High-sensitivity C-reactive protein as a biomarker of risk in coronary artery disease

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Received 23 September 2011; accepted 21 February 2012
Available online 23 October 2012

Abstract Vascular inflammation plays a crucial role in the pathogenesis of atherosclerosis and mediates various stages of atherosclerotic plaque development, from lipid streak formation to the plaque rupture and destabilization that precedes the clinical syndromes of cardiovascular disease. Inflammatory biomarkers constitute valuable tools to study this process, enabling the effects of different therapeutic interventions to be assessed. Currently, C-reactive protein (CRP) determined by high-sensitivity methods (hs-CRP) is the most extensively studied biomarker. Data regarding hs-CRP and cardiovascular risk, though largely consistent, are of unclear clinical relevance. This article provides a comprehensive review of current knowledge concerning cardiovascular risk and hs-CRP, and concludes with an evidence-based analysis of the current role of hs-CRP in cardiovascular risk assessment.

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PALAVRAS-CHAVE
Proteína C reativa de alta sensibilidade; Inflamação vascular; Doença coronária

Proteína C reativa de alta sensibilidade como biomarcador de risco na doença coronária

Resumo A inflamação vascular tem um papel crucial na patogénesis da aterosclerose e medeia vários dos estádios de desenvolvimento da placa de ateroma, desde a formação da estria lipídica à destabilização e rotação da placa que precede as síndromes clínicas da doença cardiovascular. Os biomarcadores inflamatórios constituem uma ferramenta valiosa para acompanhar a evolução deste processo, permitindo mensurar o efeito das diversas atitudes terapêuticas implementadas. Neste contexto, a proteína C reativa (PCR), determinada por métodos de alta sensibilidade (PCR-as), é o biomarcador mais extensamente estudado. Os dados relativos à associação entre PCR-as e risco cardiovascular são amplamente consistentes, embora

\textsuperscript{*} Please cite this article as: Silva D. Proteína C reativa de alta sensibilidade como biomarcador de risco na doença coronária. Rev Port Cardiol 2012. http://dx.doi.org/10.1016/j.repc.2012.02.018.

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Introduction

Atherosclerosis, once considered to result from a passive process of lipid accumulation, is now known to be an active process of cell activation, inflammation and thrombosis. Inflammation is the key mechanism in the pathogenesis of the different stages of atherosclerosis, from onset, progression of atheroma, plaque instability and rupture, and restenosis following angioplasty. The inflammatory process is exacerbated by the cardiovascular risk factors identified in epidemiological studies, particularly elevated LDL cholesterol. There is mounting evidence that modifying these risk factors reduces inflammation and thus helps prevent atherosclerotic events.

However, the inflammatory process of atherosclerosis is difficult to measure directly. No imaging techniques can assess inflammatory changes, and arterial biopsy to monitor such alterations or therapeutic interventions is neither practical nor ethical. There is therefore a growing interest in biomarkers of inflammation, plasma proteins that can be quantified in peripheral blood.

The explosion in inflammatory biomarkers

Inflammatory biomarkers provide useful information on the inflammatory process of atherosclerosis; they act as a window into the process of cell activation, recruitment of inflammatory cells and proliferation. They may be produced by inflammatory and vascular cells in the plaque or, indirectly, in organs such as the liver and spleen. However, as it is a non-specific process, inflammation in other tissues or organs raises levels of inflammatory biomarkers, which can confound the relationship between plasma levels of these biomarkers and the inflammation associated with stable atherosclerotic syndromes. There was thus a need for high-sensitivity methods to detect small variations in plasma concentrations of these molecules in uninfected individuals that could be related to the inflammatory process of atherosclerosis. Assesment of inflammatory biomarkers complements the study of markers of tissue damage (troponin), of thrombosis and thrombolysis (tissue plasminogen activator) and of lipid oxidation (oxidized LDL). Together, these biomarkers provide crucial information on the atherosclerotic process. Of the large and ever-growing list of inflammatory biomarkers (Table 1), C-reactive protein (CRP) is the most thoroughly studied in coronary artery disease (CAD), and is the subject of this review.

C-reactive protein

In recent decades, over 30 epidemiological studies have shown that CRP is associated with cardiovascular risk. The molecule has characteristics that make it a particularly attractive subject of study: as a positive acute phase protein it is a marker of systemic inflammation that increases in response to various types of injury, particularly bacterial infections, that function as inflammatory stimuli. Its production in the liver is induced mainly by interleukin-6 (IL-6) and, unlike other acute phase markers, its levels are relatively stable, with no significant diurnal variation, and can thus be accurately measured. During the 1990s high-sensitivity techniques were developed to detect lower serum CRP levels than by previous laboratory methods (down to 0.3 mg/l), known as high-sensitivity CRP (hs-CRP), and these techniques should be used when assessing the cardiovascular risk associated with the chronic vascular inflammation of atherosclerosis. There is growing evidence that CRP is not merely a marker of inflammation, but also plays an active role in atherogenesis. In 2003, Ishikawa et al. concluded that CRP is found inside atherosclerotic plaques and plays an important part in both plaque instability and post-angioplasty restenosis. Similarly, Inoue et al. demonstrated in 2005 that CRP is released by atherosclerotic plaques responsible for acute coronary syndromes (ACS). They also showed that there is a CRP gradient in the coronary circulation proximal and distal to the plaque and a transcardiac gradient (from coronary sinus to left ventricular cavity).
to peripheral blood) that gradually increases after angioplasty, peaking at 48 hours, suggesting a cardiac origin of hs-CRP. CRP levels correlate directly with various cardiovascular risk factors, including body mass index, smoking, systolic blood pressure (BP), levels of triglycerides and total cholesterol, heart rate, fasting blood glucose and history of CAD or stroke, and inversely with HDL cholesterol and diastolic BP, in both children and adults.

**Figure 1** C-reactive protein is not merely a marker of the atherosclerotic inflammatory process but also plays an active role in the pathogenesis of atherosclerosis.

**CRP and primary prevention**

Several prospective trials in apparently healthy individuals have shown that elevated hs-CRP is positively correlated with cardiovascular morbidity and mortality. The MRFIT study (Multiple Risk Factor Interventional Trial) concluded that increased hs-CRP predicted higher risk for cardiovascular disease in middle-aged men, although the association was only statistically significant for smokers. The Physician’s Health Study (PHS), a controlled prospective study of individuals without cardiovascular disease and including a low percentage of smokers, showed that those with higher baseline hs-CRP had double the risk of stroke, three times higher risk of myocardial infarction (MI), and four times higher risk of severe peripheral arterial disease. Cardiovascular risk was not affected by smoking or lipid levels. The MONICA Augsburg prospective study of 936 healthy middle-aged individuals with no clinical evidence of CAD showed a 1% greater risk of fatal and non-fatal coronary events for each increment of standard deviation after adjustment for various cardiovascular risk factors, including smoking. In the prospective PREVEND study of 8139 individuals without previous documented CAD, followed for the incidence of coronary angiography and coronary events from 1997 to 2003, hs-CRP levels were associated with angiographic characteristics and clinical consequences of plaque instability during follow-up. The Women’s Health Study (WHS), of post-menopausal women, concluded that hs-CRP was the best predictor of cardiovascular risk compared to other factors including lipid levels and homocysteine. A subgroup analysis of women with LDL cholesterol < 130 mg/l, traditionally considered to be low risk, showed that those with higher hs-CRP were at greater risk for future acute events. Follow-up of the total population revealed that hs-CRP was a strong predictor of cardiovascular events and better than LDL cholesterol. On the basis of the PHS and WHS studies, adjusted relative risk of cardiovascular events increases by 26% in men and 33% in women for each quartile of hs-CRP.

Ridker et al. assessed the ability of non-traditional risk factors to predict cardiovascular events in a population of 24,558 healthy women, and on this basis developed a cardiovascular risk score, the Reynolds risk score, which reclassified 40–50% of women previously classified as intermediate risk as high or low risk. The simplified score includes age, systolic BP, hemoglobin A1c, smoking, total and HDL cholesterol, hs-CRP and family history of premature MI (at under 60 years of age), and has greater prognostic accuracy than conventional risk scores. A similar score, also including hs-CRP and family history of MI, was assessed in men, and also has significantly better ability than traditional models to predict overall cardiovascular risk.

A 2003 study assessed the relation between hs-CRP, the presence of metabolic syndrome and cardiovascular events (MI, stroke, coronary revascularization and cardiovascular death) in 14,719 apparently healthy women, 24% with metabolic syndrome, in an 8-year follow-up. Briefly, hs-CRP levels predicted cardiovascular events, particularly in those with metabolic syndrome at inclusion in the study; this conclusion was confirmed in a subsequent study. As well as thrombotic events, hs-CRP levels also predicted type 2 diabetes, a disease that shares certain inflammatory mechanisms with atherosclerosis. This may have implications for the choice of therapeutic targets in diabetes control. Finally, hs-CRP appears to be of value in screening children at risk for developing CAD as adults.

These data suggest that hs-CRP levels add prognostic value to classic risk factors including lipid parameters, and help identify patients at risk for cardiovascular events, even those previously classified as low or intermediate risk.

However, there is not complete consensus regarding these findings. Other studies have concluded that the predictive power of hs-CRP alone and in association with

<table>
<thead>
<tr>
<th>Indicates the production of cell adhesion molecules such as endothelin-1</th>
<th>Mediates the absorption of LDL by macrophages</th>
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<tr>
<td>Is located in the atherosclerotic intima</td>
<td>Induces expression of plasminogen activator inhibitor-1</td>
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<td>Decreases production of nitric oxide</td>
<td>Induces oxidation of LDL cholesterol</td>
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<td>Reduces endothelial vasoreactivity</td>
<td>Induces complement activation</td>
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<tr>
<td>Induces production of tissue factor in monocytes</td>
<td>Mediates recruitment of monocytes to the arterial wall</td>
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<tr>
<td>Study</td>
<td>Design</td>
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<tr>
<td>Kuller et al., 1996\textsuperscript{15} (MRFIT)</td>
<td>Prospective</td>
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<td>Ridker et al., 1997\textsuperscript{16} (PHS)</td>
<td>Prospective</td>
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<tr>
<td>Koenig et al., 1999\textsuperscript{17} (MONICA Augsburg)</td>
<td>Prospective</td>
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<tr>
<td>Geluk et al., 2008\textsuperscript{18} (PREVEND)</td>
<td>Prospective</td>
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<tr>
<td>Ridker et al., 2000\textsuperscript{19} (WHS)</td>
<td>Prospective</td>
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<td>Ridker et al., 2002\textsuperscript{20}</td>
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<td>Ridker et al., 2007\textsuperscript{22}</td>
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<td>Ridker et al., 2008\textsuperscript{23}</td>
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<td>Ridker et al., 2003\textsuperscript{24}</td>
<td>Prospective</td>
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<td>Danesh et al., 2004\textsuperscript{29}</td>
<td>Prospective</td>
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<tr>
<td>Lloyd-Jones et al., 2006\textsuperscript{30}</td>
<td>Meta-analysis of prospective studies (1966–2005)</td>
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<tr>
<td>Wang et al., 2006\textsuperscript{31}</td>
<td>Prospective</td>
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</tbody>
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Table 2 (Continued)

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Population</th>
<th>Main results</th>
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</thead>
<tbody>
<tr>
<td>Blankenberg et al., 2010³²</td>
<td>Prospective</td>
<td>7915 AH men and women</td>
<td>hs-CRP has no more prognostic value than traditional risk scores.</td>
</tr>
<tr>
<td>Ridker et al., 2001⁶⁴ (AFCAPS/TexCAPS)</td>
<td>Randomized prospective</td>
<td>5742 AH men and women</td>
<td>Individuals with elevated hs-CRP, independently of cholesterol levels, had greater cardiovascular risk and benefited from allocation to the lovastatin group.</td>
</tr>
<tr>
<td>Albert et al., 2001⁶⁵ (PRINCE)</td>
<td>Randomized prospective</td>
<td>1702 AH men and women</td>
<td>Pravastatin reduced hs-CRP levels in individuals with no prior history of cardiovascular disease, irrespective of cholesterol levels.</td>
</tr>
<tr>
<td>Ridker et al., 2008⁷⁰ (JUPITER)</td>
<td>Randomized prospective</td>
<td>17 802 AH men and women (with LDL cholesterol &lt;130 mg/dl and hs-CRP &gt;2 mg/l)</td>
<td>Rosuvastatin reduced the primary endpoint of MI, hospitalization for UA, revascularization, stroke and cardiovascular death compared to placebo.</td>
</tr>
<tr>
<td>Mora et al., 2010⁷¹ (JUPITER substudy)</td>
<td>Randomized prospective</td>
<td>17 802 AH men and women (with LDL cholesterol &lt;130 mg/dl and hs-CRP &gt;2 mg/l)</td>
<td>There was no significant difference in treatment effect between the sexes (42% in men and 46% in women).</td>
</tr>
</tbody>
</table>

AH: apparently healthy; CAD: coronary artery disease; hs-CRP: high-sensitivity C-reactive protein; MI: myocardial infarction; UA: unstable angina.

Conventional risk factors is relatively low.⁸⁻¹¹ According to these authors, the focus in clinical practice should continue to be on classic risk factors such as BP, lipids, and smoking. In a 2010 study of the contribution of 30 biomarkers to cardiovascular risk estimation, Blankenberg et al. concluded that none of the biomarkers under study, including hs-CRP, provided additional prognostic value compared to traditional risk scores. However, adding a score based on three biomarkers (hs-CRP, troponin I and BNP) to a conventional risk model improved estimation of 10-year risk for cardiovascular events in two middle-aged European populations (Table 2).³²

To summarize, as measurement of hs-CRP in primary prevention is not consensual and it is not clear whether its superior predictive ability is clinically relevant by helping reduce cardiovascular morbidity and mortality, large-scale validation trials are required before it should be used in routine clinical practice.³³

**CRP and secondary prevention**

**Stable coronary artery disease**

It has been consistently demonstrated that hs-CRP is a marker of adverse events in patients with stable CAD. However, there is disagreement concerning hs-CRP levels and severity of CAD as assessed by invasive or computed tomography angiography, with some studies supporting³⁴⁻³⁶ and others denying³⁷⁻³⁹ an association. It has been shown that hs-CRP levels correlate inversely with degree of coronary collateral circulation.⁴⁰,⁴¹

A 2006 study by Sinning et al. assessing the impact of hs-CRP and fibrinogen on cardiovascular prognosis of patients with stable CAD concluded that inflammatory markers have some prognostic value but add little to that of traditional risk factors.⁴² A study of the placebo-controlled randomized Prevention of Events with Angiotensin-Converting Enzyme Inhibition (PEACE) trial of 3771 patients followed for a mean of 4.8 years, showed that hs-CRP >1 mg/l was associated with significantly higher risk of cardiovascular death, MI and stroke, even after adjustment for patients’ baseline characteristics and current treatment.⁴³

Other studies have shown that hs-CRP is inversely correlated with left ventricular ejection fraction and is an independent predictor of worsening New York Heart Association (NYHA) functional class in patients with CAD referred for elective coronary angiography, irrespective of CAD severity.⁴⁴ These authors concluded that hs-CRP was an independent predictor of adverse cardiac events (ACS and cardiovascular death) in patients with stable CAD irrespective of the presence of significant atherosclerotic lesions.⁴⁵ This may be explained by arterial wall remodeling, which is known to be associated with the development of CAD; positive correlations have been demonstrated between hs-CRP and degree of coronary remodeling,⁴⁶ and between hs-CRP and plaque composition, particularly the proportion of central necrotic tissue,⁴⁷ as assessed by intravascular ultrasound.
In patients with CAD referred for elective coronary angiography.

Inflammatory markers have also been shown to be predictors of recurrent events following MI. In a 1998 study of 391 patients, Ridker et al. concluded that high levels of inflammation measured by hs-CRP and serum amyloid A (SAA) predicted recurrence of adverse events; patients in the highest quartile of hs-CRP levels had 75% higher risk of recurrence than those in the lowest quartile (p=0.02 for both CRP and SAA). Interestingly, lipid levels were similar in those with and without evidence of inflammation. Furthermore, serum hs-CRP levels also independently predicted rapid progression of CAD. This association was also suggested in 2004 by Zouridakis et al. in a study of 124 patients with CAD awaiting elective coronary angiography (mean waiting time of 4.8 months): rapid progression of CAD (defined as ≥10% diameter reduction of a pre-existing stenosis ≥50%, ≥30% diameter reduction of a stenosis <50%, development of a new stenosis ≥30% in a previously normal segment, or progression of any stenosis to total occlusion) occurred in 35 patients (28%).

Finally, hs-CRP levels correlate with myocardial ischemia induced by stress testing. Ischemia was more likely to be induced in patients in the highest hs-CRP quintile (>3.8 mg/l) than those in the lowest (<0.7 mg/l; 75% vs. 38%). It should be noted that this association was only significant in patients not taking statins or beta-blockers.

**Unstable coronary artery disease**

It is now known that hs-CRP levels correlate with the presence of unstable plaque documented by carotid Doppler study and with increased temperature in such plaques as measured by a thermography catheter. However, their relation with extent of MI as assessed by elevated cardiac enzymes or ejection fraction is the subject of debate.

In the context of ACS, hs-CRP has consistently proved a marker of adverse cardiac events including MI, urgent revascularization, restenosis after percutaneous coronary intervention (PCI) and cardiovascular death. In the randomized Thrombolysis in Myocardial Infarction (TIMI 11A) trial, Morrow et al. showed that hs-CRP levels after ACS were significantly higher in patients who died during follow-up than in survivors (1.3 mg/l vs. 0.72 mg/l, p<0.001). They also independently predicted 14-day mortality, including in patients with negative troponin assay. In the Fragmin during Instability in Coronary Artery Disease (FRISC) trial, hs-CRP was an independent predictor of cardiovascular mortality, which was 5.7% in patients with hs-CRP of >2 mg/l, 7.8% in those with hs-CRP between 2 and 10 mg/l, and 16.5% in those with hs-CRP >10 mg/l. In the Global Use of Strategies To open Occluded arteries IV (GUSTO-IV) trial, although a rise in hs-CRP was associated with increased 30-day mortality independently of troponin levels, it was not associated with recurrence of non-fatal ischemic events and thus predicted mortality better than non-fatal ischemic events.

In 2005, Foussas et al. concluded that hs-CRP levels had prognostic usefulness when added to the well-validated TIMI risk score for ST- and non-ST elevation MI and that both should be used to stratify risk in MI patients.

hs-CRP has been found to be an independent predictor of mortality in patients with ACS even after early coronary revascularization. In a prospective study in 2002 of patients undergoing PCI following non-ST elevation MI, hs-CRP of >10 mg/l at admission was associated with increased mortality in a 20-month follow-up. Another study, of 319 patients with ST-elevation MI treated by thrombolysis, revealed that those with elevated hs-CRP (third tertile) were more likely to have reperfusion failure and had higher in-hospital mortality. Similar results were obtained in 2008 by Hoffman et al., who studied the relationship between admission hs-CRP, myocardial reperfusion assessed by myocardial blush grade after crossing the culprit lesion, and prognosis in 191 patients undergoing PCI after non-ST elevation MI. Reperfusion was more often unsuccessful in patients with elevated hs-CRP (>5 mg/l), and on multivariate analysis only hs-CRP levels and reperfusion failure were independent predictors of mortality during follow-up.

However, in a prospective study of 1360 patients with stable and unstable (MI and unstable angina [UA]) CAD, the adjusted hazard ratio (HR) for MI/death for hs-CRP above the first tertile was 1.8 for stable angina, 2.7 for UA but only 1.0 for MI. A study by Bogaty et al. in ACS patients followed for one year concluded that baseline hs-CRP had only moderate predictive ability for the primary combined endpoint of death, non-fatal MI and UA, and even this disappeared after adjustment for common clinical variables (Table 3).

On the basis of these data, it can be concluded that while hs-CRP has short- and long-term prognostic value in stable angina and UA and following MI, its usefulness is more debatable in the acute phase of MI, which suggests that it should be measured after the acute inflammatory reaction of MI, so as to ensure that the measurement reflects baseline values.

**CRP and preventive therapy (primary and secondary)**

In *vivo* and in *vivo* studies have shown that CRP is not merely a marker of inflammation, but that it plays an active part in the development of the atherosclerotic plaque and subsequent plaque instability and thrombus formation. There has accordingly been extensive research into the relation between CRP and cardioprotective drugs. An analysis of the Air Force/Texas Coronary Atherosclerosis Prevention Study (AFCAPS/TexCAPS) showed that statin therapy as primary prevention directly lowers hs-CRP levels; individuals with high LDL cholesterol (irrespective of hs-CRP levels) and those with low LDL cholesterol but high hs-CRP were at greater risk of cardiovascular events during follow-up; the lovastatin group showed substantial benefit. In the PRINCE (PRavastatin Inflammation/CRP Evaluation) study, pravastatin reduced CRP levels in individuals with no prior history of cardiovascular disease.

However, three meta-analyses of studies of statins in primary prevention concluded that they did not reduce total or coronary mortality in men or women, while in the Management of Elevated Cholesterol in the Primary Prevention Group of Adult Japanese (MEGA) study, in which many more women than men were enrolled, the reduction in events was significant only for men.
Table 3  Main studies of secondary prevention.

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Population</th>
<th>Main results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sinning et al., 2006(^{42}) (Athero Gene)</td>
<td>Prospective</td>
<td>1806 patients with stable CAD</td>
<td>hs-CRP has prognostic value but adds little to that of traditional risk factors.</td>
</tr>
<tr>
<td>Sabatine et al., 2007(^{43})</td>
<td>Prospective</td>
<td>3771 patients with stable CAD</td>
<td>hs-CRP values &gt;1 mg/l, even after adjustment for baseline characteristics and current treatment, were associated with significantly higher risk of cardiovascular death, MI and stroke.</td>
</tr>
<tr>
<td>Arroyo-Espliguero et al., 2009(^{45})</td>
<td>Prospective</td>
<td>790 patients with CAD</td>
<td>hs-CRP was an independent predictor of adverse cardiac events (ACS and cardiovascular death) irrespective of the presence of significant atherosclerotic lesions.</td>
</tr>
<tr>
<td>Zouridakis et al., 2004(^{49})</td>
<td>Prospective</td>
<td>124 patients with CAD</td>
<td>hs-CRP levels independently predicted rapid progression of CAD.</td>
</tr>
<tr>
<td>Morrow et al., 1998(^{55}) (TIMI 11A substudy)</td>
<td>Prospective</td>
<td>445 patients after ACS</td>
<td>hs-CRP levels were significantly higher in patients who died during follow-up.</td>
</tr>
<tr>
<td>Lindahl et al., 2000(^{56}) (FRISC)</td>
<td>Prospective</td>
<td>917 patients with ACS</td>
<td>hs-CRP was an independent predictor of cardiovascular mortality.</td>
</tr>
<tr>
<td>James et al., 2003(^{57}) (GUSTO-IV)</td>
<td>Prospective</td>
<td>7108 patients with ACS</td>
<td>A rise in hs-CRP during ACS was associated with increased 30-day mortality independently of troponin levels, but was not associated with recurrence of non-fatal ischemic events.</td>
</tr>
<tr>
<td>Foussas at al., 2005(^{58})</td>
<td>Prospective</td>
<td>1846 patients with ACS</td>
<td>hs-CRP levels had prognostic usefulness added to the well-validated TIMI risk score for ST- and non-ST elevation MI.</td>
</tr>
<tr>
<td>Mueller et al., 2002(^{59})</td>
<td>Prospective</td>
<td>1042 patients with non-ST elevation MI</td>
<td>hs-CRP &gt;10 mg/l at admission was associated with increased mortality in follow-up.</td>
</tr>
<tr>
<td>Zairis et al., 2002(^{60})</td>
<td>Prospective</td>
<td>319 patients with ST elevation MI treated by thrombolysis</td>
<td>Elevated hs-CRP (third tertile) was associated with reperfusion failure and higher in-hospital mortality.</td>
</tr>
<tr>
<td>Nakachi et al., 2008(^{61})</td>
<td>Prospective</td>
<td>191 patients with non-ST elevation MI treated by PCI</td>
<td>hs-CRP and reperfusion failure were independent predictors of mortality during follow-up.</td>
</tr>
<tr>
<td>Bogaty et al., 2008(^{63}) (RISCA)</td>
<td>Prospective</td>
<td>1210 patients with ACS</td>
<td>hs-CRP had only moderate predictive ability (primary combined endpoint of death, non-fatal MI and UA), and this disappeared after adjustment for common clinical variables.</td>
</tr>
<tr>
<td>Zebrack et al., 2002(^{62})</td>
<td>Prospective</td>
<td>1360 patients with stable and unstable CAD</td>
<td>hs-CRP predicted the endpoint of MI/death in patients with stable and unstable angina but not in those with MI.</td>
</tr>
<tr>
<td>Ridker et al., 1998(^{48}) (CARE)</td>
<td>Randomized prospective</td>
<td>391 patients with fatal and non-fatal MI</td>
<td>In patients taking pravastatin, reduction of risk for coronary events was greater in those with evidence of inflammation as assessed by hs-CRP levels, irrespective of lipid levels.</td>
</tr>
<tr>
<td>Ridker et al., 2005(^{77}) (PROVE-IT)</td>
<td>Randomized prospective</td>
<td>3745 patients with ACS</td>
<td>Aggressive statin therapy reduces hs-CRP levels to less than 2 mg/l, resulting in lower risk for MI and fatal coronary events, independently of reductions in LDL cholesterol.</td>
</tr>
<tr>
<td>Morrow et al., 2006(^{78}) (Aggrastat-to-Zocor)</td>
<td>Randomized prospective</td>
<td>3813 patients with ACS</td>
<td>hs-CRP levels 30 days and four months after MI are independently associated with long-term survival. More aggressive statin therapy is likely to result in low CRP.</td>
</tr>
</tbody>
</table>

ACS: acute coronary syndromes; CAD: coronary artery disease; hs-CRP: high-sensitivity C-reactive protein; MI: myocardial infarction; UA: unstable angina.
The JUPITER (Justification for the Use of Statins in Prevention: an Intervention Trial Evaluating Rosuvastatin) study was a multicenter randomized double-blind trial in 17,802 apparently healthy individuals without hyperlipidemia (LDL cholesterol <130 mg/dl) but with elevated high-sensitivity C-reactive protein (>2 mg/l). 

Rosuvastatin significantly reduced LDL cholesterol by 50% and CRP by 37%, and there were significantly fewer major cardiovascular events in the treatment group. The rate of the combined primary endpoint of stroke, MI, UA, coronary revascularization or hospitalization for unstable angina was 0.77 and 1.36 per 100 person/years in the treatment and placebo groups, respectively (HR for the rosuvastatin group: 0.56; 95% confidence interval [CI]: 0.46-0.69; p<0.00001) (Figure 2). There was no significant difference in treatment effect between the sexes (42% in men and 46% in women).  

Two meta-analyses that included the JUPITER trial concluded that statin therapy reduced the relative risk of cardiovascular events and increased survival in both sexes.  

Some authors consider that preventive treatment with statins in patients with high hs-CRP and normal LDL cholesterol is cost-effective for those with Framingham risk score ≥10%. However, others argue that it is more cost-effective to begin statin therapy without assessing hs-CRP, on the assumption that the drug is safe and is beneficial even in patients with normal CRP.  

It is important to note that the population of the JUPITER trial, although apparently healthy, all had at least one cardiovascular risk factor, such as obesity or smoking. According to Rashid, the JUPITER results warrant further LDL cholesterol lowering than is currently targeted in primary prevention groups that have a pre-existing condition or lifestyle that elevates cardiovascular risk but still do not have a high global CVD risk as assessed with current algorithms. Lifestyle modifications (smoking cessation, normalization of body weight and dietary changes) should be achieved first before considering statin therapy. Assessment of hs-CRP can help identify this patient subgroup, who should begin preventive therapy early in an attempt to reduce the prevalence of cardiovascular disease.  

With regard to secondary prevention, the findings of the Cholesterol And Recurrent Events (CARE) trial, a randomized study assessing the effect of pravastatin after MI,
Variability in hs-CRP levels

Various groups have addressed the question of short-term fluctuations (15 days - 6 months) in hs-CRP levels in clinically stable individuals. Studies have been performed in patients with stable CAD, patients under aggressive statin therapy and healthy individuals; their conclusions are that hs-CRP variability is independent of clinical events, medication, body mass index and smoking, is the same in men and women, and is age-related. Intravascular variability was 42-63% in healthy volunteers and 1.79 mg/l (95% CI: 1.60-2.00) in patients with stable CAD, and was not mirrored by variations in other measures of inflammation.

These findings suggest that there may be practical limitations to the use of this biomarker, particularly for predicting cardiovascular risk. Some authors therefore recommend that risk for CAD should be determined solely on the basis of conventional risk factors.

**Current guidelines**

In 2003, the American Heart Association and the US Centers for Disease Control and Prevention published guidelines on the use of markers of inflammation in cardiovascular risk assessment, and in 2009 the National Academy of Clinical Biochemistry published guidelines on emerging biomarkers for primary prevention of cardiovascular disease.

According to these guidelines, hs-CRP should not be measured in the general population to determine cardiovascular risk, but can be used in risk stratification of adults at intermediate risk for CAD (10-20% risk at 10 years), to help decide whether to begin primary prevention with statins. hs-CRP levels should be expressed in mg/l and patients should be classified as low risk (<1.0 mg/l), intermediate risk (1.0-3.0 mg/l), or high risk (>3.0 mg/l). If the concentration is <3 mg/l, measurement does not need to be repeated. If the value is >3 mg/l, it should be repeated at least two weeks later when there is no evidence of active systemic inflammation; the lower of the two results should be used. Values of >10 mg/l suggest a very strong acute phase response and, if not of cardiovascular cause, require further etiological investigation.

Therapy (statins or aspirin) based on hs-CRP levels should be at the discretion of the clinician, since its benefit is still uncertain, and little evidence supports the use of serial testing for hs-CRP as a means to monitor therapy in primary prevention. Individuals with persistently high levels should improve their lifestyles (e.g. weight loss, regular exercise, dietary modification and smoking cessation), irrespective of their LDL cholesterol levels.

In 2009, the Canadian Cardiovascular Society also published new guidelines on primary cardiovascular prevention, which recommend that in individuals with intermediate cardiovascular risk according to conventional risk scores, hs-CRP should be assessed as well as LDL and HDL cholesterol in order to improve risk stratification. The European Atherosclerosis Society has yet to pronounce on this issue. By contrast, the 2007 European guidelines on cardiovascular disease prevention state that incorporation of CRP and other emerging risk factors into prediction of cardiovascular risk may be premature and is therefore not recommended.

In February 2010, the US Food and Drug Administration approved rosuvastatin for prevention of cardiovascular events in women aged over 60 and in men aged over 50 with...
hs-CRP >2 mg/l and another conventional risk factor, even without hyperlipidemia.91

Both European and American guidelines consider that in patients with documented CAD hs-CRP measurement may be useful as an independent marker for assessing likelihood of death, MI or restenosis after PCI.87,92 However, secondary preventive interventions and application of ACS treatment guidelines should not be dependent on hs-CRP levels.

It should be noted that in 2010, a study by Hemingway et al. evaluating the quality of research into the prognostic value of CRP in stable CAD concluded that the 83 studies analyzed suffered from a variety of biases and that any link between hs-CRP and prognosis is so weak that it cannot be used as the basis for clinical recommendations.93

Conclusion

There is growing evidence that hs-CRP is an important marker of cardiovascular risk and is linked to the pathophysiology of atherosclerosis, providing additional value in primary and secondary prevention. Despite the limitations to its use in routine clinical practice, particularly interindividual variability, the available data indicate that selective determination of hs-CRP is useful in individuals with intermediate cardiovascular risk (10–20% risk at 10 years) in order to optimize risk stratification and clinical management.

Ethics disclosures

Protection of human and animal subjects. The authors declare that the procedures followed were in accordance with the regulations of the responsible Clinical Research Ethics Committee and in accordance with those of the World Medical Association and the Helsinki Declaration.

Right to privacy and informed consent. The authors must have obtained the informed consent of the patients and/or subjects mentioned in the article. The author for correspondence must be in possession of this document.

Conflict of interests

The authors have no conflicts of interest to declare.

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