical and laboratory studies

The diagnosis of NAFLD was established by the exclusion of common etiologic factors of liver disease and on ultrasound scanning [9]. Anthropometric, complete blood count and biochemical evaluations were performed. Biochemical assessments included alanine aminotransferase (ALT), aspartate aminotransferase (AST), γ-glutamyltransferase (GGT), alkaline phosphatase (ALP), bilirubin, albumin, total cholesterol, high density lipoprotein-cholesterol (HDL-cholesterol), triglycerides, ferritin, C-reactive protein (CRP), fasting glucose, insulin and c-peptide levels, oral glucose tolerance test (OGTT). Carotid ultrasound scanning for determination of IMT and plaque was performed. Low-density lipoprotein (LDL) cholesterol was calculated according to the Friedewald formula. Increase in CRP values accepted when above 3.5 mg/dL. Normal ferritin levels were between 28-365 mg/mL in men and 5-148 ng/mL in women. Anthropometric parameters were height, weight, body mass index (BMI), waist and hip circumferences and waist/hip ratio values. Appraisement of obesity was dependent on WHO and NCEP ATP III criteria [10-11]. Definitions of type 2 diabetes, impaired glucose intolerance were dependent on American Diabetes Association (ADA) criteria. Patients under oral antidiabetics or insulin therapy were accepted as diabetics. Hypertension was assumed to be present when resting blood pressure was ≥140/90 mm Hg or patients were receiving antihypertensive drug therapy. The homeostasis model assessment of IR (HOMA-IR) method was utilized to establish insulin resistance (IR) [12]. Patients were accepted as ‘insulin resistant’ when HOMA-IR value was >2.70.

Liver biopsy was not performed for ethical reasons. Ultrasound examination is most extensively applicable method to diagnose NAFLD. The diagnosis of metabolic syndrome was set up according to National Cholesterol Education Program (NCEP) Adult Treatment Panel III (ATP-III) and WHO criteria [10-11]. Patients should have at least three of the criteria to be diagnosed with metabolic syndrome. The study was approved by the hospital ethics committee.

Carotid ultrasound

A Philips HD 11 XE- L12-3 and L12-5 equipment with a 9-MHz multi frequency transducer was used for B-mode and Doppler carotid ultrasound. Aradio diagnostics and sonography specialist who was unaware of the patients’ and control subjects’ circumstances scanned the right and left carotid arteries and recorded images on videotape. In the present study IMT measurements were carried out from the far wall of the distal 10 mm of left and right common carotid arteries. IMT values were evaluated according to protocols of standard measurements of carotid artery [13-14]. Increased IMT was defined as a focal thickening of 1.0 mm in any of 12 carotid segments. A plaque was defined as a focal thickening above of 1.2 mm in any of carotid artery segments.

Statistical analyses

Comparisons of patients and control subjects were made with unpaired t tests or the Mann–Whitney U test, when appropriate, for continuous variables and by 2 analyses for categorical variables. Pearson’s correlation coefficients were constructed to test the relationship between continuous variables. ANOVA statistic was used to compare sex- and age-adjusted IMT values between different groups of NAFLD and MetS. P values <0.05 were considered as statistically significant. Analyses were performed with SPSS 10.0 software.

Results

Anthropometric, clinical features and laboratory results

Table 1: Clinical and Laboratory Data of Patients with NAFLD and controlled subject.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Patients (n=64)</th>
<th>Controls(n=64)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men/women</td>
<td>31/33</td>
<td>31/33</td>
<td></td>
</tr>
<tr>
<td>Age, Years</td>
<td>48.6±11.6</td>
<td>45.92±13.1</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>High Blood pressure</td>
<td>27(42.1)</td>
<td>14(21.8)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Diabetes</td>
<td>13(20.3)</td>
<td>6(9.37)</td>
<td>0.136</td>
</tr>
<tr>
<td>History of CHD</td>
<td>10(15.6)</td>
<td>8(12.5)</td>
<td>0.120</td>
</tr>
<tr>
<td>Dislipidemia</td>
<td>30</td>
<td>31</td>
<td>0.669</td>
</tr>
<tr>
<td>Current Smoker</td>
<td>17(26.5)</td>
<td>13(20.3)</td>
<td>0.142</td>
</tr>
<tr>
<td>BMI, kg/m²</td>
<td>30.6±5.24</td>
<td>27.4±5.31</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Waist Circumference, cm</td>
<td>102.2±13.0</td>
<td>91.48±12.5</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Waist in IP ratio</td>
<td>0.92±0.07</td>
<td>0.88±0.08</td>
<td>0.010</td>
</tr>
<tr>
<td>Systolic blood pressure, mm Hg</td>
<td>129.7±14.5</td>
<td>129.2±13.2</td>
<td>0.782</td>
</tr>
<tr>
<td>Diastolic blood pressure, mm Hg</td>
<td>79.8±7.21</td>
<td>78.8±8.43</td>
<td>0.195</td>
</tr>
<tr>
<td>Obesity n who</td>
<td>51(79.6)</td>
<td>41(64)</td>
<td>0.119</td>
</tr>
<tr>
<td>Obesity n nce p</td>
<td>52(81.2)</td>
<td>27(42.1)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>
Sixty four patients (31 male, 33 female) and sixty four control subjects (31 male and 34 female) who were diagnosed with fatty liver by ultrasonographic examination participated in the study. Anthropometrical, clinical features and laboratory data in both group were compared and shown at (Table 1). Patients with NAFLD had a higher frequency of high blood pressure than control group (34.9% and 25.9% respectively). According to the presence of metabolic syndrome, in NAFLD group plaque formation was significantly more frequent (23.4%) of control subjects (P<0.001). For all that, interestingly, control group with high CRP values had increased IMT and plaque formation significantly.

Findings due to metabolic syndrome

Three metabolic risk factors related to MetS (obesity-increased BMI, central obesity, hypertension, insulin resistance) were significantly(P<0.001) more frequent in NAFLD patients than those in control subjects. But the frequency of diabetes and dislipidemia were similar in both NAFLD and control groups. As to both WHO and ATP-III criteria, the frequency of MetS in NAFLD patients was higher than normal subjects (60.9% and 37.5% versus 35.9% and 14% respectively). According to the presence of metabolic syndrome, in NAFLD group plaque formation was higher than control group (Table 2).

Table 2: Relationship of individual metabolic risk factors and defined MetS with abnormal IMT and plaques in NAFLD patients and control groups.

Outcomes of carotid ultrasound examinations

Aimed to present the predictors inducing the occurrence of carotid atherosclerosis in NAFLD patients comparing to control group (Table 2). At the same time, the abnormal IMT rates and plaque formation according to the presence of metabolic risk factors in NAFLD patients and control group were shown at (Table 2) and no risk factor seemed to be as the predictor of carotid atherosclerosis.
Table 3: Carotid IMT and Plaque in Patients with NAFLD and Control subjects.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Patients(n=64)</th>
<th>Controls(n=64)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean IMT, mm</td>
<td>1.06±0.71</td>
<td>0.96±0.66</td>
<td>0.125</td>
</tr>
<tr>
<td>Maximum IMT, mm</td>
<td>2.70±0.71</td>
<td>3.90±0.66</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Carotid plaque</td>
<td>12(18.7%)</td>
<td>6(9.37%)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Patients with NAFLD showed increased mean IMT and a 2-fold higher frequency of plaque compared to normal subjects, but conversely maximum IMT value was higher in normal group than those in patients with NAFLD (Table 3). The differences for mean IMT between NAFLD and controls were 0.10 mm in favour of NAFLD group and 1.1 mm for maximum IMT in favour of healthy controls. Figure 1 shows patient-control differences in IMT and plaque frequency according to the gender. In NAFLD group IMT values were higher in women than those in men. Conversely, in control group IMT values were higher in men than those in women.

When we compared all participants subdividing into 4 subgroups as with and without NAFLD and with and without MetS, IMT values did not show significant differences and were almost similar in four subgroups (Figure 2).

Discussion

This study aimed to evaluate the coexistence and size of cardiovascular risk factors and carotid atherosclerosis in patients with primary NAFLD diagnosed by ultrasound examination. As to recent studies, patients with NAFLD frequently presents various combinations of parameters related to MetS [3-4]. While MetS has high risk of atherosclerosis and is associated with NAFLD, studies to determine early atherosclerosis and detection of novel atherosclerotic risk factors in NAFLD patients were widely studied recently as stated by Targher G et al. [5] & Lim S et al. [6].

In this study, the prevalence presence of carotid atherosclerosis was investigated in patients with NAFLD being coexistence with or without metabolic syndrome. Carotid atherosclerosis has a significant value to predict the oncoming atherosclerotic process. Stated that values of carotid intima-media thickness were reliable and accurate method to detect early atherosclerosis [7-8]. Various methods are available for measurements of carotid artery intima-media thickness as showed by Casella IB and Baldassarre D [13-14]. NAFLD and the progress of an atherosclerosis now a rising issue in the field of cardiovascular risk factors as stated by Brea A et al. [14], Volzke H et al. [15] Nestel PJ et al. [16].

In the present study, abnormal IMT and carotid plaque incidence, as the signs of developing atherosclerosis, were not associated with MetS and its individual parameters in patients with NAFLD and in controls (Table 2). According to the literature, in subjects with MetS, incidence and progression of augmented carotid IMT and carotid plaque occurance were increased Kim HC et al, Targher G et al & Bonora et al. [18-20] said that presence of Mets in NAFLD cases enhances occurrence of carotid atherosclerosis [18-20]. In this study in NAFLD group with WHO-MetS had an increase in plaque formation than those in controls but this result was not significant. Regardless of MetS, in NAFLD and control groups have similar ratio according to the presence of increased IMT and carotid plaque formation and these findings suggest that, solely NAFLD did not increase the occurrence of atherosclerosis (Table 3). Kim HJ et al and Younossi Zobair M et al. [21-22] said that NAFLD could occur in adolescents and in leans even in the absence of MetS [21-22], likewise, carotid atherogenesis might progress even so in healthy and young persons [23-27]. These findings give hints that NAFLD is not always and un questionable an atherogenic state. Large numbers of individuals with and without NAFLD as well as with and without MetS should be studied for carotid atherosclerosis.

Prevalence of MetS in our NAFLD and control groups were 60.9% and 35.9% respectively and results were statistically significant. But in the present study NAFLD did not have close relation with increased IMT and carotid plaque. The presence of MetS did not change the outcomes. Presence of MetS did not alter the generation of abnormal IMT and carotid plaque and these findings were not concordant with the view of NAFLD.
as a hepatic component of MetS [28]. Additionally, hepatic fat accumulation was not significantly related to patients’ lipid profile, atherogenic condition.

Howbeit, conversely to certain previous study findings, in the present study we determined that patients with NAFLD might not have advanced carotid atherosclerosis and NAFLD could not be a predictor of an increased IMT [23-25]. Targher G et al, Petit JM et al and Oren A et al revealed that carotid arteriosclerosis could be present in young and healthy adults.

Process of atherogenesis in NAFLD can be revealed by measuring CRP levels [29]. In the pathogenesis of NAFLD oxidative stress has an important role. Pro-atherogenic effect in NAFLD is considered to become from excessive oxidative stress. Alongside being the source of oxidative stress, ROS (reactive oxidative species) eventuate from fatty acid beta-oxidation and cause hepatocyt injury, cytokin release and yield an inflammatory milieu which can initiate also steatosis and steatohepatitis and then additionally an atherogenic effect together with the increased level of serum CRP. In our study CRP levels were higher in control group than those in NAFLD subjects, despite the presence of MetS. In the present study CRP levels were not increased in insulin resistant individuals. Moreover, CRP levels were not related to the serum ALT levels and IMT values. So CRP and ALT both did not show any association with the inflammatory state.

Additionally, abnormal lipoprotein metabolism (due to the insulin resistance and MetS) in NAFLD can enhance the cardiovascular risk and effect the formation of atherosclerosis [30]. A considerable and common mechanism of hepatosteatosis is as belows: increased fatty acid flow from adipose tissue and small intestine because of the removed inhibition of lipoprotein lipase enzyme effect on lipolysis secondary to insulin resistance, reduced beta-oxidation and increased synthesis of free fatty acids in hepatocytes and reduced triglyceride excretion from liver cells. The latest depends on the deteriorated synthesis of Apo-B100 and diminished formation of VLDL. Because of the reducing hepatic Apo B synthesis in NAFLD, triglyceride rich VLDL is not excreted and accumulates in liver. Increased intracellular free fatty acids cause an enhancement of cytochrome P450 4A and cytochrome P 2E1. These products then induce the occurrence of ROS. Excessive ROS initiate lipid peroxidation of hepatocyte membrane lipids and then destruction of liver cells emerges [31]. In the present study, in NAFLD patients and controls with dyslipidemia, percentages of those with abnormal IMT and carotid plaque were similar and results were not significant. Whereas, serum triglyceride levels were increased in NAFLD patients than those in control subjects significantly.

Free radicals are occured also during the enzymatic and non-enzymatic oxidationreactions reactions concerned with iron and copper [32]. Free radicals break up double bonds between carbon atoms in unsaturated fatty acids with the catalytic effect of iron and ascorbic acid. The result is the onset of lipid peroxidation. Ferritin is the form of iron storage, and iron is released to provide the necessity of the body. The role of excessive iron storage is not exactly clear in pathogenesis of NAFLD. In NAFLD, because of being an acute phase reactant ferritin may be increased secondary to the inflammation and liver cell damage. In this study, only one patient had high ferritin level. This female NAFLD patient was obese and insulin resistant and had hypertension with normal ALT levels. In both groups ferritin levels were also not correlated with increased IMT values and presence of plaque.

In conclusion, in our study NAFLD was not associated with carotid atherosclerosis or atherogenic state even with and without MetS. While NAFLD is considered as a component of MetS, the findings and results of our study maydirect attentions to other causes which lead to the formation of atherosclerosis. The frequency of CAD, components of MetS or defined MetS may show disparity in NAFLD according to the recent studies. Howbeit, in NAFLD patients with or without MetS, should be evaluated for an unknown and occult and potential cardiovascular risk as well as a serious liver disease.

References


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