The prevalence of haemochromatosis gene mutations in the West of Scotland and their relation to ischaemic heart disease

S Campbell, D K George, S D Robb, R Spooner, T A McDonagh, H J Dargie, P R Mills

The accumulation of excess iron stores has been postulated to enhance the risk of ischaemic heart disease. This study aims to determine whether the two major mutations of the haemochromatosis (HFE) gene (C282Y and H63D) are associated with ischaemic heart disease (IHD) or myocardial infarction (MI).

**Objectives:**
Excess iron stores have been postulated to enhance the risk of ischaemic heart disease. This study aims to determine whether the two major mutations of the haemochromatosis (HFE) gene (C282Y and H63D) are associated with ischaemic heart disease (IHD) or myocardial infarction (MI).

**Design:** Cross sectional case-control study.

**Setting:** The geographical area studied by the MONICA (monitoring trends and determinants in cardiovascular disease) heart attack register for North Glasgow in Scotland, UK.

**Patients:** 1009 control subjects chosen at random from general practitioner registers were studied. Additionally, 924 subjects who had survived a first MI sustained between 1985 and 1992 were identified from the MONICA register.

**Main outcome measures:** C282Y and H63D mutations, previous MI, and presence or absence of IHD.

**Results:**
Mutant gene prevalences in the whole control population were as follows: C282Y: homozygote 0.9%, heterozygote 17.7%; H63D: homozygote 2.1%, heterozygote 25.5%; and compound heterozygote: 2.4%. Analysis by \( \chi^2 \) test and logistic regression analysis did not identify any significant difference in genotype prevalence between normal control, IHD control, and MI survivor groups.

**Conclusions:** The C282Y homozygote and heterozygote prevalences are among the highest reported worldwide. No association between IHD or MI and HFE genotype was identified. However, these results need to be interpreted in the light of the cross sectional case-control nature of the study.

**Abbreviations:**
HFE, haemochromatosis gene; IHD, ischaemic heart disease; MI, myocardial infarction; MONICA, monitoring trends and determinants in cardiovascular disease.
from 962 subjects. The response rate was higher for men than for women (63.1% v 56.8%; p = 0.008) and was higher in the first 10 years of the age range than in the second (64.7% v 55.4%, p < 0.001). The subjects who had any evidence of current or previous IHD (MI, angina pectoris, coronary revascularisation procedure, or the ECG abnormalities described above) identified from the medical history, physical examination, or ECG were placed into a group denoted “IHD controls”. The remaining subjects, who had no evidence of IHD, were placed into a group denoted “normal controls”.

Nine hundred and twenty-four subjects who had sustained a first validated MI and who attended a follow-up visit were identified from the MONICA register. The MONICA project maintains a database of all coronary events in selected populations. The Glasgow MONICA project identifies all people resident in North Glasgow aged between 25 and 64 years at the time of MI on the basis of hospital discharge coding, death certificate data from the Registrar General for Scotland, and postmortem and general practitioner data.24 Two thousand and two hundred and fifty eight people were initially identified from the register as having survived a first MI between 1985 and 1992. Five hundred and sixty five (24.6%) had died, 170 (7.5%) had moved out of the area, 82 (3.6%) were within the other IHD risk factors. One way analysis of variance was used to compare the means of continuous variables. The 95% confidence interval (CI) was taken as being p < 0.05. Analyses were performed using SPSS statistical software, version 10 (SPSS Inc, Chicago, Illinois, USA).

RESULTS
Table 1 shows the number of subjects in each of the three groups (normal control, IHD control, and MI survivor), together with a breakdown of age, sex, and other IHD risk factors. There was a significant difference, by univariate analysis, between the normal control group and the MI survivor group for all variables (p < 0.01), with the exception of mean serum cholesterol concentration and the proportion of subjects who were diabetic, or were former smokers. Table 1 also shows the odds ratio for each risk factor. There was no difference in age, sex, or other IHD risk factors between the normal control and IHD control group. The overall prevalence of IHD in the entire control group was 46%. This was subdivided as follows: ECG evidence of previous MI (Q/QS waves) 6.6%; left bundle branch block, ST segment depression, or T wave inversion 26.8%; antianginal treatment 9.9%; self reported history of MI 10.7%; and self reported history of angina 16.4% (note that subjects could be included in more than one category).

Table 2 shows the frequencies in the whole control population (normal controls and IHD controls) of the H63D and C282Y homozygotes, heterozygote carriers, compound heterozygotes, and individual allele frequencies. The distributions of these genotypes were all in Hardy-Weinberg equilibrium (p = 0.24, p = 0.74, p = 0.79, for wild type, H63D, and C282Y, respectively).

Table 3 shows the prevalence of each of the six possible genotypes for each subject group. This table also shows the odds ratios and 95% CIs by logistic regression analysis comparing the normal control versus IHD control and normal control versus MI survivor groups, respectively. There was no significant difference in the genotype frequencies (as assessed by univariate analysis) between the groups with the exception of the C282Y heterozygotes, which occurred less frequently in the post-MI group than in the normal control group (p = 0.04). After correction for differences between the two
found in studies of the Irish population, lead to an increase in the risk of IHD. 

years) in the population studied (data not shown). 

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DISCUSSION 

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gene mutations in a randomly selected mainland UK or Irish 

population. The C282Y heterozygote and homozygote frequen-

cies were higher in this study than in any other study of the 

mainland UK population. 

alleles are comparable with frequencies found in studies of the Irish population, and are among the highest reported frequencies of any study worldwide. This study also confirmed our expectations that the west of 

Scotland is an area of high prevalence of IHD. Although this 
population sample does not include the extremes of age, we 

felt that the gene frequencies were still likely to be a reasonable estimate of those in the overall population. We did not detect any change in the frequency of the HFE gene mutations with increasing age cohorts (for example, of 5 or 10 years) in the population studied (data not shown).

The “iron hypothesis” proposes that increased iron stores lead to an increase in the risk of IHD. This may account for the higher incidence of IHD in men and postmenopausal women than in premenopausal women. As iron stores increase with age in both sexes, the iron hypothesis may also account for the increasing incidence of IHD with aging. Iron is a pro-oxidant and can increase the peroxidation of low density lipoprotein, which may promote atherogenesis. It may also promote IHD by augmenting free radical mediated myocardial damage occurring after an ischaemic event. This effect, in theory, is independent but additive to any effect on atherogenesis. The iron hypothesis also proposes that iron depletion may protect against or decrease the severity of ischaemic coronary events. 

In the absence of randomised controlled studies of iron depletion in normal populations, evidence to support the iron hypothesis has been sought from biochemical studies of iron stores and, with the discovery of the major mutations associated with haemochromatosis in 1996, from studies of the HFE genotype. 

Results of studies of iron stores have been conflicting. Biochemical measurement of iron status is prone to interference by multiple factors such as inflammation, recent blood loss, and medication. An early study from Finland showed a positive association between iron stores and IHD; but further large studies and a meta-analysis of all prospective studies have been negative.

Genotype studies are unaffected by the factors discussed above, although these have also shown conflicting results. Cross sectional case-control studies have had similar findings to our own, namely no association between IHD and HFE genotype. The study by Hetet and colleagues is of particular note, as it showed an association between C282Y heterozygosity and IHD in a subset analysis of women from the same geographical population as that of our study. Analysis of women as a separate subset from our data suggested the opposite. We found a non-significant trend towards a negative association between IHD and C282Y heterozygosity.

Three prospective studies have addressed the association between HFE genotype and IHD. The Utrecht study showed a non-significant increased relative risk (approximately 2) for MI in postmenopausal women that was associated with C282Y heterozygosity but a significantly increased relative risk was found (between approximately 2 and 3). These three studies did not consider the H63D mutation.

Our study had a cross sectional case-control design and therefore identified only surviving members of the population. In particular, the post-MI group had all survived between 2–11 years after MI. A survival disadvantage may explain why the prevalences of left ventricular hypertrophy and hypertension were lower in the MI survivor group. If the HFE mutations confer a survival disadvantage to those with IHD or MI, then differences in genotype prevalence apparent in prospective studies may not be detected in a cross sectional case-control study. It is theoretically possible therefore that the one genotype to show a trend towards a differing prevalence between groups (albeit losing significance after adjustment for risk factors or multiple significance testing), namely the lower frequency of C282Y heterozygotes in the MI survivor group, may confer a survival disadvantage related to iron stores following MI.

| Table 2 | Allele and genotype frequencies (%) in the whole control population of 920 patients |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
|                | Homozygote (95% CI) | Heterozygote (95% CI) | Compound heterozygote (95% CI) | Allele frequency (95% CI) |
| Wild type      | 2.06 (1.15 to 2.98) | 25.54 (22.73 to 28.36) | 2.39 (1.40 to 3.38) | 14.84 (12.54 to 17.13) |
| C282Y homozygote | 0.87 (0.27 to 1.47) | 17.72 (15.25 to 20.18) | 9.73 (7.81 to 11.64) | 75.43 (72.65 to 78.22) |

| Table 3 | Prevalence of the possible HFE genotypes in each subject group |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
|                | Normal control (n=493) | IHD control (n=427) | MI survivor (n=828) | Normal control v IHD control OR (95% CI) | Normal control v MI survivor OR (95% CI) |
| Wild type      | 268 (54.4%) | 249 (58.3%) | 468 (56.5%) | 1.17 (0.90 to 1.5) | 1.14 (0.87 to 1.5) |
| H63D homozygote | 10 (2.0%) | 9 (2.1%) | 23 (2.8%) | 1.02 (0.41 to 2.6) | 1.22 (0.51 to 2.9) |
| H63D heterozygote | 115 (23.3%) | 98 (23.0%) | 198 (23.9%) | 0.97 (0.71 to 1.3) | 1.04 (0.76 to 1.4) |
| Compound heterozygote | 15 (3.0%) | 7 (1.6%) | 31 (3.7%) | 0.53 (0.21 to 1.3) | 0.87 (0.42 to 1.8) |
| C282Y homozygote | 5 (1.0%) | 3 (0.7%) | 7 (0.8%) | 0.71 (0.17 to 3.0) | 1.20 (0.23 to 6.2) |
| C282Y heterozygote | 80 (16.2%) | 61 (14.3%) | 101 (12.2%) | 0.88 (0.61 to 1.3) | 0.70 (0.48 to 1.04) |

Note: One of the genotype groups achieved significance. 
HFE, haemochromatosis gene.
Conclusion
The C282Y homozygote and heterozygote prevalence in this West of Scotland population is among the highest reported worldwide. There was no association between IHD or MI and HFE genotype in this large study despite a high prevalence of IHD. However, these results need to be interpreted in the light of the cross sectional case-control nature of our study.

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