Leukocyte gene expression in post-thrombotic syndrome

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**Keywords**
Venous thrombosis
Post-thrombotic syndrome
Leukocytes function/activation
Case-control study
Transcriptomics

Post-thrombotic syndrome (PTS) is the most common long-term complication of deep vein thrombosis (DVT), with an incidence of one in three patients [1]. It has a significant impact on quality of life and is associated with considerable societal costs [1]. The onset of PTS is understood to be a consequence of hampered DVT recanalization, which is a combination of fibrinolysis, thrombus reorganization and neovascularization [1]. This process is guided by leukocytes, which infiltrate the thrombus and vein wall [1]. Pro-inflammatory leukocyte activity can slow thrombus resolution and damage the vein wall, causing venous outflow restriction and valvular reflux [1]. The ensuing venous hypertension is transmitted to the microcirculation, where leukocytes adhere and migrate across the endothelium under low shear stress [1]. The resultant perivascular inflammation leads to the characteristic manifestations of PTS, including pain, edema and skin changes of the leg [1].

Despite the paramount role of leukocytes in the onset of PTS, clinical studies have largely been limited to measurement of circulating inflammatory markers. Meanwhile, the actual activity of leukocytes is reflected by their transcriptome, which is the collection of all RNA species expressed by a particular cell type at a particular point in time. We hypothesized that the leukocyte transcriptome of patients with PTS is different from patients who did not develop PTS after DVT.

In a previously conducted case-control study, we recruited 30 patients with PTS (cases) and 30 patients with a history of DVT without PTS (controls). The study design and patient characteristics are described in a previous publication [2]. In brief, patients were selected from a cohort that was followed prospectively after acute DVT. PTS was defined as a Villalta score, the recommended diagnostic tool, of ≥5 on two consecutive visits with at least 3 months in between [1]. The study was approved by the medical ethical committee and all patients gave written informed consent. Patient characteristics were analyzed in SPSS (mean: 17.4 ng/μL), purity (mean 260/280 nm: 1.72) and RIN (mean: 260/280 nm: 1.72) and RIN (mean: 6.5). Baseline characteristics were comparable between groups (Table 1), except for a significantly higher BMI in cases. Naturally, the Villalta score in cases was higher than in controls. Cases had mostly mild PTS, which is defined as a Villalta score below 10.

Differentially expressed genes (DEGs) between patient groups were determined according to a common data analysis pipeline in the R base package [3]. This included an assessment of sequence quality with FastQC, computation of counts with HTSeq, and differential expression analysis with DESeq2. DEGs needed to be well expressed, defined as ≥10 counts in at least 90% of the samples. Differences between groups were expressed as fold changes (FC). DEGs were considered significant at a false discovery rate (FDR) adjusted p-value ≤0.10. Principal component analysis and enrichment analysis were performed with the top 50 DEGs ranked by FDR adjusted p-value.

Assessment of RNA quality revealed a low overall concentration (mean: 17.4 ng/μL), purity (mean 260/280 nm: 1.56) and RIN (mean: 5.4). It was thus decided to select only patients with the highest RNA quality at a RIN > 5 for sequencing. Samples from 6 cases and 7 controls were selected, having an acceptable concentration (mean: 11.4 ng/μL), purity (mean 260/280 nm: 1.72) and RIN (mean: 6.5). Baseline characteristics were comparable between groups (Table 1), except for a significantly higher BMI in cases. Naturally, the Villalta score in cases was higher than in controls. Cases had mostly mild PTS, which is defined as a Villalta score below 10.

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Sequencing yielded about 30 million single reads for each sample, corresponding with nearly 64,000 unique transcripts of which 26,000 were well expressed. Principal component analysis revealed reasonable separation of patient groups on the first principal component, which explained 25% of variance. The top 50 DEGs all had an FDR adjusted p-value <0.30, and enrichment analysis revealed an overrepresentation of ribosomal pathways. Twelve DEGs were significantly different, which were HDGFL3 (FC = 1.52), ADIPOR1 (FC = 0.29), PPIA (FC = 0.40), RPL12 (FC = 0.60), RP13A (FC = 0.64), RPS14 (FC = 0.64), RPL41 (FC = 0.51), KCNQ1OT1 (FC = 1.89), AC011462.2 (FC = 1.75), AC092384.2 (FC = 1.90), AI275777.1 (FC = 0.61), and AL596202.1 (FC = 2.96). The FDR adjusted p-value was 0.02 for HDGFL3, and 0.09 for all other DEGs.

The twelve significant DEGs included five long non-coding RNAs (KCNQ1OT1, AC011462.2, AC092384.2, AI275777.1, AL596202.1) of which the cellular effect in leucocytes is unknown. Another four downregulated DEGs (RPL12, RP13A, RPS14, RPL41) coded for ribosomal proteins. Downregulation of ribosomal proteins has previously been observed in leucocytes as part of an inflammatory response [4]. The remaining three DEGs were considered to have pathologic potential due to the effects of their protein products. The increased expression of HDGFL3 indicates an upregulation of its product, the potent angiogenic factor hepatoma-derived growth factor-related protein-3 (HDGFRP3) [5]. Indeed, angiogenic factors are known to be essential in thrombus resolution by stimulating neovascularization (Fig. 1A) [1]. The decreased expression of ADIPOR1 suggests downregulation of the adiponectin receptor 1. Its ligand, adiponectin, is an anti-inflammatory and anti-fibrotic hormone which is not only systemically released by adipocytes, but also locally by the endothelium (Fig. 1B) [6]. In a recent cohort study, low adiponectin levels at three months after DVT were shown to predict the onset of PTS. [7] Finally, there was a decreased expression of the gene PPIA, which codes for cyclophilin A. Besides an intracellular role in protein trafficking, this protein is also secreted by leucocytes in response to inflammatory stimuli. It has chemotactic effects and is thought to have an important role in inflammation and vascular remodeling (Fig. 1C) [8].

Limitations of our study are the lack of technical validation and the significantly higher BMI in cases. However, RNA sequencing data is often considered to be reliable in itself, since DESeq2 normalization corrects for all gene expression. In respect to the difference in BMI, it is promising that the predictive value of adiponectin was shown to be independent of BMI [7]. Nevertheless, additional research is needed to confirm our findings.

In conclusion, our study found differences between the leucocyte transcriptomes of patients with and without the onset of PTS after DVT. This was found despite our cases having mostly mild PTS. The results suggest an underlying inflammatory state in PTS, which is in accordance with other studies on circulating inflammatory markers [9]. We identified candidate markers of inflammation and angiogenesis which have not been previously associated with PTS. Once confirmed in larger case-control studies, our results could provide further pathologic insight and might even lead to much-needed therapeutic targets in the prevention and treatment of PTS. To the best of our knowledge, this is the first transcriptomics study in the field of PTS. We hope that these findings will encourage the utilization of this bottom-up approach to advance knowledge in the field of PTS.

Abbreviations: HRP-3, hepatoma-derived growth factor-related protein-3; ADIPOR1, adiponectin receptor 1; VSMC, vascular smooth muscle cell.

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**Table 1**

Characteristics of selected patients.

<table>
<thead>
<tr>
<th></th>
<th>Cases (n = 6)</th>
<th>Controls (n = 7)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, median (IQR)</td>
<td>66 (55–73)</td>
<td>71 (56–80)</td>
<td>0.445</td>
</tr>
<tr>
<td>Male sex (%)</td>
<td>3 (50%)</td>
<td>1 (14%)</td>
<td>0.266</td>
</tr>
<tr>
<td>BMI, median (IQR)</td>
<td>32 (28.9–33.9)</td>
<td>24.6 (23.3–32.0)</td>
<td>0.035</td>
</tr>
<tr>
<td>Villalta score, median (IQR)</td>
<td>6.75 (5.5–12.2)</td>
<td>2.33 (2.0–3.0)</td>
<td>0.001</td>
</tr>
<tr>
<td>Recurrent DVT (%)</td>
<td>4 (67%)</td>
<td>4 (57%)</td>
<td>1.000</td>
</tr>
<tr>
<td>Follow-up after first DVT, median months (IQR)</td>
<td>57.5 (33.5–83.0)</td>
<td>60 (21–144)</td>
<td>0.234</td>
</tr>
<tr>
<td>Follow-up after most recent DVT, median months (IQR)</td>
<td>42 (7.5–62.75)</td>
<td>60 (40–75)</td>
<td>0.234</td>
</tr>
<tr>
<td>Oral anticoagulant use (%)</td>
<td>3 (50%)</td>
<td>2 (29%)</td>
<td>0.592</td>
</tr>
<tr>
<td>Statin use (%)</td>
<td>2 (33%)</td>
<td>3 (43%)</td>
<td>1.000</td>
</tr>
</tbody>
</table>

Abbreviations: IQR, interquartile range; BMI, body mass index; DVT, deep vein thrombosis.

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![Fig. 1. DEGs with pathophysiological potential.](https://example.com/fig1.png)

**Abbreviations:** HRP-3, hepatoma-derived growth factor-related protein-3; ADIPOR1, adiponectin receptor 1; VSMC, vascular smooth muscle cell.
Authors’ contributions

AFJI and AW performed the laboratory analyses; MS and EC supervised the laboratory analyses; AtC, MS and HtC conceived the study concept; AtC contributed to the study design, funding, recruitment of patients, data collection and data interpretation; AFJI wrote the manuscript; AtC supervised the writing; all other authors contributed equally to the review of the manuscript and approved the final manuscript.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

References