Abnormal In Vivo Metabolism of Apolipoprotein E<sub>4</sub> in Humans

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Abstract

Apolipoprotein E (apoE) is important in modulating the catabolism of remnants of triglyceride-rich lipoprotein particles. It is a polymorphic protein with the three common alleles coding for apoE<sub>2</sub>, apoE<sub>3</sub>, and apoE<sub>4</sub>. ApoE<sub>3</sub> is considered the normal isoform, while apoE<sub>4</sub> is associated with hypercholesterolemia and type V hyperlipoproteinemia. We quantitated the kinetics of metabolism of apoE<sub>4</sub> in 19 normolipidemic apoE<sub>3</sub> homozygotes and 1 normolipidemic apoE<sub>4</sub> homozygote, and compared this with the metabolism of apoE<sub>3</sub> in 12 normolipidemic apoE<sub>3</sub> homozygotes. In the apoE<sub>3</sub> homozygous subjects, apoE<sub>4</sub> was catabolized twice as fast as apoE<sub>3</sub>, with a mean plasma residence time of 0.37±0.01 d (±SEM) and 0.73±0.05 d (P < 0.001), respectively. When plasma was fractionated into the lipoprotein subclasses, the greatest amount of labeled apoE<sub>4</sub> was present on very low density lipoproteins, while the largest fraction of labeled apoE<sub>3</sub> was associated with high density lipoproteins.

The plasma apoE concentration was decreased in an apoE<sub>4</sub> homozygote compared with the apoE<sub>3</sub> homozygotes (3.11 mg/dl vs. 4.83±0.35 mg/dl). The reduced apoE<sub>4</sub> concentration was entirely due to a decreased apoE<sub>4</sub> residence time in the apoE<sub>4</sub> homozygote (0.36 d vs. 0.73±0.05 d for apoE<sub>3</sub> in apoE<sub>3</sub> homozygotes).

These results indicate that apoE<sub>4</sub> is kinetically different than apoE<sub>3</sub>, and suggest that the presence of apoE<sub>4</sub> in hypercholesterolemic and type V hyperlipoproteinemic individuals may play an important pathophysiological role in the development of these dyslipoproteinemias.

Introduction

Human apolipoprotein E (apoE)<sup>3</sup> is a polymorphic plasma protein with three common isoforms present in the normal population (1, 2). These three isoforms, apoE<sub>2</sub>, apoE<sub>3</sub>, and apoE<sub>4</sub>, are coded by three separate alleles, E<sup>2</sup>, E<sup>3</sup>, and E<sup>4</sup>, that are inherited in a codominant fashion at a single genetic locus (2). Type III hyperlipoproteinemia is associated with homozygosity for the E<sup>2</sup> allele (2, 3) while the E<sup>4</sup> allele is associated with type V hyperlipoproteinemia (4) and increased plasma cholesterol levels (5-7).

Preliminary results of these investigations were presented at the American Heart Association Meeting, Dallas, TX, November, 1982.

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1. Abbreviations used in this paper: apo, apolipoprotein; IDL, intermediate density lipoprotein.

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The primary amino acid sequence of the apolipoproteins for the three common isoforms of apoE are known. These isoforms differ only at amino acid positions 112 and 158, with apoE<sub>2</sub> having cysteines at both positions, apoE<sub>3</sub> having a cysteine at position 112 and an arginine at position 158, and apoE<sub>4</sub> containing arginines at both positions (8). ApoE<sub>3</sub> has been previously shown to be catabolized more slowly than apoE<sub>3</sub> in vivo human studies (9) and to have reduced receptor binding properties in vitro cell membrane binding studies when compared with apoE<sub>3</sub> (10, 11). Therefore, apoE<sub>3</sub> is both functionally and metabolically different from apoE<sub>2</sub>, and the homozygous apoE<sub>2</sub> phenotype is linked both genetically and metabolically with type III hyperlipoproteinemia (12).

The ability of apoE<sub>2</sub> to bind to cellular membrane receptors has also been reported. ApoE<sub>2</sub> had the same binding properties as apoE<sub>3</sub> (10), and we interpreted these results as indicating that apoE<sub>2</sub> is a metabolically normal isoform. However, the findings that apoE<sub>2</sub> is associated with type V hyperlipoproteinemia and with increased plasma cholesterol levels is consistent with apoE<sub>2</sub> being an abnormal isoform (4–7). In order to gain further insight into the metabolism of apoE<sub>2</sub>, we have compared the in vivo kinetics of radiolabeled apoE<sub>2</sub> and apoE<sub>4</sub> metabolism in normal individuals with a homozygous apoE<sub>3</sub> phenotype as well as in a subject with a homozygous apoE<sub>4</sub> phenotype.

Methods

Study subjects. 19 normal subjects were studied with a homozygous apoE<sub>3</sub> phenotype; there were 9 males and 10 females between the ages of 18 and 24 yr. In addition, a 22-yr-old normal male with a homozygous apoE<sub>2</sub> phenotype was studied. All of these individuals were hospitalized for study in the Clinical Center of the National Institutes of Health. All subjects had normal fasting glucose levels, as well as normal thyroid, liver, and renal function. The subjects were not on any medication and had no serious illnesses. All subjects gave informed consent and the study protocol was approved by the Institute Review Board of the National Heart, Lung, and Blood Institute.

Isolation of apoE. ApoE<sub>3</sub> and apoE<sub>4</sub> were isolated from an individual homozygous for the E<sup>3</sup> allele and E<sup>4</sup> allele, respectively. ApoE was isolated and characterized as previously described (13). Briefly, very low density lipoprotein (VLDL) was obtained by ultracentrifugation (<em>d</em> < 1.006 g/ml) and delipidated with chloroform/methanol 2:1 (vol/vol). ApoE was separated from the other apolipoproteins by heparin affinity and Sephacryl S-200 gel permeation chromatography. Purified apoE migrated as a single electrophoretic band on sodium dodecyl sulfate and pH 8.4 urea polyacrylamide gel electrophoresis.

Iodination of apoE. ApoE was iodinated as previously described by a modification of the iodine monochloride method (14). Lyophilized apoE was redissolved in a buffer of 6 M guanidine-HCl and 1 M glycine (pH 8.5), 5 MCl of Na<sup>125</sup>I or Na<sup>131</sup>I was added to the solution and followed by the slow addition of iodine monochloride during vortexing of the sample. ApoE was iodinated with an efficiency of 30–50% with incorporation of ~0.5 mol of iodine per mole of apoE. Radiolabeled apoE was incubated with plasma for 30 min at 37°C, the density of the plasma adjusted to 1.21 g/ml with solid KBr, and centrifuged for 2.2 × 10<sup>5</sup> g/min. The <em>d</em> < 1.21 g/ml supernatant was isolated by tube slicing and dialyzed against 150 mM NaCl, 100 mM Tris-HCl (pH 7.4), and 0.01%
EDTA. Human serum albumin was added at a final concentration of 1% and the solution sterilized by filtration through a 0.22-μm filter. Each preparation was tested for pyrogens before injection into the study subjects.

**Study protocol.** The study subjects were placed on a defined isoweight diet containing 42% carbohydrate, 42% fat, 16% protein, 200 mg of cholesterol per 1,000 kcal, and a polyunsaturated/saturated fat ratio of 0.1:0.3 for 10 d before beginning the apoE metabolic studies. The diet was changed to a liquid formula of the same nutrient composition given every 6 h beginning 3 d before the apoE injection, and continued for the duration of the study. This dietary regimen was required in order to maintain a metabolic steady state in which to study the kinetics of the metabolism of apoE. 3 d before the injection, the subjects were also started on potassium iodide (1,200 mg/d) and ferrous gluconate (900 mg/d) in divided doses. Subjects were injected intravenously with up to 25 μCi of [131I]-radiolabeled and 100 μCi of [125I]-radiolabeled apoE ~5.5 h after the previous meal. In some studies, the subjects received only one form of radioiodinated apoE while in others they received both forms. In addition, there were no alterations in the kinetics of metabolism of apoE if it was labeled with 125I or 131I, i.e., there was no isolate affect on the metabolism of apoE. Blood samples were obtained at 10 min and at 6, 12, 18, 24, 36, and 48 h, and then daily through day 7. All blood samples except the first one were drawn just before the meal (i.e., after a 6-h fast, while the first one was drawn after a 5.5-h fast).

Blood samples (20 ml) were collected into tubes containing EDTA at a final concentration of 0.1%. Blood was kept at 4°C and plasma separated by low speed centrifugation (2,000 rpm, 30 min) in a refrigerated centrifuge (4°C). Sodium azide and aprotonin (Boehringer Mannheim, Mannheim, Federal Republic of Germany) were added to each plasma sample at a final concentration of 0.05% and 200 Kallikrein inhibitor units/ml, respectively. 1 ml of plasma was frozen at ~20°C for apoE quantitation. The plasma lipoproteins were isolated by ultracentrifugation (15), the radioactivity quantitated, and the apoE concentration determined. The radioactivities in plasma and the lipoprotein subfractions were quantitated in a gamma counter (Autogamma 5260; Packard Instrument Co., Inc., Downers Grove, IL).

**Analytical methods.** In each subject the apoE phenotypes were ascertained by analytical isoelectrofocusing (4). Plasma cholesterol and triglycerides were quantitated on an enzymic analyzer (Gilford System 3500; Gilford Instrument Laboratories, Inc., Oberlin, OH). High density lipoprotein (HDL) cholesterol was determined in plasma after dextran sulfate precipitation (16). All other lipid and lipoprotein analyses were performed by the methods of the Lipid Research Clinics (17). ApoE was quantitated by a double antibody radioimmunoassay (13). The residence time (1/fractional catabolic rate) was determined from the area under the plasma decay curve by a multiexponential computer curve-fitting technique (18). The production rate was calculated from the following formula: production rate = (apoE concentration × plasma volume)/ (residence time × weight) with the plasma volume being determined by dividing the total quantity of radioactivity injected by the radioactivity per unit volume determined in the sample obtained 10 min after injection of the radiolabeled apoE. Intergroup comparisons were performed using Student’s t test.

**Results**

The clinical characteristics of the study subjects are given in Table I. These data include the individuals who had radioiodinated apoE3 studies that we have previously reported (14).

**Lipoprotein distribution of radiolabeled apoE3 and apoE4.** ApoE is present on all classes of lipoprotein particles but is found predominantly on VLDL and HDL. Radiolabeled apoE3 and apoE4 were injected into normal subjects with a homozgous apoE3 phenotype and a plasma sample was obtained from each individual at 10 min. The distribution of radiolabeled apoE in the lipoprotein subfractions was determined after isolation of the lipoproteins by ultracentrifugation. As presented in Table II, HDL contained the largest amount of apoE3, followed by VLDL and the d > 1.21 g/ml infranate. The distribution of radiolabeled apoE4 differed markedly in these normal subjects. ApoE4 was present primarily on VLDL, with much less present on HDL when compared with apoE3 (Table II). There was approximately the same quantity of apoE3 and apoE4 on the other lipoprotein subfractions. Therefore, apoE3 and apoE4 differ markedly in their affinity for different classes of lipoprotein particles.

**Radiolabeled apoE kinetic studies in subjects with a homozgous apoE3 phenotype.** Radiolabeled apoE3 and/or apoE4 were injected into normal subjects with an apoE3 phenotype and plasma samples obtained periodically over a 7-d period. The radioactivity was determined at each time point in plasma and the isolated lipoprotein subfractions. The plasma cholesterol, triglyceride, and apoE concentration did not differ between the groups of normal subjects receiving either apoE3 or apoE4 (Table

**Table I. Clinical and Laboratory Data for Subjects Undergoing Metabolic Study**

<table>
<thead>
<tr>
<th>ApoE phenotype</th>
<th>Male</th>
<th>Female</th>
<th>Age</th>
<th>Cholesterol</th>
<th>Triglyceride</th>
<th>VLDL</th>
<th>LDL</th>
<th>HDL</th>
<th>Plasma apoE4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>yr</td>
<td>mg/dl</td>
<td>mg/dl</td>
<td>mg/dl</td>
<td>mg/dl</td>
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<tr>
<td>Subjects for apoE3 kinetics studies (n = 12)</td>
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<tr>
<td>E3</td>
<td>6</td>
<td>6</td>
<td>20–23*</td>
<td>125–185</td>
<td>54–88</td>
<td>5–13</td>
<td>64–112</td>
<td>28–94</td>
<td>3.1–6.6</td>
</tr>
<tr>
<td>Subjects for apoE4 kinetics studies (n = 19)</td>
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<tr>
<td>E3</td>
<td>4</td>
<td>15</td>
<td>19–23</td>
<td>130–210</td>
<td>60–130</td>
<td>8–20</td>
<td>65–120</td>
<td>35–70</td>
<td>3.7–7.1</td>
</tr>
<tr>
<td>Subject with homozygous apoE3 phenotype (n = 1)</td>
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</tr>
<tr>
<td>E4</td>
<td>1</td>
<td>—</td>
<td>22</td>
<td>175</td>
<td>75</td>
<td>15</td>
<td>93</td>
<td>67</td>
<td>3.1</td>
</tr>
</tbody>
</table>

* Range of the subjects. † Normal range, 5.7±1.4 mg/dl (±SD, reference 13).

Table II. Lipoprotein Distribution of Radiolabeled ApoE in Normolipidemic ApoE3 Homozygotes

<table>
<thead>
<tr>
<th>Lipoprotein</th>
<th>ApoE3</th>
<th>ApoE4</th>
</tr>
</thead>
<tbody>
<tr>
<td>VLDL</td>
<td>23.1±1.7§</td>
<td>39.8±3.9‖</td>
</tr>
<tr>
<td>LDL</td>
<td>4.5±0.3</td>
<td>5.2±0.4</td>
</tr>
<tr>
<td>HDL</td>
<td>11.9±0.7</td>
<td>12.3±0.7</td>
</tr>
<tr>
<td>d &lt; 1.21 g/ml</td>
<td>20.9±1.0</td>
<td>16.6±1.5</td>
</tr>
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</table>

* n = 12.
‡ n = 19.
§ ±SEM.
‖ P < 0.01.

Fig. 1 illustrates representative catabolic decay curves for apoE3 and apoE4 injected simultaneously into a normal subject. ApoE4 is catabolized much more rapidly than apoE3. Both decay curves are multiexponential, indicating multiple metabolic compartments for apoE. The residence time of apoE was determined in each individual, using computer-assisted multiexponential curve fitting (18) in order to quantitate the catabolic difference between apoE3 and apoE4. The residence time of apoE4 was ~50% of the residence time of apoE3 (i.e., there was a much greater fractional catabolic rate for apoE4, Table III).

In order to insure that the differences in the metabolism between apoE3 and apoE4 were not due to an artifact during one isolation procedure or unique to the apoE from one particular subject, these kinetic investigations utilized apoE from a total of four different apoE isolations from two different subjects, and apoE3 from a total of three different apoE isolations from two different subjects. There were no significant differences in the catabolic rates for the different lots of apoE3 or the different lots of apoE4. In addition, in one subject the catabolic rates of apoE3 isolated from two different subjects was directly compared; the catabolic decay curves are illustrated in Fig. 2. It is apparent that the decay curves are virtually identical. We have therefore concluded that the differences in the catabolism between apoE3 and apoE4 are not due to an artifact in the isolation procedure or to a unique form of apoE from a particular subject, but result from the known primary amino acid sequence difference between apoE3 and apoE4.

The catabolic decay curves for apoE4 in the individual lipoprotein subfractions are illustrated in Fig. 3. In each panel the corresponding decay curve for apoE3 is given for comparison. ApoE4 is catabolized most rapidly from VLDL and at the slowest rate from HDL. In addition, these results for apoE4 are similar to our previously reported data for apoE3 in normal subjects where the catabolic rates from intermediate density lipoprotein (IDL), low density lipoprotein (LDL), and HDL, were similar to the catabolic rate for whole plasma (14). ApoE4 is catabolized more rapidly than apoE3 from the plasma and all of the lipoprotein subfractions (e.g. VLDL, IDL, LDL, and HDL), however it is catabolized at nearly the same rate as apoE3 in the d > 1.21 g/ml infranate. Thus, apoE4 is catabolized more rapidly than apoE3 in plasma and the lipoprotein subfractions. Even though apoE does not normally exist as a free apolipoprotein in plasma, the results from the d > 1.21 g/ml infranate would suggest that the apoE in this lipoprotein-free fraction may be derived from a separate intravascular metabolic pool and does not reflect the catabolic behavior of apoE from any particular class of lipoprotein particles. This is because the d > 1.21 g/ml infranate decay curve is different than any of the lipoprotein subfraction decay curves and because both apoE3 and apoE4 are catabolized at the same rate from it.

Figure 2. Catabolism of apoE3 isolated from two different subjects homozygous for apoE3. The subject into whom radiiodinated apoE3 was injected was homozygous for apoE3 and the study was performed as outlined for Fig. 1.

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Figure 3. Catabolism of apoE3 and apoE4 in the lipoprotein subfractions of a normolipidemic subject homozygous for apoE3. ApoE3 iodinated with 125I (— o —) and 131I apoE4 (— x —) were injected into a subject, plasma was obtained, and lipoprotein fractions were separated at the indicated times. The decrease of radiolabeled apolipoproteins from each lipoprotein fraction is plotted over time after normalization to 1 at time 0.

Radiolabeled apoE kinetic studies in a patient with a homozygous apoE4 phenotype. The clinical characteristics of an individual with a homozygous apoE4 phenotype are given in Table I. This subject was a normal healthy volunteer without a history of any significant medical problems, and his apoE phenotype was established while screening normolipidemic volunteer subjects. His plasma lipid and lipoprotein concentrations are normal while his cholesterol concentration was in the low normal range (Table I). The kinetics of the metabolism of 125I-apoE3 and 131I-apoE4 were determined in this individual, and the plasma and lipoprotein subfraction catabolic decay curves for apoE3 and apoE4 are illustrated in Fig. 4. The decay for both types of apoE from plasma are multieponential with the decay of apoE3 being much faster than apoE4. As was determined in the homozygous apoE3 subjects, apoE3 was catabolized more rapidly than apoE4 in LDLs, IDLs, LDLs, and HDL. The catabolism of apoE3 and apoE4 were similar in the $d > 1.21$ g/ml infranate.

The kinetic parameters of apoE metabolism in this apoE4 subject are presented in Table IV. The plasma apoE concentration in this individual was $\sim 65\%$ of the apoE concentration in the other subjects with a homozygous apoE3 phenotype. The residence times for apoE3 and apoE4 were similar to the corresponding residence times in the apoE3 individuals, with the apoE4 residence time being approximately half the residence time of apoE3. The plasma production rate for apoE4 was increased when compared with the production rate of apoE3 in apoE3 individuals. Therefore, the apoE isoform was more important than the phenotype of the individual in determining the catabolic rate for apoE in this subject. The decreased apoE concentration in the apoE4 subject resulted from rapid catabolism of apoE and not from a decreased production rate, in that there was actually an increased production rate of apoE.

Discussion

Current data indicate that apoE is important in modulating the catabolism of remnants of triglyceride-rich lipoprotein particles. ApoE2, which is associated with type III hyperlipoproteinemia, has been shown to be abnormal in both in vivo and in vitro studies (1-3, 9-12). ApoE4 is associated with hypercholesterolemia (5-7) and with type V hyperlipoproteinemia (4), but has been reported to be normal in in vitro receptor binding studies (10). In order to gain further insights into the function of apoE4 in lipoprotein metabolism, we investigated the in vivo metabolism of radioiodinated apoE4 in normal humans. We have previously described in detail and validated the methods used for these kinetic studies (14). The studies validating these methods have demonstrated that apoE iodinated on a lipoprotein particle is metabolized at the same rate as isolated iodinated apoE, and that iodinated apoE reassociated with lipoproteins in plasma either in vivo or in vitro has a constant specific activity in the different lipoprotein subfractions (14).

ApoE4 was found to differ from apoE3 in its distribution on lipoprotein particles. A higher percentage of apoE4 bound to LDL with less on HDL when compared with apoE3. The
reason for this difference in distribution is as yet unknown. One possibility is that the additional positive charge on apoE4 may lead to a higher affinity to VLDL through protein-protein or protein-lipid interactions. A second possibility is that apoE4, with no cysteines, can't form apoE/apoA-II (19) or other mixed dimers that may lead to an altered lipoprotein particle distribution of the E apolipoprotein. It is clear, however, that apoE4 has an altered lipoprotein particle distribution when compared with apoE3.

In addition to altered lipoprotein particle distribution, apoE4 was kinetically abnormal in individuals with a homozygous

Table IV. Kinetics of ApoE Metabolism*

<table>
<thead>
<tr>
<th></th>
<th>E3 Phenotype</th>
<th>E4 Phenotype</th>
</tr>
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<tbody>
<tr>
<td>Chol. (mg/dl)</td>
<td>169±8*</td>
<td>180</td>
</tr>
<tr>
<td>TG (mg/dl)</td>
<td>124±12</td>
<td>190</td>
</tr>
<tr>
<td>ApoE (mg/dl)</td>
<td>4.83±0.35</td>
<td>3.11</td>
</tr>
<tr>
<td>Residence time (d)</td>
<td>0.73±0.05</td>
<td>0.36</td>
</tr>
<tr>
<td>Production rate (mg/kg per d)</td>
<td>2.84±0.31</td>
<td>4.88</td>
</tr>
</tbody>
</table>

* Kinetics of apoE3 metabolism in apoE3 homozygotes and apoE4 metabolism in the apoE4 homozygote.

§ n = 12.

§ n = 1.

II Mean±SEM of the values obtained after 6-h fasts during the kinetic study.
epidemic apoE4 individuals in which we have quantitated apoE levels. The metabolic reason for the low plasma level of apoE4 was a rapid fractional catabolic rate, with the apoE4 production rate being actually increased in the apoE4 subject when compared with the apoE3 subjects. Therefore, the low plasma concentration of apoE4 was due to rapid catabolism. In the apoE4 subject, the rate of catabolism of apoE4 was faster than that of apoE3, and the catabolic rates were very similar to the apoE3 and apoE4 catabolic rates in the apoE3 subjects. Therefore, the catabolic rate of apoE in this normolipidemic subject was much more dependent on the isoform of the apoE than on the apoE phenotype of the individual and is consistent with the mechanism for apoE catabolism being similar in normolipidemic apoE3- and apoE4-homozygous individuals. The normal lipid and lipoprotein concentrations of the apoE4 subject indicates that the apoE concentration was sufficient for normal lipoprotein metabolism in this individual.

These results, combined with the previous epidemiologic studies, are interpreted as indicating that apoE4 is an abnormal apoE isoform. This evidence includes: (a) an association of the E4 allele with type V hyperlipoproteinemia (4), (b) an association of the E4 allele with increased plasma and LDL cholesterol concentrations (5–7), (c) an altered lipoprotein distribution of apoE4, (d) a decreased plasma apoE concentration in subjects with a homozygous apoE4 phenotype, and (e) rapid catabolism of apoE4 compared with apoE3 in both apoE3 and apoE4 subjects, establishing that apoE4 is metabolically different than apoE3.

We propose the following conceptual scheme, based on these results, to explain the observed effects of the different forms of apoE on the metabolism of remnant particles and LDL. Within this framework it is assumed that apoE has both an effect on the conversion of VLDL remnants into LDL and on the direct catabolism of remnants of triglyceride-rich lipoprotein particles by hepatic receptors. In addition, it is assumed that normal metabolism is metabolism in normolipidemic subjects with the homozygous apoE4 phenotype.

In subjects with a homozygous apoE4 phenotype, the apoE is defective in both its ability to bind to the hepatic apoE receptor (10) and in the conversion of remnants to LDL (21–23). This results in an accumulation of remnants of triglyceride-rich lipoprotein particles and a decreased uptake of cholesterol-containing lipoproteins by the liver, due to a block in remnant uptake and a decrease in the conversion to LDL. The liver compensates by up-regulating the LDL receptor pathway, which further decreases plasma LDL concentrations (24). These combined effects result in a decreased catabolic rate for apoE3, an increase in plasma remnant concentration, a decreased LDL concentration, an up-regulated LDL receptor pathway, and, presumably, an increased cholesterol synthesis pathway. If the individual also has an additional cause for hyperlipidemia, type III hyperlipoproteinemia develops, along with an increased risk for premature cardiovascular disease (3).

The evidence is less complete for the effect of apoE on lipoprotein metabolism in individuals with a homozygous apoE4 phenotype; however, the present evidence is consistent with apoE acting at the same sites as in apoE3 subjects, but with an effect opposite that of apoE2. We propose that apoE2 is more effective than apoE3 in modulating direct remnant uptake and in converting remnants to LDL. This change in apoE metabolism results in rapid catabolism of apoE4, rapid catabolism of cholesterol-enriched remnant particles, a down-regulation of the LDL receptor pathway, increased conversion of VLDL remnants to LDL, and an increased LDL concentration due to both increased conversion from IDL and decreased LDL catabolism.

The mechanism for the association of apoE4 with type V hyperlipoproteinemia is unknown; however, apoE may modulate the hydrolysis of triglycerides on large triglyceride-rich lipoprotein particles (25, 26). Alternatively, since it is on chromosome 19 (27), it may act as a marker for some other abnormal gene on chromosome 19, particularly since the apoE gene is on the same chromosome as the genes for apoC-I (28), apoC-II (29), and the LDL receptor gene (30).

In conclusion, the combined epidemiological and metabolic studies provide convincing evidence that the apoE4 is a metabolically abnormal apoE isoform that is associated with significant changes in lipoprotein metabolism.

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