Relationship between Biomarkers of Cigarette Smoke Exposure and Biomarkers of Inflammation, Oxidative Stress, and Platelet Activation in Adult Cigarette Smokers

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Running Title: Biomarkers of Exposure & Potential Harm in Adult Cigarette Smokers

Key words: biomarker, cigarette, smoke exposure, smoke constituent, inflammation, oxidative stress, platelet activation, cardiovascular risk

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Abstract

Background: Cigarette smoking is a risk factor for several diseases including cardiovascular disease, chronic obstructive pulmonary disease and lung cancer, but the role of specific smoke constituents in these diseases has not been clearly established.

Methods: The relationship between biomarkers of potential harm (BOPH), associated with inflammation [white blood cell (WBC), high sensitivity C-reactive protein (hs-CRP), fibrinogen, von Willebrand factor (vWF)], oxidative stress [8-epi-prostaglandin F$_2$α (8-epiPGF2α)] and platelet activation –[11-dehydro-thromboxin B$_2$ (11-dehTxB$_2$)], and machine measured tar yields (grouped into 4 categories), biomarkers of exposure (BOE) to cigarette smoke, nicotine and five metabolites [(Nicotine equivalents) - NE], 4-methylnitrosamino-1-(3-pyridyl)-1-butanol (total NNAL), carboxyhemoglobin (COHb), 1-hydroxypyrene (1-OHP), 3-hydroxypropylmercapturic acid (3-HPMA) and monohydroxybutenyl-mercapturic acid (MHBMA), was investigated in 3,585 adult smokers (AS) and 1,077 nonsmokers (NS).

Results: Overall, AS had higher levels of BOPHs than NS. Body mass index (BMI), smoking duration, tar category and some of the BOEs were significant factors in the multiple regression models. Based on the F-Value, BMI was the highest ranking factor in the models for WBC, hs-CRP, Fibrinogen and 8-epiPGF2α; gender and smoking duration for 11-dehTxB$_2$ and vWF, respectively.
Conclusions: Although several demographic factors and some BOEs were statistically significant in the model, the R-squared values indicate that only up to 22% of the variability can be explained by these factors, reflecting the complexity and multifactorial nature of the disease mechanisms.

Impact: The relationships between the BOEs and BOPHs observed in this study may help with the identification of appropriate biomarkers and improve the design of clinical studies in smokers.
INTRODUCTION

Cigarette smoke is a complex aerosol that consists of thousands of chemical compounds. Some of the smoke constituents have been identified as carcinogens by International Agency for Research on Cancer (IARC) (1). Additionally, smoking is considered as an independent risk factor for atherosclerosis (2) and coronary heart disease (CHD) (3). Numerous studies have shown that cigarette smoking is associated with inflammation (4-7), oxidative stress (8, 9) and platelet activation (10). There is much evidence to suggest that atherosclerosis is an inflammatory disease (11, 12). Increased risks of cardiovascular disease (CVD) are associated with elevated white blood cell (WBC) count (13,14), high sensitivity C-reactive protein (hs-CRP ) (13,15), fibrinogen (13,16,17), and von Willebrand factor (18), which have been considered as markers of low grade systemic inflammation. WBC count is a marker of inflammation and has been found to be an independent predictor for future coronary events (19,20). Several studies have reported a positive association of WBC counts with smoking (21-23). However, little is known about the relationship between inflammatory markers and the biomarkers of smoke exposure. 8-epi-prostaglandin F$_{2\alpha}$ (8-epiPGF2\(_\alpha\)), which is involved in lipid peroxidation and is often used as an index of in vivo oxidative stress (24,25), has been reported to be associated with CHD risk (26). Levels of 8-epiPGF$_{2\alpha}$ are elevated in smokers (27) and are associated with the number of cigarettes smoked daily (28). Thromboxane A$_2$ is a COX-mediated product of arachidonic acid that is involved in platelet activation. Urinary 11-dehydro-thromboxin B$_2$ (11-dehTxB$_2$) is a marker of \textit{in vivo} thromboxane A$_2$ formation (29) and has been reported to be associated with
cerebral infarction (30) and CVD risk in aspirin-resistant patients (31). The level of 11-dehTxB2 has been reported to be higher in smokers as compared to nonsmokers (27).

Switching from smoking cigarettes to transdermal nicotine patch (32) or smoking cessation leads to decreased urinary 11-dehTxB2 excretion (33).

Biomarkers of exposure (BOE) represents either a chemical compound or its metabolite that reflect the internal dose of exposure to tobacco constituents (34). Biomarkers of potential harm (BOPH) represent the changes in any levels of the biological system resulted from exposure to harmful substances (34). Although the systemic responses to noxious stimuli often result in elevation of these biomarker levels, bilateral changes are also seen in many situations as the results of homeostatic mechanisms. The role of individual smoke constituents on smoking related diseases has not been fully understood, particularly given that cigarette smoke is a complex mixture of numerous compounds, thereby making it difficult to identify the role of specific constituents in smoking related diseases. Tar is often considered a composite mixture of cigarette smoke constituents. Tar yield is a smoking-machine derived estimate calculated by subtracting the amount of water and nicotine from the total particulate matter obtained on a Cambridge Filter Pad (35). Machine-derived tar yields simply represent the relative yield of different cigarette types according to standard procedures, but not actual human smoking conditions (36 - 38). Nevertheless, the objective of the current report was to investigate the relationship of tar category and biomarkers of exposure with biomarkers of inflammation, oxidative stress and platelet activation, referred as
biomarkers of potential harm (BOPH) using the data from a population based, multi-
center, observational study, the Total Exposure Study (TES) (38, 39). The BOE analyzed
in this study included nicotine equivalents (NE - Nicotine and its five major metabolites:
nicotine-glucuronide, cotinine and its glucuronide, trans-3′-hydroxycotinine and its
glucuronide), which has been estimated to reflect about 90% of the nicotine absorbed
(40); 4-methylnitrosamo-1-(3-pyridyl)-1-butanol (NNAL) and its glucuronides (total
NNAL), which are metabolites of the particulate-phase smoke constituent NNK, a
tobacco specific nitrosamine; 1-hydroxypyrene (1-OHP) and its glucuronides and sulfates,
metabolites of pyrene, a surrogate for polycyclic aromatic hydrocarbons; 3-
hydroxypropylmercapturic acid (3-HPMA), a metabolite of acrolein;
monohydroxybutenyl-mercapturic acid (MHBMA), a metabolite of 1,3-butadiene; and
carboxyhemoglobin (COHb), a marker of carbon monoxide exposure. The BOPH for
inflammation, lipid oxidation and platelet activation included WBC, hs-CRP, fibrinogen,
von Willebrand factor, 8-epiPGF$_{2\alpha}$, and 11-dehTxB$_2$.

MATERIALS AND METHODS

Study Design

The Total Exposure Study (TES) was a cross-sectional, observational, multi-center
ambulatory study. Detailed aspects of the study design has been previously reported
(38, 39). The study population was enrolled such that diverse groups would be
represented according to a stratification scheme based on smoking status (smokers vs.
nonsmokers), 3 stratification variables (gender, age, and body mass index [BMI]), and,
for adult smokers, 4 tar delivery categories (<2.9, 3.0 – 6.9, 7.0 – 12.9, > 12.9 mg) based
on the smokers’ current, regular brand of cigarette smoked. Weights of age, gender, 
BMI, and smoking status was based on the population proportions from the Behavioral 
Risk Factor Surveillance System (BRFSS). The population estimates have been published 
previously (39). 4,000 adult smokers and 1,000 nonsmokers from 39 investigative sites 
in 31 states across four census regions of the U.S. (Northeast, South, Midwest, West) 
were to be enrolled for the levels of smoke exposure and biomarkers of potential harm 
comparison. Participant recruitment and study conduct was managed by Covance 
Clinical Research Unit Inc. Participants were required to visit the study site on two 
separate days.

Subjects

Participants included males and females who were 21 years of age or older at the time 
of the first visit and in generally good health. Smoker status was defined as self 
reported smoking of at least 1 cigarette per day for at least the past 12 months, and no 
use of any other nicotine-containing products prior to Visit 1. Pregnant or nursing 
women were excluded.

The study was approved by the local Institutional Review Board and conducted in 
accordance with Good Clinical Practice and the principles of the Declaration of Helsinki.

Participants were recruited through advertising. Written informed consent was 
obtained from each subject prior to entering the study.
Study Conduct

At Visit 1, smoking information was documented for each smoker and a cigarette butt collection container was provided to the smokers. All subjects received another container with refrigerant gel packs for urine collection and storage. Each participant collected his/her urine for a 24-hour period and smokers also collected their cigarette butts during the same period, before Visit 2, which was scheduled within 3 days of Visit 1.

At Visit 2, urine samples were brought to the sites and blood samples were obtained from each subject after at least a 6 hour fast. For adult smokers, the number of cigarettes smoked per day was recorded as the number of the cigarette butts collected during the same time period of urine sample collection, and was used as cigarettes per day (CPD) in the analysis. Urine samples were considered incomplete if the 24-hour creatinine excretion was <750 mg/24h for males or <500 mg/24h for females and these samples were excluded from analyses. Aliquots from the 24h urine sample were transferred into tubes and stored at -20 °C until analysis for each of the biomarkers.

Biomarker Measurements and Analytical Methods

Blood Biomarkers

Blood samples were analyzed by Covance Central Laboratories Services (Indianapolis, IN). Complete blood count was determined using the Bayer Advia 120 automated hematology system. High sensitivity C-reactive protein (hs-CRP) was analyzed in serum.
by immunonephelometry, using a Dade Behring Nephelometer II instrument. Subjects with hs-CRP values >10.0 mg/L were excluded for possible acute inflammations other than cardiovascular causes. Fibrinogen was measured in plasma by a photometric light-scattering technique using the MLA-1600 instrument (Medical Laboratory Automation, Inc., Pleasantville, NY). Plasma von Willebrand factor was analyzed using a commercially available antigen activity enzyme immunoassay kit (Diagnostica Stago, Inc., Parsippany, NJ). COHb in whole blood was measured spectrophotometrically as percent saturation (%).

**Urine Biomarkers**

Nicotine Equivalents (NE: Nicotine and its 5 major metabolites, nicotine-N-glucuronide, cotinine, cotinine-N-glucuronide, trans-3’-hydroxycotinine, and trans-3’-hydroxycotinine-O-glucuronide), total NNAL, 1-OHP, 3-HPMA, 8-epi PGF$_{2\alpha}$ and 11-dehTxB$_2$ were analyzed as previously described (27,38).

**Statistical Analysis**

Stepwise Regression Model was used to examine the differences in WBC, hs-CRP, fibrinogen, vWF, 8-epi PGF$_{2\alpha}$ and 11-dehTxB$_2$ between adult smokers and nonsmokers, adjusted for age, gender, race and body mass index (BMI). In the models, the response variables were BOPH levels, and the factors were smoking status, age category (21- 34, 35 – 49, ≥ 50 years), gender, race (White vs. Black) and BMI class (< 25 kg/m$^2$ vs. ≥ 25 kg/m$^2$).
The values of a BOE in adult smokers were categorized by quartiles, and the corresponding values of BOPH were calculated at each BOE quartile. Percent differences in mean BOPH in reference to the mean BOPH in the first quartile were calculated as:

\[
\frac{(\text{BOPH}_{qi} - \text{BOPH}_{q1})}{\text{BOPH}_{q1}} \times 100,
\]

where \( \text{BOPH}_{qi} \) is the mean value of BOPH in subjects whose BOE levels were within the \( i \)th quartile (\( i = 2, 3 \) or 4); \( \text{BOPH}_{q1} \) is the mean value of BOPH in subjects whose BOE levels were in the first quartile.

The association between number of cigarettes smoked per day (CPD: 1-10, 11-20, 21-30, >31), and each BOPH was assessed using a linear trend analysis. Least-squared means for a factor were obtained assuming that the levels of other factors were equally represented. Results of this type of analysis were considered statistically significant at \( p < 0.05 \).

Multiple regression stepwise elimination method was used to examine the effects of biomarkers of exposure (NE, total NNAL, COHb, total 1-OHP, 3-HPMA and MHBMA) in relationship with the BOPHs (WBC, hs-CRP, fibrinogen, vWF, 8-epi PGF\(_{2\alpha}\) and 11-dehTxB\(_2\)) in adult smokers. The relationship between machine measured tar yield (determined by the Cambridge Filter Test Method) grouped into four categories T1 (<2.9 mg), T2 (3.0 – 6.9 mg), T3 (7.0 – 12.9 mg) and T4 (> 13.0 mg), and BOPHs was also tested in a separate model. All models included gender, race, BMI and years of smoking. This method excludes variables that did not contribute to the model at a \( p \)-value of 0.10 significance level. The residuals for the models tended to follow a normal distribution, therefore no
data transformation was applied. In the models, number of years smoked, NE, total NNAL, COHb, total 1-OHP, 3-HPMA and MHBMA were continuous variables. Gender, race, BMI and tar category were categorical variables. Races other than White or Black were excluded from the analysis due to the small sample sizes. $F$ values for the variables from the final models were used to rank the variables’ importance in determining the variability of the biomarkers of potential harm in the model (41). In the regression models, variables were considered statistically significant at $p < 0.10$.

SAS$^*$ for Windows release 9.1.3 (SAS Institute, Cary, NC) was used for conducting the statistical analyses. SAS procedure Proc REG was used for the stepwise regression and Proc GLM was used for the analysis of covariance and trend analysis, respectively. It was also used for least squared mean comparison between the tar categories.

**RESULTS**

The study enrolled 4,706 subjects, of which 3,585 adult smokers and 1,077 nonsmokers were evaluable. Of the evaluable subjects, 174 smokers and 17 nonsmokers did not have complete urine sample, and 302 smokers and 69 nonsmokers had their hs-CRP greater than 10 mg/dl. These subjects were not included in the final analysis for the corresponding biomarkers. Demographic and smoking characteristics of the study population are summarized in **Table 1**.
The least square mean values of BOPH in adult smokers and nonsmokers by smoking status and smoking intensity are presented in Tables 2a and 2b. The quartile ranges of BOE in adult smokers are presented in Table 3.

Biomarkers of Inflammation

Mean WBC count, hs-CRP, fibrinogen and von Willebrand factor levels were statistically significantly higher in adult smokers compared to nonsmokers (Table 2a). In adult smokers, WBC, hs-CRP and fibrinogen showed a positive correlation with CPD (p < 0.05) (Table 2b). When grouped by subjects’ quartiles of NE and total NNAL, mean WBC, hs-CRP and fibrinogen in adult smokers were positively correlated with subjects’ quartile values of NE (p < 0.0001 for trend) (Figure 1a and b). Compared to the first quartile, the mean values of WBC, hs-CRP and fibrinogen in subjects in the 4th quartile were 17, 18, and 7% higher for NE and 24, 37 and 11% higher for total NNAL, respectively. vWF showed a negative correlation with subjects’ quartile values of NE (p = 0.0123 for trend), with a 5% differences between the 4th and the first quartiles of NE. A 4% difference in vWF between the 4th and first quartiles of total NNAL was observed, but it did not reach statistical significance (p=0.218 for trend) (Figure 1a and b).

Mean WBC and hs-CRP of subjects whose 1-OHP levels were in the highest quartile were less than 12% higher as compared to the values in the first quartile, although they were positively correlated with the quartiles of 1-OHP (p < 0.0001 for WBC; p = 0.0445 for hs-CRP). Fibrinogen and vWF did not show any trend of increase with the quartiles of 1-OHP (Figure 1c). When grouped by subjects’ COHb and 3-HPMA quartiles, mean WBC,
hs-CRP and fibrinogen in the 4th quartile were 18, 19 and 10% higher for COHb; 17, 20 and 7% higher for 3-HPMA; and 14, 21 and 5% higher for MHBMA respectively, compared to the values in the 1st quartile. vWF did not show any correlation with the quartile of COHb, 3-HPMA and MHBMA (Figure 1d, e and f).

BMI was the highest ranking statistically significant factor for WBC, hs-CRP and fibrinogen. NE was not a statistically significant factor in the model for hs-CRP. In the model for vWF, smoking duration was the most important statistically significant factor and gender, COHb and MHBMA were not statistically significant factors (Table 4).

Collectively, the statistically significant factors in the final stepwise regression model with BOEs explained 12%, 20%, 16% and 5% of the variability in the levels of WBC, hs-CRP, fibrinogen and vWF, respectively. In the models exploring the relationship between machine measured tar categories and these inflammatory biomarkers, tar category was a statistically significant factor for WBC, hs-CRP and fibrinogen but not vWF. The relative ranking of importance based on F-values was lower compared to other factors in the model. The model with tar category explained 6%, 19%, 15% and 5% of the variability in the levels of WBC, hs-CRP, fibrinogen and vWF respectively. Upon comparison of the least square mean (LSMean) across the four tar category groups, statistically significant (p<0.05) higher levels of WBC, hs-CRP and fibrinogen were observed in the T4 category (>13.0 mg) group as compared to the T1 category (0-2.9 mg) group, as well as in the T4 as compared to the T2 category (3.0-6.9 mg) groups for WBC and fibrinogen.
Biomarker of Oxidative Stress

In adult smokers, mean 8-epiPGF$_{2\alpha}$ was statistically significantly higher than nonsmokers, and showed a positive correlation with CPD ($p = 0.0003$ for trend) (Table 2b).

Mean 8-epiPGF$_{2\alpha}$ in adult smokers was positively correlated with subjects’ quartile values of NE, total NNAL, 1-OHP, 3-HPMA and MHBMA ($p < 0.0001$ for trend, Figure 1a-f), and were negatively correlated with COHb ($p = 0.0003$ for trend). Mean 8-epiPGF$_{2\alpha}$ in subjects whose NE, total NNAL, 1-OHP, COHb, 3-HPMA and MHBMA levels were in the 4th quartile were 48, 53, 61, 12, 50 and 30% higher, respectively, compared to those whose BOE levels were in the first quartile (Figure 1a-f). The mean 8-epiPGF$_{2\alpha}$ in subjects whose COHb levels were in the 4th quartile were 2% and 3% lower as compared to those whose COHb levels were in the 2nd and 3rd quartiles, respectively (Figure 1d).

In the regression model, BMI was the highest ranked statistically significant factor. The regression model with BOEs explained 22% of the variability in urinary 8-epiPGF$_{2\alpha}$ (Table 4). 8-epiPGF$_{2\alpha}$ was inversely correlated with COHb (Coefficient = -91.06) and smoking duration (-5.12 - 8.57). Machine measured tar category was a statistically significant factor and was ranked after BMI and Gender in the regression model with tar categories. This model explained 10% of the variability in urinary 8-epiPGF$_{2\alpha}$. The LS Mean values of 8-epiPGF$_{2\alpha}$ were statistically significantly ($p<0.05$) higher in the T4 tar category group as compared to the T1, T2 and T3 tar category groups, respectively, as well as in the T3 category group as compared to the T2 tar category groups.
Biomarker for Platelet Activation

Mean 11-dehTxB_2 was statistically significantly higher in adult smokers than in nonsmokers, and was positively correlated with CPD (p = 0.0284 for trend) (Table 2).

Mean 11-dehTxB_2 in adult smokers was positively correlated with subjects’ quartile values of NE, total NNAL, COHb, 1-OHP, 3-HPMA and MHBMA (p = 0.0002 for trend for COHb, p < 0.0001 for the rest) (Figure 1a-f). Mean 11-dehTxB_2 in subjects whose NE, total NNAL, 1-OHP, COHb, 3-HPMA and MHBMA levels were in the 4th quartile were 46, 47, 76, 14, 46, and 29% higher, respectively, compared to those whose BOE levels were in the first quartile (Figure 1a-f).

In the stepwise regression model, gender was the highest ranked statistically significant factor for 11-dehTxB_2. 11-dehTxB_2 was inversely correlated with COHb (-40.95) and smoking duration (-5.01). Models with BOEs explained 13% of the variability in urinary 11-dehTxB_2 (Table 4).

Tar category was a statistically significant factor in the model investigating tar and was ranked after Gender and BMI, explaining 7% of the variability in urinary 11-dehTxB_2. The LSMean values of 11-dehTxB_2 were statistically significantly (p<0.05) higher in the T4 tar category group as compared to the T1, T2 and T3 tar category groups, respectively.

DISCUSSION
In this cross-sectional, population-based study involving a total of 3,585 adult smokers and 1,077 nonsmokers, we were able to investigate relationships between demographic characteristics, biomarkers of exposure and biomarkers of potential harm associated with inflammation, oxidative stress and platelet activation.

The role of inflammation in the development of coronary atherosclerosis has been established in the literature. In the present study, we found that WBC count correlated with biomarkers of exposure to nicotine, tobacco specific nitrosamine, 1,3-butadiene and carbon monoxide. These observations along with the trend analysis with number of cigarettes smoked per day are suggestive of an association between overall smoke exposure and WBC count. The relative ranking of the statistically significant parameters, in the stepwise regression model, varied for the two tobacco specific biomarkers, NE and total NNAL. This phenomenon may be due to the differences in the half-life (approximately 20 hrs for NE (40) and ~10-18 days for total NNAL (42) of these constituents. It is possible that due to its long elimination rate, NNAL tracks consistently with the BOPHs and therefore, might be considered a measure of an average level of long-term exposure rather than daily variations of exposure due to possible variation in cigarette consumption which is better measured by NE. It cannot be ruled out that the association between tobacco specific BOEs and BOPHs could be due to colinearity of a particular constituent with total smoke exposure or a surrogate measure of another smoke constituent not investigated. The weak correlations between the BOPHs and both the demographic and BOEs limits the ability to make any general inferences.
The observations of higher hs-CRP levels in adult smokers in this study are similar to previous reports (5). Our results show that in adult smokers, BMI was the highest ranking parameter associated with hs-CRP levels (43-45). Interestingly, NE was not a significant factor in the final model for hs-CRP, and total NNAL was listed as the 4th most important factor after BMI, smoking duration and gender. The statistically significant parameters included in the final stepwise regression model were different between hs-CRP and WBC (Table 4) suggesting possible differences in mechanisms for these two biomarkers of inflammation.

Our findings show that adult smokers have higher levels of fibrinogen than nonsmokers, which is similar to the findings by Sinha et al (46) and Smith et al (47). In addition, we found that fibrinogen is positively correlated with BMI, smoking duration, and with some BOEs such as COHb, 3-HPMA, NE and total NNAL.

Kumari et al (48) reported that von Willebrand factor was higher in male smokers than male nonsmokers and men who smoked > 21 CPD had statistically significantly elevated levels of vWF compared to those who smoked fewer CPD. No such differences were found between female smokers as reported by Kumari et al. In the present study, we found that adult smokers had higher levels of vWF compared to adult nonsmokers, but no relationship exists with CPD. Smoking duration was found to be the most important factor affecting the variability of vWF. However, the model showed the weakest
correlations (R²=0.05), suggesting that vWF is not a sensitive marker in the detection of
changes of BOPH in the smoking population.

A statistically significant effect of machine measured tar yield categories was observed
for the surrogate biomarkers of inflammation, WBC, hs-CRP and fibrinogen. However,
the overall R-squared values for the models evaluating tar categories were relatively
smaller compared to those models investigating the relationship of BOPH with BOEs.
This is not surprising since the tar yield is an indirect, machine derived estimate. In
contrast, the BOEs are measured in the body fluids and are more direct measures of
systemic exposure. Smoking has been suggested to be one of the factors playing a role
in oxidative stress through its generation of reactive oxygen species (49). 8-epiPGF₂α is
an in vivo measurement of oxidative stress and has been reported to be elevated in
smokers (50). We found that 8-epiPGF₂α levels were inversely correlated with smoking
duration and COHb. The inverse correlation between 8-epiPGF₂α and COHb is supported
by recent evidence from animal studies that suggested CO may have antioxidant
properties (51). Exhaled CO and 8-isoprostane were found to be elevated in patients
with severe asthma (52) and cystic fibrosis (53), suggesting a homeostatic mechanism of
CO production in response to oxidative stress. BMI was the highest ranking factor in the
regression model for 8-epiPGF₂α. Since all the BOEs investigated were statistically
significant factors in the regression model, 8-epiPGF₂α might be a useful biomarker to
be considered in future clinical studies investigating different potentially reduced
exposure tobacco products.
The results of the current study indicate that 11-dehydro-thromboxin B$_2$ excretion is elevated in adult smokers, which is in accordance with the findings in the literature that thromboxane biosynthesis in smokers is increased (54). This biomarker was found to be inversely correlated with smoking duration and COHb. The inverse association with smoking duration suggests that an age related effect could be primarily influencing this relationship. The inverse association with COHb, however, is not clear. A protective effect of CO on platelet activation has been reported in aortic transplantation animals that were treated with CO-releasing molecules (55). Sato et al (56) found that treatment of animals with 250-500 ppm CO prevented platelet activation and coronary thrombosis. In the current study however, the effect of COHb on 11-dehTx B$_2$ is small (based on the F value in the model).

Although this study provides valuable insight regarding the role of cigarette smoke exposure on disease related mechanistic pathways, there are some limitations that may need to be considered. This is a cross-sectional study, therefore causality could not be established between the biomarkers of exposure and the biomarkers of potential harm. A single measurement of COHb saturation level was conducted, which may not accurately reflect the steady state blood CO levels, however, there is substantial evidence based on the relatively long half-life of COHb (57), that the evening measurements are reflective of daily uptake (58). Nevertheless, the relationship between COHb with BOPHs should be interpreted with caution.
The association between the biomarkers of potential harm and the biomarkers of exposure reflect the overall effect of cigarette smoking as well as many additional internal and external factors such as BMI and those not included in this analysis such as lifestyle, genetics etc. In addition the fact that cigarette smoke is a complex mixture of thousands of chemicals further complicates our ability to unravel the role of individual smoke constituents. The possibility of collinearity among smoke constituents or classes of chemicals should be kept in mind when interpreting the relationships of the biomarkers of potential harm and biomarkers of exposure. Our estimates on the importance of the correlation between BOE and BOPH showed that BMI was ranked the most important factor in four of the six BOPH in models when BOEs were tested. It should be noted that the variables in the final model collectively could only explain a small proportion of the variability in BOPH. The R-squared values ranged between 0.05 in the model for vWF and 0.22 for 8-epiPGF$_{2\alpha}$, suggesting that the BOE together with demographics and smoking duration account for only a small portion of the variability in the BOPHs investigated. Furthermore, in several models, considering the relative rank order of importance based on F-value, the BOE were usually several-fold lower than the highest ranking variable, e.g., the F value in the model of 8-epiPGF$_{2\alpha}$ was 171 for BMI, and 72 for total NNAL. This rank order highlights the complexity of the disease mechanisms and suggests that important confounders such as BMI must be taken into consideration when investigating the association between BOE and BOPHs.
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FIGURE LEGENDS

Figure 1. Percent difference in BOPH of adult smokers from first quartile of NE (a), total NNAL (b), 1-OHP (c), COHb (d), 3-HPMA (e), and MHBMA (f).
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Figure 1a

![Graph showing % difference against NE quartile for various markers including 8-epiPGF2a, 11-dehTxB2, WBC, hs-CRP, Fibrinogen, and Wf.](graph.png)
Figure 1d
Figure 1e

[Graph showing % difference against 3-HPMA quartile for different variables: 8-epiPGF2a, 11-dehTxB2, WBC, hs-CRP, Fibrinogen, Wf]
**Table 1. Characteristics of the Study Population**

<table>
<thead>
<tr>
<th></th>
<th>Adult Smoker (n=3,585)</th>
<th>Nonsmoker (n=1,077)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>41.7 ± 12.7</td>
<td>43.3 ± 14.7</td>
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<tr>
<td>Gender n, (%)</td>
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<tr>
<td>Male</td>
<td>1,526 (42.6)</td>
<td>438 (40.7)</td>
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<tr>
<td>Female</td>
<td>2,059 (57.4)</td>
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<td>Race* n, (%)</td>
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<td>851 (79.0)</td>
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<tr>
<td>Black</td>
<td>614 (17.1)</td>
<td>151 (14.0)</td>
</tr>
<tr>
<td>Other</td>
<td>218 (6.1)</td>
<td>67 (6.2)</td>
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<tr>
<td>BMI (kg/m²)</td>
<td>27.8 ± 6.7</td>
<td>28.1 ± 6.7</td>
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<tr>
<td>Smoking Years</td>
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<td>-</td>
</tr>
<tr>
<td>CPD</td>
<td>16.0 ± 8.9</td>
<td>-</td>
</tr>
</tbody>
</table>

Data shown as mean ± SD, unless otherwise indicated.

BMI: body mass index; CPD: cigarette smoked per day.

* Racial information was missing in 26 (0.7%) smokers and 8 (0.7%) nonsmokers.
**Table 2a. Levels of WBC, hs-CRP, Fibrinogen, von Willebrand Factor, 8-epiPGF2α and 11-dehTxB2 by Smoking Status**

<table>
<thead>
<tr>
<th></th>
<th>WBC (x1000/μL)</th>
<th>hs-CRP (mg/L)</th>
<th>Fibrinogen (mg/dL)</th>
<th>vWF (%)</th>
<th>8-epi PGF2α (ng/24)</th>
<th>11-deh TxB2 (ng/24)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-Smokers</strong></td>
<td>6.22 (6.07, 6.37)</td>
<td>2.27 (2.10, 2.44)</td>
<td>305.18 (300.13, 310.23)</td>
<td>100.56</td>
<td>1325.09 (1259.65, 1390.54)</td>
<td>1092.79 (1027.02, 1158.56)</td>
</tr>
<tr>
<td><strong>Smokers</strong></td>
<td>7.56 (7.47, 7.66)</td>
<td>2.69 (2.58, 2.80)</td>
<td>325.55 (322.35, 328.75)</td>
<td>108.39</td>
<td>1872.36 (1830.30, 1914.43)</td>
<td>1393.59 (1351.35, 1435.82)</td>
</tr>
<tr>
<td><strong>p-value</strong></td>
<td>&lt;0.0001</td>
<td>&lt;0.0001</td>
<td>&lt;0.0001</td>
<td>&lt;0.0001</td>
<td>&lt;0.0001</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

Values shown as least square mean (95% confidence interval), adjusted for age, gender, race and body mass index.
Table 2b. Levels of WBC, hs-CRP, Fibrinogen, von Willebrand Factor, 8-epiPGF2α and 11-dehTxB2 by Smoking Intensity

<table>
<thead>
<tr>
<th>CPD</th>
<th>WBC (x1000/μL)</th>
<th>hs-CRP (mg/L)</th>
<th>Fibrinogen (mg/dL)</th>
<th>vWF (%)</th>
<th>8-epi PGF2α (ng/24)</th>
<th>11-deh TxB2 (ng/24h)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-10</td>
<td>7.39 (7.24, 7.53)</td>
<td>2.50 (2.32, 2.68)</td>
<td>316.0 (310.7, 321.2)</td>
<td>103.6 (100.4, 106.9)</td>
<td>1707.9 (1639.0, 1776.7)</td>
<td>1239.0 (1170.1, 1307.9)</td>
</tr>
<tr>
<td>11-20</td>
<td>7.98 (7.86, 8.10)</td>
<td>2.78 (2.64, 2.92)</td>
<td>327.3 (323.1, 331.4)</td>
<td>104.5 (102.0, 107.1)</td>
<td>1944.9 (1890.3, 1999.5)</td>
<td>1360.3 (1305.8, 1414.8)</td>
</tr>
<tr>
<td>21-30</td>
<td>8.45 (8.27, 8.63)</td>
<td>3.07 (2.85, 3.28)</td>
<td>336.6 (330.3, 342.9)</td>
<td>104.0 (100.1, 107.9)</td>
<td>1975.0 (1891.6, 2058.5)</td>
<td>1404.3 (1321.2, 1487.4)</td>
</tr>
<tr>
<td>31+</td>
<td>8.95 (8.64, 9.25)</td>
<td>3.19 (2.81, 3.56)</td>
<td>349.8 (339.1, 360.6)</td>
<td>102.4 (95.7, 109.1)</td>
<td>2000.0 (1857.3, 2142.7)</td>
<td>1403.5 (1262.7, 1544.4)</td>
</tr>
</tbody>
</table>

*p-trend* < 0.0001 0.0003 < 0.0001 0.7200 0.0003 0.0284

Values shown as least square mean (95% confidence interval). CPD: cigarette per day.
Table 3. Quartile of Biomarkers of Exposure in Adult Smokers

<table>
<thead>
<tr>
<th>Biomarker of Exposure</th>
<th>Percentiles</th>
<th>25th</th>
<th>50th</th>
<th>75th</th>
</tr>
</thead>
<tbody>
<tr>
<td>NE (mg/24h)</td>
<td></td>
<td>7.72</td>
<td>12.28</td>
<td>17.68</td>
</tr>
<tr>
<td>Total NNAL (ng/24h)</td>
<td></td>
<td>216.19</td>
<td>382.52</td>
<td>591.45</td>
</tr>
<tr>
<td>COHb (%)</td>
<td></td>
<td>3.80</td>
<td>5.10</td>
<td>6.70</td>
</tr>
<tr>
<td>Total 1-OHP (ng/24h)</td>
<td></td>
<td>135.15</td>
<td>219.35</td>
<td>353.40</td>
</tr>
<tr>
<td>3-HPMA (µg/24h)</td>
<td></td>
<td>1092.50</td>
<td>1742.00</td>
<td>2616.00</td>
</tr>
<tr>
<td>MHBMA (µg/24h)</td>
<td></td>
<td>1.14</td>
<td>2.77</td>
<td>4.98</td>
</tr>
</tbody>
</table>
Table 4. Results of Stepwise Regression Model “B”, for Biomarkers of Potential Harm in Smokers

<table>
<thead>
<tr>
<th>Variable</th>
<th>WBC</th>
<th>hs-CRP</th>
<th>Fibrinogen</th>
<th>vWF</th>
<th>8-epi PGF2α</th>
<th>11-deh TxB2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>-</td>
<td>NS</td>
<td>0.50&lt;sup&gt;i&lt;/sup&gt;</td>
<td>&lt;.0001</td>
<td>-</td>
<td>NS</td>
</tr>
<tr>
<td>Race</td>
<td>0.78&lt;sup&gt;i&lt;/sup&gt;</td>
<td>&lt;.0001</td>
<td>0.27&lt;sup&gt;i&lt;/sup&gt;</td>
<td>0.0320</td>
<td>-11.57&lt;sup&gt;i&lt;/sup&gt;</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>BMI</td>
<td>0.051&lt;sup&gt;i&lt;/sup&gt;</td>
<td>&lt;.0001</td>
<td>0.17&lt;sup&gt;i&lt;/sup&gt;</td>
<td>&lt;.0001</td>
<td>-11.57&lt;sup&gt;i&lt;/sup&gt;</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Years of Smoking</td>
<td>0.006&lt;sup&gt;i&lt;/sup&gt;</td>
<td>0.0039</td>
<td>0.026&lt;sup&gt;i&lt;/sup&gt;</td>
<td>&lt;.0001</td>
<td>9.18&lt;sup&gt;i&lt;/sup&gt;</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>NE</td>
<td>0.013&lt;sup&gt;i&lt;/sup&gt;</td>
<td>0.0907</td>
<td>-</td>
<td>NS</td>
<td>0.59&lt;sup&gt;i&lt;/sup&gt;</td>
<td>0.0384</td>
</tr>
<tr>
<td>Total NNAL</td>
<td>0.0015&lt;sup&gt;i&lt;/sup&gt;</td>
<td>&lt;.0001</td>
<td>0.0004&lt;sup&gt;i&lt;/sup&gt;</td>
<td>0.0069</td>
<td>0.0013&lt;sup&gt;i&lt;/sup&gt;</td>
<td>0.0437</td>
</tr>
<tr>
<td>COHb</td>
<td>0.11&lt;sup&gt;i&lt;/sup&gt;</td>
<td>&lt;.0001</td>
<td>3.53&lt;sup&gt;i&lt;/sup&gt;</td>
<td>NS</td>
<td>3.53&lt;sup&gt;i&lt;/sup&gt;</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Total 1-OHP</td>
<td>-</td>
<td>NS</td>
<td>0.0003&lt;sup&gt;i&lt;/sup&gt;</td>
<td>0.0283</td>
<td>-</td>
<td>NS</td>
</tr>
<tr>
<td>MHBMA</td>
<td>0.028&lt;sup&gt;i&lt;/sup&gt;</td>
<td>0.0396</td>
<td>0.028&lt;sup&gt;i&lt;/sup&gt;</td>
<td>0.0620</td>
<td>-</td>
<td>NS</td>
</tr>
<tr>
<td>3-HPMA</td>
<td>-</td>
<td>NS</td>
<td>-</td>
<td>NS</td>
<td>0.005&lt;sup&gt;i&lt;/sup&gt;</td>
<td>0.0016</td>
</tr>
<tr>
<td>R²</td>
<td>0.12</td>
<td>0.20</td>
<td>0.16</td>
<td>0.05</td>
<td>0.22</td>
<td>0.13</td>
</tr>
</tbody>
</table>

Note: In the models, for categorical variables, “0” was entered for male gender, White race, and BMI < 25 kg/m², “1” was entered for female gender, Black race, and BMI ≥ 25 kg/m².

Superscript indicates the ranking of corresponding variable based on their F values in each model. NS: not significant.
Cancer Epidemiology, Biomarkers & Prevention

Relationship between Biomarkers of Cigarette Smoke Exposure and Biomarkers of Inflammation, Oxidative Stress, and Platelet Activation in Adult Cigarette Smokers

Jianmin Liu, Qiwei Liang, Kimberly Frost-Pineda, et al.

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