Plasma PCSK9 in nephrotic syndrome and in peritoneal dialysis: a cross-sectional study.

https://escholarship.org/uc/item/5fj1n26f

American journal of kidney diseases : the official journal of the National Kidney Foundation, 63(4)

0272-6386

Jin, Kyubok
Park, Bong-Soo
Kim, Yang-Wook
et al.

2014-04-01

10.1053/j.ajkd.2013.10.042

Peer reviewed
Heavy glomerular proteinuria, otherwise known as nephrotic syndrome, is associated with hypercholesterolemia and marked elevation of serum low-density lipoprotein (LDL) cholesterol levels. Hypercholesterolemia in nephrotic syndrome is largely due to impaired clearance and catabolism of LDL and apolipoprotein B100, which is the LDL’s principal apoprotein. In an attempt to discern the mechanism of impaired LDL clearance in nephrotic syndrome, in a series of earlier studies we explored the expression of LDL receptor (LDLR) in the liver of 2 model systems, rats with puromycin aminonucleoside-induced nephrotic syndrome and Imai rats with spontaneous focal glomerulosclerosis showing heavy glomerular proteinuria, otherwise known as nephrotic syndrome, is associated with heavy losses of protein in urine and peritoneal dialysate, respectively. Hypercholesterolemia in nephrotic syndrome is associated with and largely due to acquired LDL receptor (LDLR) deficiency. Because PCSK9 (proprotein convertase subtilisin/kexin type 9) promotes degradation of LDLR, we tested the hypothesis that elevation of LDL cholesterol levels in patients with nephrotic syndrome and PD patients may be due to increased PCSK9 levels.

Study Design: Cross-sectional study.

Setting & Participants: Patients with nephrotic syndrome or treated by PD or hemodialysis and age- and sex-matched healthy Korean individuals (n = 15 in each group).

Predictor: Group and serum total and LDL cholesterol levels.

Outcomes: Plasma PCSK9 concentration.

Measurements: Concentrations of fasting serum PCSK9, lipids, and albumin, and urine protein excretion.

Results: Mean serum total and LDL cholesterol levels in patients with nephrotic syndrome (317.9 ± 104.2 [SD] and 205.9 ± 91.1 mg/dL) and PD patients (200.0 ± 27.6 and 126.7 ± 18.5 mg/dL) were significantly (P < 0.05) higher than in hemodialysis patients (140.9 ± 22.9 and 79.1 ± 19.5 mg/dL) and the control group (166.5 ± 26.5 and 95.9 ± 25.2 mg/dL). This was associated with significantly (P < 0.05) higher plasma PCSK9 levels in patients with nephrotic syndrome (15.13 ± 4.99 ng/mL) and PD patients (13.30 ± 1.40 ng/mL) than in the control (9.19 ± 0.60 ng/mL) and hemodialysis (7.30 ± 0.50 ng/mL) groups. Plasma PCSK9 level was directly related to total and LDL cholesterol concentrations in the study population (r = 0.559 [P < 0.001] and r = 0.497 [P < 0.001], respectively).

Limitations: Small number of participants may limit generalizability.

Conclusions: Nephrotic syndrome and PD are associated with higher plasma PCSK9 concentration, which can contribute to elevation of LDL levels by promoting LDLR deficiency.
the clearance of LDL and its cholesterol cargo, the acquired LDLR deficiency shown in the aforementioned rat studies 5-8 elucidates the principal cause of impaired LDL clearance and elevated serum LDL level in nephrotic syndrome. However, the underlying mechanism(s) by which nephrotic syndrome decreases hepatic LDLR protein expression is not known.

PCSK9 (proprotein convertase subtilisin/kexin type 9) plays an important part in the post-translational regulation of LDLR expression and hence LDL metabolism. 9-10 PCSK9 is a serine protease that is produced and released in the circulation by the liver and to a lesser extent by the intestine and kidney. On the surface of hepatocytes, PCSK9 binds to the LDLR, forming a complex that is internalized and directs LDLR for intracellular degradation. 11 It should be noted that PCSK9 acts as a chaperone to facilitate intracellular degradation of LDLR, and that this role is independent of its enzymatic activity. 12,13 By promoting LDLR degradation, PCSK9 prevents recycling of LDLR to the cell membrane, leading to a post-translational reduction in LDLR expression. 10 Individuals with loss-of-function mutation of PCSK9 exhibit a very low plasma LDL cholesterol level and a significant reduction in the risk of coronary heart disease. 14 For this reason, PCSK9 has emerged as a novel therapeutic target for the treatment of hypercholesterolemia.

Unlike the majority of hemodialysis patients, in whom serum total and LDL cholesterol levels are within or below normal limits, patients maintained on peritoneal dialysis (PD) therapy have significantly elevated levels. In this context, the lipid profile in PD patients resembles that commonly found in patients with nephrotic syndrome. 15,16 Heavy losses of protein in urine in patients with nephrotic syndrome and in PD effluent in PD patients represent a shared feature that may account for the similarity in their serum cholesterol and LDL cholesterol levels. It therefore is reasonable to assume that similar mechanisms may be involved in the pathogenesis of these lipid disorders in patients with nephrotic syndrome and PD patients.

Given the central role of PCSK9 in preventing the recycling of LDLR, the present study was undertaken to test the hypothesis that LDLR deficiency may be due in part to increased plasma PCSK9 levels. To this end, plasma PCSK9 levels were determined in a group of patients with nephrotic-range proteinuria. A group of age-, sex-, and ethnicity-matched healthy individuals served as controls. To determine the potential role of PCSK9 in the pathogenesis of hypercholesterolemia in PD patients, cohorts of patients with end-stage renal disease maintained on PD and hemodialysis therapy were included in the study as well.

METHODS

Participant Characteristics

Fifteen patients (6 men and 9 women aged 41.9 ± 17.1 [SD] years) with nephrotic-range proteinuria (urine protein excretion ≥ 3.5 g/24 h), 15 PD patients (7 men and 8 women aged 48.6 ± 7.6 years), and 15 hemodialysis patients (7 men and 8 women aged 47.4 ± 12.6 years) were recruited into the study. The underlying causes of nephrotic syndrome were as follows: immunoglobulin A nephropathy in 4; minimal change disease, membranous nephropathy, membranoproliferative glomerulonephritis, focal segmental glomerulosclerosis, and lupus nephritis in 2 patients each; and crescentic glomerulonephritis in one patient. The underlying causes of kidney disease in the hemodialysis group were diabetes mellitus in 8, hypertension in 5, and chronic glomerulonephritis in 2. The underlying causes of kidney disease in the PD group were diabetes mellitus in 8, hypertension in 4, and chronic glomerulonephritis in 3. Fifteen apparently healthy individuals (6 men and 9 women; mean age, 45.7 ± 6.4 years) served as controls.

Individuals younger than 18 years, those with a history of malignancy or chronic liver disease, and those with a history of infection within the previous 4 weeks were excluded from the study. The study protocol was approved by the Human Subjects Institutional Review Board of the Inje University Haenundae Paik Hospital, and all participants signed the informed consent forms.

Laboratory Measurements

Fasting blood samples were obtained by venipuncture from all patients and controls and 24-hour urine samples were collected in patients with nephrotic syndrome using standard containers. Urinary protein excretion and serum concentrations of albumin, total cholesterol, LDL cholesterol, high-density lipoprotein cholesterol, triglycerides, creatinine, and urea nitrogen were measured by the central laboratory of the Inje University Haenundae Paik Hospital. Plasma PCSK9 was measured by an enzyme-linked immunosorbent assay using the kit purchased from Cell Biolabs Inc according to the manufacturer’s specifications.

Data Analysis

Mann-Whitney U test for continuous variables and Spearman coefficient for regression analysis were used in statistical analysis of the data, which are expressed as mean ± standard deviation. Correlations between PCSK9, total cholesterol, LDL cholesterol, and serum albumin levels initially were analyzed by univariate regression analysis followed by multivariate regression analysis. P ≤ 0.05 was considered significant.

RESULTS

Characteristics of Study Groups

Data are summarized in Table 1. As expected, the nephrotic-syndrome group had marked proteinuria (urinary protein-creatinine ratio, 8.69 ± 7.0 [range, 3.53-29.2] g/g) and hypoalbuminemia. In contrast, serum albumin concentration was within normal limits and proteinuria was absent in the control group. Heavy proteinuria in the nephrotic-syndrome group was associated with marked elevations in serum total cholesterol, LDL cholesterol, very low-density lipoprotein cholesterol, and triglyceride concentrations. No significant difference was found in serum high-density lipoprotein cholesterol or creatinine concentrations between the nephrotic-syndrome and control groups.
Likewise, arterial blood pressure was similar in the 2 groups. However, serum urea nitrogen concentration was significantly higher in the nephrotic-syndrome group compared with controls. As in the group with nephrotic syndrome, serum total and LDL cholesterol concentrations were elevated in the PD group, but were within or below normal values in the hemodialysis group.

**Table 1.** Characteristics of Nephrotic Syndrome, PD, and HD Patients and Apparently Healthy Controls

<table>
<thead>
<tr>
<th></th>
<th>Control (n = 15)</th>
<th>Nephrotic Syndrome (n = 15)</th>
<th>HD (n = 15)</th>
<th>PD (n = 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (y)</td>
<td>45.7 ± 6.4</td>
<td>41.9 ± 17.1</td>
<td>47.4 ± 12.6</td>
<td>48.6 ± 7.6</td>
</tr>
<tr>
<td>Female sex</td>
<td>9 (60)</td>
<td>9 (60)</td>
<td>8 (53)</td>
<td>8 (53)</td>
</tr>
<tr>
<td>Blood pressure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systolic (mm Hg)</td>
<td>119.3 ± 5.3</td>
<td>121.9 ± 16.1</td>
<td>137.7 ± 19.4</td>
<td>140.5 ± 23.6</td>
</tr>
<tr>
<td>Diastolic (mm Hg)</td>
<td>74.7 ± 6.7</td>
<td>74.2 ± 9.9</td>
<td>81.1 ± 12.1</td>
<td>85.1 ± 15.8</td>
</tr>
<tr>
<td>Cholesterol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total (mg/dL)</td>
<td>166.5 ± 26.5</td>
<td>317.9 ± 104.2</td>
<td>140.9 ± 22.9</td>
<td>200.0 ± 27.6</td>
</tr>
<tr>
<td>LDL (mg/dL)</td>
<td>95.9 ± 25.2</td>
<td>205.9 ± 91.1</td>
<td>79.1 ± 19.5</td>
<td>126.7 ± 18.5</td>
</tr>
<tr>
<td>HDL (mg/dL)</td>
<td>53.4 ± 12.2</td>
<td>56.9 ± 12.5</td>
<td>41.1 ± 11.2</td>
<td>39.3 ± 8.1</td>
</tr>
<tr>
<td>Triglycerides (mg/dL)</td>
<td>94.6 ± 51.9</td>
<td>273.5 ± 111.1</td>
<td>103.8 ± 52.3</td>
<td>169.9 ± 104.4</td>
</tr>
<tr>
<td>Serum urea nitrogen (mg/dL)</td>
<td>11.2 ± 2.8</td>
<td>26.7 ± 22.9</td>
<td>73.8 ± 12.2</td>
<td>58.3 ± 15.1</td>
</tr>
<tr>
<td>Serum creatinine (mg/dL)</td>
<td>0.8 ± 0.1</td>
<td>1.5 ± 0.9</td>
<td>10.6 ± 2.6</td>
<td>11.1 ± 4.6</td>
</tr>
<tr>
<td>Serum albumin (mg/dL)</td>
<td>4.5 ± 0.2</td>
<td>2.6 ± 1.0</td>
<td>3.7 ± 0.3</td>
<td>3.3 ± 0.4</td>
</tr>
<tr>
<td>PCSK9 (ng/mL)</td>
<td>9.19 ± 0.60</td>
<td>15.13 ± 4.99</td>
<td>7.30 ± 0.50</td>
<td>13.30 ± 1.46</td>
</tr>
<tr>
<td>Urine PCR (g/g)</td>
<td>NA</td>
<td>8.69 ± 7.0</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

Note: Values for categorical variables are given as number (percentage); values for continuous variables, as mean ± standard deviation. Conversion factors for units: creatinine in mg/dL to μmol/L, × 88.4; urea nitrogen in mg/dL to mmol/L, × 0.357; HDL, LDL, and total cholesterol in mg/dL to mmol/L, × 0.02586; triglycerides in mg/dL to mmol/L, × 0.01129.

Abbreviations: HD, hemodialysis; HDL, high-density lipoprotein; LDL, low-density lipoprotein; NA, not applicable; PCR, protein-creatinine ratio; PCSK9, proprotein convertase subtilisin/kexin type 9; PD, peritoneal dialysis.

\[ aP < 0.001 \text{ versus control group.} \]
\[ bP < 0.05 \text{ versus control group.} \]
\[ cP < 0.001 \text{ versus HD group.} \]
\[ dP < 0.05 \text{ versus HD group.} \]

**Plasma PCSK9 Data**

Plasma PCSK9 concentration in the group with nephrotic syndrome (15.13 ± 4.99 ng/mL) was significantly \( (P < 0.05) \) higher than that in the control group (9.19 ± 0.60 ng/mL; Fig 1). Plasma PCSK9 concentration correlated positively with total cholesterol and LDL cholesterol concentrations and negatively with serum albumin concentration. As in the group with nephrotic syndrome, plasma PCSK9 level was elevated in PD but not hemodialysis patients. Multiple regression analysis revealed a significant direct correlation between plasma PCSK9 and serum total cholesterol and LDL cholesterol concentrations in the nephrotic-syndrome and PD groups (Fig 2; Table 2).

**DISCUSSION**

The present study demonstrated the association of hypercholesterolemia and elevated LDL cholesterol concentration, which are the hallmarks of nephrotic syndrome, with a significant increase in plasma PCSK9 levels in patients with nephrotic syndrome. Our finding of elevated plasma PCSK9 levels in patients with nephrotic syndrome is consistent with a study conducted in rats with nephrotic syndrome, which showed marked elevation of serum total and LDL cholesterol levels and a significant reduction in hepatic LDLR, accompanied by marked upregulation of hepatic tissue PCSK9 expression and heightened liver X receptor activation. In addition, rats with...
nephrotic syndrome showed a significant increase in expression of inducible degrader of LDLR, which is the intracellular counterpart of PCSK9. Together, upregulation of plasma PCSK9 and hepatocyte-inducible degrader of LDLR work in concert to cause LDLR deficiency in nephrotic syndrome. Previously, we had shown in animal models of spontaneous and puromycin aminonucleoside–induced nephrotic syndrome that hepatic LDLR gene expression level is normal; these new findings help explain why the receptor nevertheless is depleted in nephrotic syndrome.5-8

By mediating degradation and limiting recycling of LDLR, upregulation of PCSK9 must play a major role in the pathogenesis of hypercholesterolemia and the associated risk of cardiovascular disease, as we have shown in both humans and animals with nephrotic syndrome. Several studies have demonstrated significant direct correlations between plasma PCSK9 and LDL cholesterol levels in the general population.18-20 Moreover, elevated plasma PCSK9 level has been shown to be predictive of recurrent clinical events in patients with stable cardiovascular disease treated with low-dose atorvastatin.21

PCSK9 expression is regulated primarily by the transcription factor sterol regulatory element-binding protein 2 (SREBP-2),22,23 which is activated when intracellular free cholesterol levels decline and is

![Figure 2](image-url)
nephrotic syndrome strongly supports the validity in our carefully conducted study in animals with nephrotic syndrome. In addition, by lowering with administration of ACAT inhibitor in animals and marked reduction in plasma LDL cholesterol level by the dramatic amelioration of hypercholesterolemia in dialysis patients supports this contention.

Plasma PCSK9 level found in PD patients but not the other relevant variables in nephrotic syndrome. The elevation in serum cholesterol and LDL cholesterol levels usually are within or below normal limits, PD patients frequently exhibit increased serum cholesterol and LDL cholesterol levels. This is associated with and most likely due to losses of proteins in PD effluent, which simulates nephrotic syndrome in animals with nephrotic syndrome and PD patients. Results from a separate animal study suggest that increases in plasma PCSK9 levels can cause LDLR deficiency by promoting degradation and limiting recycling of the receptor. The resulting LDLR deficiency in turn can be expected to heighten the risk of cardiovascular events by increasing the concentration and prolonging the residence time of LDL in the circulation. Therefore, strategies aimed at lowering plasma PCSK9 levels may be effective in attenuating hypercholesterolemia and the associated risk of cardiovascular events in patients with nephrotic syndrome and PD patients.

**ACKNOWLEDGEMENTS**

Support: This work was supported in part by a 2013 Inje University research grant.

**Financial Disclosure:** The authors declare that they have no other relevant financial interests.

**REFERENCES**

9. Wang L, Shearer GC, Budamagunta MS, Voss JC, Molfino A, Kaysen GA. Proteinuria decreases tissue lipoprotein

---

**Table 2. Spearman Correlation of Serum Cholesterol Concentrations With Plasma PCSK9 Levels**

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th>Nephrotic syndrome</th>
<th>Hemodialysis</th>
<th>Peritoneal dialysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cholesterol</td>
<td>0.348</td>
<td>0.509</td>
<td>0.389</td>
<td>0.499</td>
</tr>
<tr>
<td>LDL cholesterol</td>
<td>0.396</td>
<td>0.414</td>
<td>0.361</td>
<td>0.384</td>
</tr>
<tr>
<td>LDL cholesterol</td>
<td></td>
<td>0.001</td>
<td>0.03</td>
<td>0.005</td>
</tr>
</tbody>
</table>

Abbreviations: LDL, low-density lipoprotein; PCSK9, proprotein convertase subtilisin/kexin type 9.
receptor levels resulting in altered lipoprotein structure and increasing lipid levels. *Kidney Int.* 2012;82(9):990-999.


