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Extent and Composition of Coronary Lesions in Relation to Fat Distribution in Women Younger Than 50 Years of Age

Marja-Leena Kortelainen, Terttu Särkioja

Abstract—To ascertain the relationship between the extent and composition of coronary arterial lesions and the regional distribution of fat in healthy women younger than 50 years of age, a series of 30 forensic autopsy cases were investigated. Body height and weight, waist and hip circumferences, and the thickness of the subscapular and abdominal subcutaneous fat were measured; the body mass index (BMI) and waist-to-hip ratio (WHR) were calculated, and omental and mesenteric fat deposits were weighed. The extent of coronary lesions was measured by planimetry, and the thickness of the intima-media was measured by computerized image analysis. Intimal macrophage foam cells and smooth muscle cells were detected by immunohistochemistry, and macrophages were quantified. The intima media thickness in the left anterior descending artery, circumflex artery, and right coronary artery varied significantly across the tertiles of WHR when age and BMI were adjusted, being highest when WHR exceeded 0.87. The thickest lesions also contained the largest numbers of macrophage foam cells. The intima-media thicknesses were highest with increased amounts of intraperitoneal fat. These results indicate that the severity of clinically silent coronary lesions in younger female individuals is associated with increased WHR and increased amounts of intraperitoneal fat. These results emphasize the importance of WHR as a coronary risk indicator in younger women. (Arterioscler Thromb Vasc Biol. 1999;19:695-699.)

Key Words: coronary artery disease • obesity • body fat distribution • heart

The accumulation of fat in the abdominal region is a well-known independent risk factor for coronary heart disease in both men and women. Angiographic studies have revealed a positive association between clinically significant coronary narrowings and abdominal obesity in both sexes,1–4 and our previous study of ante mortem healthy female forensic autopsy cases indicates that both coronary lesions are more advanced as the numerical value for waist-to-hip ratio (WHR) increases.5 The subjects in that study were both young and postmenopausal women, and the severity of coronary involvement was evaluated only by visual inspection. Because the degree of less severe lesions can often be underestimated when only a visual method is used,6 a more detailed investigation of the lesions is needed when obesity-associated cardiovascular pathology is studied in younger individuals. The type of plaque, especially its tendency to rupture, is considered more important than the mere narrowing caused by the lesion.7,8

Acute cardiovascular events are very rare in young or premenopausal women, and even in Finland, where cardiovascular morbidity and mortality are high, the incidence of fatal acute myocardial infarction in 1995 was no more than 8/100 000 among women from 45 to 49 years of age and only 1.5/100 000 in the age group 40 to 44 years,9 compared with the incidences of 116/100 000 and 42/100 000, respectively, in the corresponding male age groups.9 The protective effect of estrogens on the cardiovascular system has been concluded to be a major factor associated with the sex difference in cardiovascular disease.10 It would be of great importance to focus research on young women who develop premature coronary artery disease despite the protective effect of estrogen. To test the hypothesis that younger women with an android type of body fat distribution would probably have a greater risk of a future cardiovascular event, we designed a prospective autopsy study in which a detailed examination of coronary lesions was carried out. The purpose was to find out whether the actual degree of coronary pathology, evaluated in terms of the extent of intima involved, narrowing caused by the lesions, and the microscopic composition of the lesions, is associated with increased abdominal accumulation of fat.

Methods

Subjects

The material was collected from medicolegal autopsies performed at the Department of Forensic Medicine, University of Oulu, Finland, from 1995 to 1997. Thirty women from 19 to 49 years of age (median 37) were examined. The subjects were not known to have had any ante mortem clinical signs of coronary artery disease, hypertension, lipid disorders, or any other cardiovascular abnormalities. Chronic alcoholics, diabetics, and individuals with other chronic diseases or marked changes in body structure (eg, severe crush injuries or marked ante mortem changes in body weight) were also excluded. The cases consisted of violent deaths from accidental

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The arteries were then removed en bloc so that the smaller branches were also excised free of surrounding tissues as far as could be judged with the naked eye. The degree of coronary narrowing was visually estimated in the LM, LAD, CX, and RCA, separately. A numerical score was added to the percentage of coronary plaques, coronary narrowing score and macrophages/mm² to avoid the logarithm of zero. All measurements were made at 40× magnification on a microscope connected to a computerized image analysis system (Imaging Research Inc.). The results represent means of at least 5 measurements made on each vessel.

Macrophages were counted at a magnification of 200× in the immunostained sections using the computerized image analysis system. Three intimal areas were measured from the cross-sections in which the lesions were found. The fields were selected either from the shoulder regions of the lesions, where maximum density of macrophages is usually seen, or from other parts of a plaque with maximal amount of macrophages. Three fields were examined also from cross-sections with only a few macrophages and no apparent lesion formation. The results represent means of the 3 measurements.

Statistical Analysis
All the analyses were performed using the Statistical Package for the Social Sciences (SPSS) software. All variables except height showed some skewness in their distribution, and therefore logarithmic transformation was performed on them. A small constant (0.01) was added to the percentage of coronary plaques, coronary narrowing score and macrophages/mm² to avoid the logarithm of zero. Normal distributions were achieved with BMI, abdominal and subscapular fat, and the intima-media thickness of LM, LAD, and CX. The distributions of the other variables still remained somewhat skewed. Pearson correlation coefficients were calculated between age and the other variables, and between the cardiac parameters. Tertiles of BMI, WHR, abdominal and subscapular fat, and intraperitoneal fat were calculated. The cutoff points were 20.3 kg/m² and 25.4 kg/m² for BMI, 0.78 and 0.87 for WHR, 18 mm and 29 mm for abdominal fat, 4 mm and 11 mm for subscapular fat, and 243 g and 475 g for intraperitoneal fat. An analysis of covariance with age as a covariate was used to compare the means of coronary parameters across the tertiles of BMI, WHR, subcutaneous fat thicknesses, and intraperitoneal fat. An analysis of covariance was also carried out with age and BMI together as covariates, comparing the means of the various cardiac parameters across tertiles of WHR and the fat tissue measurements.

Results
The descriptive statistics, including means, standard deviations and ranges, are presented in Table. The variation in the various indicators of body size and obesity was wide. The BMI scores ranged from 0% to 30%, but no
significant variation across the tertiles of BMI was seen. In 15 cases, no fatty streaks were seen at all. The visually determined degree of coronary narrowing was generally mild. In only 2 cases was >50% of the coronary arterial lumen estimated to be narrowed.

The proximal part of the LAD was most often seen to be affected on visual inspection (15 cases), followed by the RCA (10 cases). The intima-media was thickest in the LAD, followed by LM, RCA, and finally CX (Table). Many of the macroscopically normal arteries showed diffuse intimal thickening with smooth muscle proliferation. The maximal

thicknesses of the raised lesions with a visible lipid core all exceeded 900 μm, and all these lesions were rich in macrophages, which were occasionally seen also in the lesions without distinct lipid cores. A raised lesion with a lipid core, together with the dimensions of the plaque, is shown in Figure 1.

Figure 1. Transverse section of a raised lesion in the LAD of a 34-year-old woman with WHR 0.87 stained by the Verhoeff-Masson trichrome method. (i) indicates intima; (m), media; and (l), lipid. Magnification ×100; bar=500 μm.

Figure 2. Means of LAD, CX, and RCA intima-media thickness across tertiles of WHR. Values were compared by analysis of covariance. LAD: Age adjusted, \( F=2.404, P=0.090 \); Age and BMI adjusted, \( F=4.717, P=0.006 \). CX: Age adjusted, \( F=2.800, P=0.060 \); Age and BMI adjusted, \( F=4.341, P=0.008 \). RCA: Age adjusted, \( F=3.849, P=0.022 \); Age and BMI adjusted, \( F=7.050, P=0.001 \).

Age was positively correlated with the various coronary parameters, but statistical significance was reached only with the thickness of the intima-media in the CX \( (r=0.441, P<0.05) \) and RCA \( (r=0.444, P>0.05) \). The various indicators of obesity also showed positive correlations with age, but these were not statistically significant.

The intima-media thicknesses of the LM, LAD, CX, and RCA were highest in the third tertile of WHR \( (>0.87) \). The intima-media thicknesses of the LAD and CX varied significantly across the tertiles of WHR when adjusted for age and BMI together (Figure 2). The intima-media thickness of the RCA varied significantly across the tertiles of WHR both when adjusted for age alone and when adjusted for age and BMI together (Figure 2). The number of macrophages/mm² in

Descriptive Statistics for Series of 30 Autopsy Cases

<table>
<thead>
<tr>
<th></th>
<th>Mean±SD</th>
<th>Range</th>
</tr>
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<tbody>
<tr>
<td>Age, y</td>
<td>35±10</td>
<td>19–49</td>
</tr>
<tr>
<td>Height, cm</td>
<td>166±7</td>
<td>154–175</td>
</tr>
<tr>
<td>Weight, kg</td>
<td>67±18</td>
<td>46–115</td>
</tr>
<tr>
<td>BMI, kg/m²</td>
<td>24.4±6.5</td>
<td>18.0–43.3</td>
</tr>
<tr>
<td>Waist circumference, cm</td>
<td>79±15</td>
<td>60–116</td>
</tr>
<tr>
<td>WHR</td>
<td>0.83±0.07</td>
<td>0.73–0.98</td>
</tr>
<tr>
<td>Subcutaneous fat, mm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdominal</td>
<td>28±17</td>
<td>5–75</td>
</tr>
<tr>
<td>Subcapular</td>
<td>9±8</td>
<td>1–32</td>
</tr>
<tr>
<td>Intraperitoneal fat, g</td>
<td>517±448</td>
<td>86–2322</td>
</tr>
<tr>
<td>Mesenteric</td>
<td>245±213</td>
<td>61–1037</td>
</tr>
<tr>
<td>Omental</td>
<td>272±261</td>
<td>25–1285</td>
</tr>
<tr>
<td>Coronary plaques, % of intimal surface area</td>
<td>5±8</td>
<td>0–30</td>
</tr>
<tr>
<td>Coronary narrowing, score 0–20</td>
<td>2±2</td>
<td>0–10</td>
</tr>
<tr>
<td>Thickness of intima-media, μm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LM</td>
<td>631±192</td>
<td>257–1056</td>
</tr>
<tr>
<td>LAD</td>
<td>663±363</td>
<td>224–1713</td>
</tr>
<tr>
<td>CX</td>
<td>414±246</td>
<td>85–1024</td>
</tr>
<tr>
<td>RCA</td>
<td>457±303</td>
<td>200–1733</td>
</tr>
<tr>
<td>Macrophage foam cells/mm²</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LM</td>
<td>2±9</td>
<td>0–50</td>
</tr>
<tr>
<td>LAD</td>
<td>120±241</td>
<td>0–837</td>
</tr>
<tr>
<td>CX</td>
<td>36±112</td>
<td>0–481</td>
</tr>
<tr>
<td>RCA</td>
<td>36±168</td>
<td>0–920</td>
</tr>
</tbody>
</table>
the RCA and CX varied significantly across the tertiles of WHR when adjusted for age and BMI together (F=3.413, P=0.023 for RCA; F=2.806, P=0.047 for CX), being highest when WHR exceeded 0.87. The visually estimated coronary narrowing and the percentage of intima covered by the lesions did not show any significant variation over the tertiles of WHR. The percentage of coronary lesions and the intima-media thickness of the LAD and CX were highest in the second tertile of BMI (20.3 to 25.4 kg/m²), but the intima-media thickness of the RCA was highest in the leanest group, with BMI<20.3 kg/m². The degree of coronary narrowing was highest in the second tertile of BMI, but this was not statistically significant. Most of the coronary parameters attained their highest values in the second tertile of abdominal subcutaneous fat (18 to 29 mm) but in the highest tertile of subscapular subcutaneous fat (4 to 11 mm). The intima-media thicknesses of the LM, LAD, CX, and RCA were highest in the third tertile of intraperitoneal fat, the variation across the tertiles being significant in the RCA when adjusted for age alone or for age and BMI together (Figure 3).

The correlations between the various coronary parameters were generally positive and significant, the degree of coronary narrowing being associated with the percentage of intimal plaques (r=0.577, P<0.01) and with the intima-media thickness of the LAD (r=0.471, P<0.05), CX (r=0.527, P<0.01), and RCA (r=0.635, P<0.001). There were also significant positive correlations between intima-media thickness and the numbers of macrophages/mm² in the LAD (r=0.645, P<0.001), CX (r=0.412, P<0.05), and RCA (r=0.843, P<0.001).

**Figure 3.** Means of RCA intima-media across tertiles of intra-abdominal fat. Values were compared by analysis of covariance. Age adjusted, F=3.824, P=0.022; Age and BMI adjusted, F=4.780, P=0.006.

**Discussion**

The present autopsy study revealed a positive association between the abdominal type of body fat accumulation and the severity of coronary artery pathology in ante mortem healthy women from 19 to 49 years of age. Advanced coronary lesions with lipid cores and large amounts of macrophage foam cells were seen in women with high WHR, even women in their twenties and thirties. Previous autopsy-based studies have brought out some positive associations between obesity and coronary atherosclerosis in other individuals, but mainly in men. Significant associations between the extent of intimal fatty streaks and raised lesions in the RCA and both BMI and the thickness of the panniculus adiposus in men younger than 34 years of age were reported by McGill et al., but they used only visual estimation of the RCA. We have previously found a positive association between increased WHR and clinically silent coronary lesions in men younger than 40 years of age.13 Our other previous autopsy study on females also included postmenopausal women, and the results of both that and the present survey suggest that the severity of coronary atherosclerosis does not increase with increasing BMI values in women although it does so with increasing WHR and with the size of the intraperitoneal fat deposits.

The general limitations of autopsy studies must be considered when evaluating the present results: the effects of early autolytic changes in a cadaver, with consequent effects on tissue processing; the reliability of the ante mortem data; and the difficulties in adjusting for the various confounding lifestyle factors such as smoking habits and habitual alcohol consumption, physical activity, dietary habits, and emotional stress. As in our previous autopsy studies, we did not find any evidence of heavy alcohol consumption at autopsy, but post mortem lipid analyses were not performed because they can be regarded as somewhat unreliable even during the first 24 hours after death. Thiocyanate measurements would have revealed recent smoking, but lifetime smoking habits would still have remained unknown. It is significant that women with high WHR have been reported to smoke more frequently. Individuals with impaired glucose tolerance could also not be excluded from the present study.

The android type of body fat accumulation is associated with severity of coronary atherosclerosis as measured by various methods in ante mortem healthy women younger than 50 years of age. The estimation of the degree of coronary narrowing in this study was entirely subjective, but it was significantly positively correlated with the intima-media thicknesses measured. Even normal-weight women with high WHR have plaques with lipid cores and an abundance of macrophage foam cells. Young women with an android type of body structure would probably need very careful elimination of other major coronary risk factors to stabilize the lesions and alleviate their progression.

**Acknowledgment**

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**References**


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