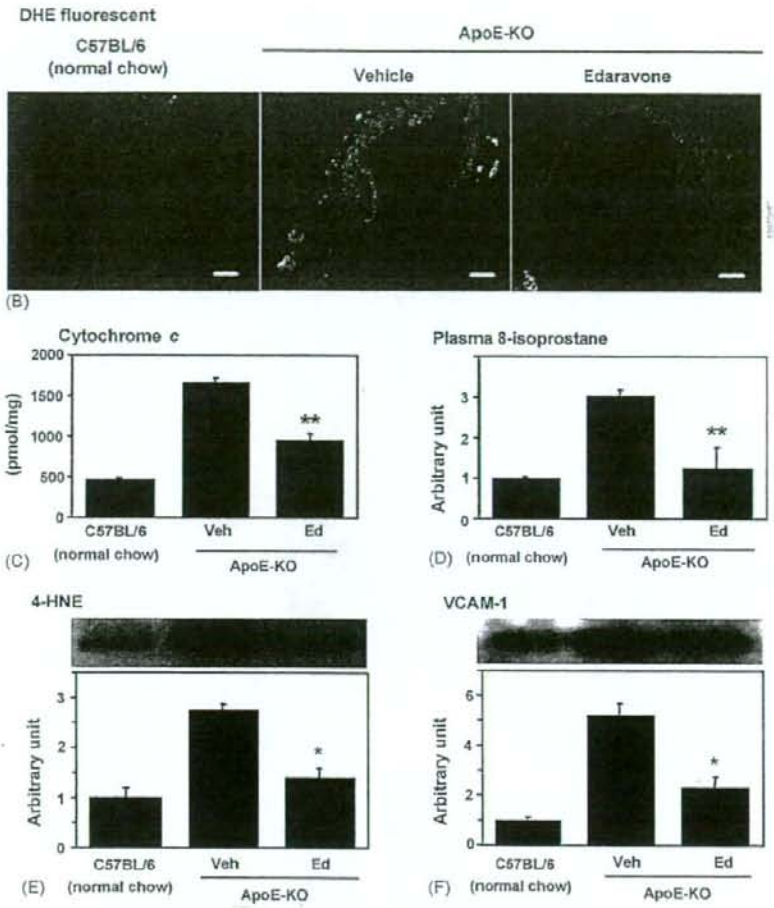

Fig. 4. (*Continued*).

duced via NAD(P)H oxidase [35], •OH as well as LOO• [36] and $ONOO^-$ [37] play a role in atherogenesis. In particular, •OH is extremely strong in terms of oxidative activity and cellular damage [38]. Therefore, it might be essential to scavenge the wide range of ROS for the prevention of atherosclerosis. As a matter of fact, recent clinical trials have denied the protective effects of Vitamin E, which predominantly reacts with LOO• [39], on cardiovascular events [18,19].

Edaravone, a potent free radical scavenger with unique properties, works by donating an electron from edaravone anion to free radicals [22]. Edaravone quenches •OH and inhibits both •OH-dependent and •OH-independent lipid peroxidation [22]. Edaravone shows inhibitory effects on both water-soluble and lipid-soluble LOO-induced peroxidation systems [22]. Edaravone also inhibits $ONOO^-$-induced tyrosine nitration [22]. These properties are different from those of water-soluble Vitamin C and lipid-soluble Vitamin E.

In the present study, we demonstrated that edaravone suppressed endothelial apoptosis and fatty streak formation. Reduced expression of VCAM-1, a marker of vascular injury and activation [32], were corroborated with these results. In cultured ECs, protein expression of VCAM-1 was induced as early as 3 h after H_2O_2 treatment (actually 4.5 h after addition of H_2O_2, Fig. 2C). This is reasonable based on our time course experiments (data not shown), and is consistent with the previous reports that VCAM-1 protein has been induced 4–6 h after cytokine stimulation through an antioxidant-sensitive mechanism [40,41]. Although the experimental conditions were different between the cell culture and animal studies, edaravone inhibited both the rapid induction of VCAM-1 in cultured ECs and the chronic upregulation of VCAM-1 in the aorta of ApoE-KO mice, further supporting the vasoprotective effects of edaravone.

Edaravone has been clinically used as a neuroprotectant in the treatment of ischemic stroke in Japan from 2001. The dose of edaravone used in this study (intraperitoneal injection of 10 mg/kg) has been reported to be comparable to that of intravenous injection in clinical use in terms of plasma concentration [42]. This compound has been reported to preserve endothelial function in ischemic brain [43] and ameliorate ischemia-reperfusion injury in various organs such as kidney [44] and heart [45]. Also, edaravone has been shown to inhibit pressure overload-induced cardiac hypertrophy [42]. To our knowledge, however, the effect of edaravone on atherosclerosis has never been reported till now.

The effects of edaravone on endothelial injury and atherosclerosis were associated with the decrease in ROS production including peroxynitrite, superoxide anion and 8-isoprostane, suggesting the mechanistic role of antioxidation in vascular protection. Edaravone also inhibited the expression of 4-HNE in vascular tissues, further indicating the antioxidant activity and suggesting the signaling cascade leading to endothelial injury, because 4-HNE triggers cellular damages through the MAP kinase pathway as an end-product of ROS [34]. Antioxidant effects of edaravone on lipoproteins were not determined in the present study because of the methodological limitation in mice. It has been reported, however, that edaravone can inhibit oxidative modification of low-density lipoprotein *in vitro* and in rats [46]. Consequently, it is likely that reduced lipoprotein oxidation would have played a role in the anti-atherosclerotic effects of edaravone in ApoE-KO mice. Furthermore, edaravone has been reported to stimulate the expression of endothelial nitric oxide synthase in cultured ECs [46] and the artery [47], leading to the increased production of nitric oxide. Taken together with the effects on peroxynitrite formation, edaravone might synergistically increase the availability of nitric oxide, which exerts vasoprotective and anti-atherosclerotic action.

The effects of edaravone on advanced and complicated lesions of atherosclerosis were not investigated in this study. Neither, the effects on plaque ruptures nor consequent cardiovascular events are known. This study demonstrated that edaravone might be a potential new therapeutic agent for the prevention and treatment of early atherosclerosis. For the purpose of chronic use, however, the innovation of drug preparation for oral administration is necessary. Another application of edaravone might be the prevention of restenosis after percutaneous coronary interventions, since ROS plays an important role in neointimal formation after angioplasty [48]. Intravenous injection of edaravone for several days might inhibit neointimal formation in addition to ischemia reperfusion injury of cardiomyocytes [45]. Taken together, edaravone is expected to show protective effect on ROS-related vascular diseases beyond cerebral infarction.

In summary, edaravone, a free radical scavenger with unique properties, attenuated oxidative stress-induced endothelial damage in rats and early atherosclerosis in ApoE-KO mice in association with the inhibition of ROS formation. These findings provide new information on the role of ROS in atherogenesis and the therapeutic strategy for atherosclerosis.

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Statins Protect Human Aortic Smooth Muscle Cells From Inorganic Phosphate-Induced Calcification by Restoring Gas6-Axl Survival Pathway

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Abstract—Vascular calcification is clinically important in the development of cardiovascular disease. It is reported that hydroxy-3-methylglutaryl coenzyme A (HMG CoA) reductase inhibitors (statins) inhibited vascular calcification in several clinical trials. However, the mechanism is poorly understood. Recently, it has been suggested that apoptosis is one of the important processes regulating vascular smooth muscle cell (VSMC) calcification. In this study, we investigated the effect of statins on VSMC calcification by testing their effect on apoptosis, focusing in particular on regulation of the survival pathway mediated by growth arrest-specific gene 6 (Gas6), a member of the vitamin K–dependent protein family, and its receptor, Axl. In human aortic smooth muscle cells (HASMC), statins significantly inhibited inorganic phosphate (Pi)-induced calcification in a concentration-dependent manner (reduced by 49% at 0.1 μmol/L atorvastatin). The inhibitory effect of statins was mediated by preventing apoptosis, which was increased by Pi in a concentration-dependent manner, and not by inhibiting sodium-dependent phosphate cotransporter (NPC) activity, another mechanism regulating HASMC calcification. Furthermore, the antiapoptotic effect of statins was dependent on restoration of Gas6, whose expression was downregulated by Pi. Restoration of Gas6 mRNA by statins was mediated by mRNA stabilization, and not by an increase in transcriptional activity. Suppression of Gas6 using small interfering RNA and the Axl-extracellular domain abolished the preventive effect of statins on Pi-induced apoptosis and calcification. These data demonstrate that statins protected HASMC from Pi-induced calcification by inhibiting apoptosis via restoration of the Gas6-Axl pathway. (*Circ Res.* **2006;98:1024-1031.**)

Key Words: calcification ■ statins ■ apoptosis ■ Gas6 ■ Axl

Vascular calcification, such as coronary and aortic calcification, is a significant feature of vascular pathology, because this lesion is associated with cardiovascular disease.[1,2] It has been recognized that statins exhibit various protective effects against atherosclerosis, including modification of endothelial function,[3] decreased inflammation,[4] and inhibition of vascular smooth muscle cell (VSMC) proliferation and migration,[5] all of which cannot be accounted for by lipid reduction. One of the interesting pleiotropic effects of statins is the inhibition of vascular calcification. Results from clinical trials suggest an association of statin use with slowed progression of calcific aortic stenosis[6–8] and coronary artery calcification.[9] Statins also inhibited calcification of atherosclerotic plaques in experimental hyperlipidemic animals.[10,11] On the other hand, some recent clinical trials were not able to find such an inhibitory effect.[12,13] To clarify these discrepancies, it is important to identify the detailed regulatory mechanism of vascular calcification and the target of effect of statins.

Based on clinical findings,[14] inorganic phosphate (Pi) has been shown to be an important inducer of VSMC calcification, which is morphologically similar to that observed in calcified human heart valves and the aortic media. Transport of Pi into VSMC has been suggested to play an important role in the initiation of extracellular matrix calcification.[15] Recently, it has been shown that similar structures to matrix vesicles, derived from apoptotic VSMC, have been identified in human calcified arteries.[16] These vesicles have the capacity to concentrate and crystallize Ca, initiating calcification. Pi has been shown to induce apoptosis of hypertrophic chondrocytes, which is associated with cell maturation and extracellular matrix mineralization.[17] However, it is not clear whether or not apoptosis plays a regulatory role in the occurrence of VSMC calcification induced by Pi.

Recently, it was shown that growth arrest-specific gene 6 (Gas6), a member of the vitamin K–dependent protein family, and its receptor, Axl, a membrane receptor tyrosine kinase, are decreased on calcification of vascular pericytes.[18]

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Gas6 is a secreted protein that harbors a γ-carboxylglutamic acid–rich domain and 4 epidermal growth factor–like repeats.[19] Gas6-Axl interaction has been shown to be implicated in the regulation of multiple cellular functions, including growth, survival, adhesion, and chemotaxis.[20–23] In particular, they are known to protect a range of cell types from apoptotic death. However, there is no evidence that Gas6-Axl interaction is involved in Pi-induced apoptosis and calcification of VSMC.

In the present study, we found that statins inhibited Pi-induced calcification by preventing apoptosis in human aortic smooth muscle cells (HASMC). The effect of statins was dependent on restoration of the Gas6-Axl pathway. Furthermore, this beneficial effect was mediated by Gas6 mRNA stabilization, and not by increasing the transcription rate. Our results reveal a novel pathway by which statins regulate Pi-induced calcification in HASMC.

Materials and Methods

Materials

Pravastatin, atorvastatin, and fluvastatin were supplied by Sankyo Co Ltd, Pfizer Inc (New York), and Tanabe Seiyaku Co Ltd, respectively. Recombinant human Gas6 (rhGas6) and Axl-ECD were prepared as described previously.[22,24] All other reagents were of analytical grade.

Cell Culture

HASMC were obtained from Clonetics. They were cultured in DMEM supplemented with 20% FBS, 100 U/mL penicillin, and 100 mg/mL streptomycin at 37°C in a humidified atmosphere with 5% CO_2. HASMC were used up to passage 8 for the experiments.

Induction and Quantification of Calcification

For Pi-induced calcification, Pi (a mixed solution of Na_2HPO_4 and NaH_2PO_4 whose pH was adjusted to 7.4) was added to serum-supplemented DMEM to final concentrations of 2.0, 2.6, and 3.2 mmol/L ("calcification medium"). After the indicated incubation period, cells were decalcified with 0.6 mol/L HCl, and Ca content in the supernatant was determined by the *o*-cresolphthalein complexone method (C-Test, WAKO). The remaining cells were solubilized in 0.1 mol/L NaOH/0.1% SDS, and cell protein content was measured by Bio-Rad protein assay. Calcification was visualized by von Kossa's method. Briefly, the cells were fixed with 4% formaldehyde and exposed to 5% aqueous $AgNO_3$.

Induction of Apoptosis

Two different time courses were tested to investigate Pi-induced apoptosis and examine the effect of statins. (1) Short-term condition: Pi was added at final concentrations of 2.0, 2.6, and 3.2 mmol/L for 24 hours at confluence, after the cells were incubated with serum-free DMEM for 48 hours. To test the effect of statins on apoptosis, they were added 24 hours after incubating the cells with serum-free DMEM (12 hours before adding Pi). (2) Long-term condition: at confluence, the medium was switched to calcification medium and cells were cultured for up to 10 days. The medium was changed every 2 days. To test the effect of statins, each was added simultaneously when the medium was switched to the calcification medium.

RNA Extraction, Northern Blot, and mRNA Stability Analysis

The 304-bp product of the Gas6 cDNA probe (forward, 5′-GCGTGGCCAAGAGTGTGAAGT-3′; reverse, 5′-CGCCACTCC-TCAACAGAGAT-3′) was amplified by RT-PCR. For Northern blot analysis, harvested RNA (≈5 to 10 μg) was fractionated on 1.4% formaldehyde-agarose gel and transferred to a nylon filter. The filter was hybridized at 68°C for 2 hours with ^{32}P-labeled Gas6 cDNA and 18S probe in QuickHyb solution (Stratagene) and autoradiographed. To examine Gas6 mRNA stability, serum-starved HASMC were incubated with actinomycin D (Act D, 5 μg/mL) in the presence of 2.6 mmol/L Pi after 12 hours of atorvastatin (0.1 μmol/L) treatment. Total RNA was harvested at 0, 1, 3, and 6 hours for Northern blot analysis. Signal density of the Gas6 mRNA was normalized to that

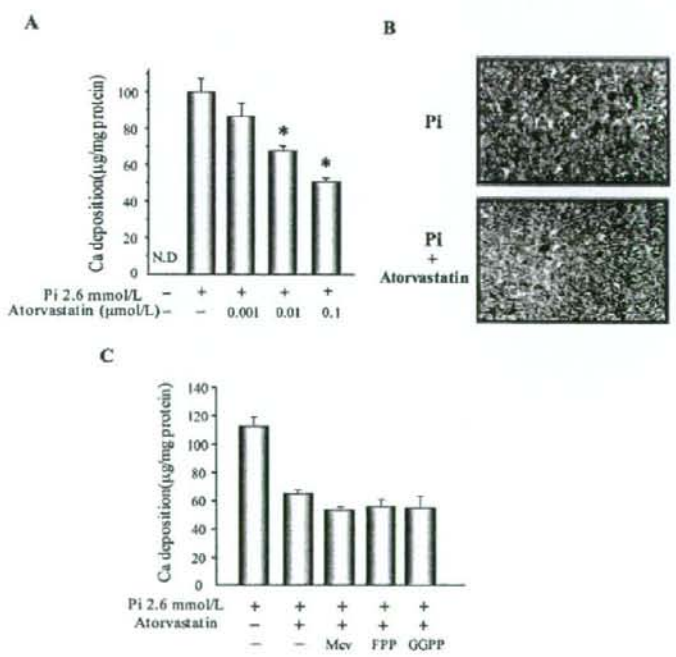

Figure 1. Statins prevent HASMC calcification. A, HASMC were cultured with the indicated concentrations of atorvastatin in the presence of 2.6 mmol/L Pi for 6 days. Ca deposition was measured by *o*-cresolphthalein complexone method and normalized by cell protein content. All values are presented as mean±SEM (n=6). *$P<0.05$ vs statin (-) by Fisher's test. N.D. indicates not detected. B, On day 6, the inhibitory effect of atorvastatin (0.1 μmol/L) on 2.6 mmol/L Pi-induced Ca deposition was evaluated at the light microscopic level with von Kossa's staining. The arrow points to an area of Ca deposition. C, HASMC were cultured with mevalonate (100 μmol/L), farnesylpyrophosphate (1 μmol/L), or geranylgeranylpyrophosphate (1 μmol/L) in the presence of atorvastatin (0.1 μmol/L) and 2.6 mmol/L Pi for 6 days. All values are presented as mean±SEM (n=6).

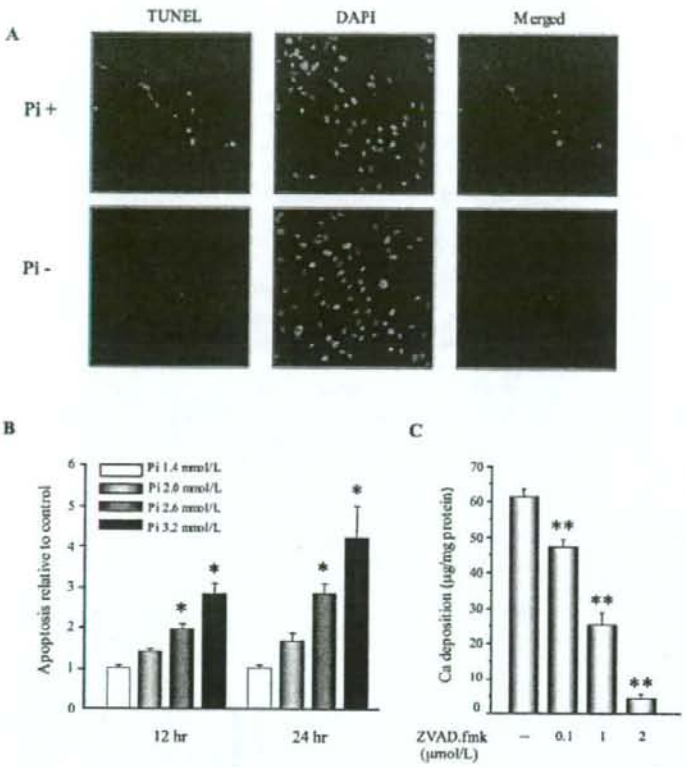

Figure 2. Pi induces apoptosis, and ZVAD.fmk inhibits Pi-induced calcification. A, After incubation with 1.4 (Pi-) and 3.2 mmol/L (Pi+) Pi for 10 days, apoptotic cells were identified by TUNEL staining (green). Nuclei were counterstained with 4',6-diamidino-2-phenylindole (DAPI) (blue). B, Serum-starved HASMC were cultured with the indicated concentration of Pi for 24 hours. A quantitative index of apoptosis, determined by ELISA, is presented as the relative value to that with 1.4 mmol/L Pi. All values are presented as mean±SEM (n=3). *$P<0.05$ vs 1.4 mmol/L Pi by Fisher's test. C, HASMC were incubated with the indicated concentration of ZVAD.fmk in the presence of 2.6 mmol/L Pi for 6 days. Ca content was measured and normalized by cell protein content. All values are presented as mean±SEM (n=6). **$P<0.01$ vs 2.6 mmol/L Pi, ZVAD.fmk(-) by Fisher's test. Experiments were performed with at least 3 different cell populations.

of the 18S RNA at each time point, and the half-life was calculated by linear extrapolation.

Preparation of Small Interfering RNA Targeting Gas6 and Transfection

Two small interfering RNAs (siRNAs) were designed to target human Gas6 (accession no. NM_000820) using siRNA design software (Dharmacon). The sequences for Gas6 were 5'-GGACCTGCCAAGACATAGA-3' and 5'-ACCTCGTGCAGCCT-ATAAA-3'. Nonspecific control siRNA was synthesized using standard templates (Dharmacon). Twenty-four hours after HASMC seeding onto 12-well plates, cells were cultured in serum-free medium for an additional 24 hours, then transfected with Gas6 (100 nmol/L) and control siRNA using transfection reagent (Upstate). To evaluate the effect of Gas6 siRNA on Ca deposition, siRNA was transfected when HASMC had reached 80% to 90% confluence and then transfected every time the medium was changed (every 2 days) up to 6 days. The loss of Gas6 by transfection of siRNA was validated by immunoblotting for Gas6 protein in the cell lysates 48 hours and 6 days after siRNA transfection.

Statistical Analysis

All results are presented as mean±SEM. Statistical comparisons were made by ANOVA, unless otherwise stated. A value of $P<0.05$ was considered to be significant.

An expanded Materials and Methods section can be found in the online data supplement available at http://circres.ahajournals.org.

Results

Statins Inhibit Pi-Induced HASMC Calcification

To induce HASMC calcification, cells were incubated with calcification medium for 10 days. We confirmed that high phosphate (≥2.6 mmol/L) induced Ca deposition in a concentration- and time-dependent manner, whereas 1.4 mmol/L Pi, equivalent to the human physiological serum phosphate level, was not able to induce Ca deposition up to 10 days. To investigate the effect of statins on Pi-induced calcification, HASMC were incubated with atorvastatin in the presence of 2.6 mmol/L Pi. On day 6, Ca deposition was significantly suppressed by atorvastatin in a concentration-dependent manner (51.1±1.9% of control at 0.1 μmol/L) (Figure 1A). An inhibitory effect of the statins on Ca deposition was also found by von Kossa's staining (Figure 1B). Atorvastatin was able to be added at as high a concentration as 0.1 μmol/L without cell damage. The inhibitory effect was also observed with fluvastatin (0.001 to 0.1 μmol/L) and pravastatin (0.01 to 50 μmol/L) (data not shown). The inhibitory effect of statins was not blocked by mevalonate (100 μmol/L), farnesylpyrophosphate (1 μmol/L), or geranylgeranylpyrophosphate (1 μmol/L), suggesting that the effect is not dependent on the mevalonate pathway (Figure 1C).

Inhibitory Effect of Statins on Calcification Is Caused by Preventing Apoptosis, Not by Inhibiting Sodium-Dependent Phosphate Cotransporter Activity

Two different time courses were tested to examine the effect of Pi on HASMC apoptosis: short-term (up to 24 hours) and long-term (up to 10 days; practical time course of calcifica-

tion process). During calcification, Pi increased the rate of apoptotic cell death detected by terminal deoxyribonucleotidyl transferase-mediated dUTP-digoxigenin nick-end labeling (TUNEL) assay (Figure 2A). Furthermore, cytoplasmic histone-associated DNA fragments determined by ELISA, as a quantitative index of apoptosis, were also increased by Pi in a concentration- and time-dependent manner in both short-term (Figure 2B) and long-term conditions (supplemental Figure I). In addition, caspase 3 activation, detected by immunoblotting, by 2.6 mmol/L Pi was observed in short-term and long-term conditions (data not shown). To investigate the relationship between apoptosis and calcification, we used ZVAD.fmk, a general caspase inhibitor. We found that ZVAD.fmk significantly inhibited Pi-induced apoptosis as well as calcification in a concentration-dependent manner (Figure 2C).

It has been reported that sodium-dependent phosphate cotransporter (NPC) activity is an important pathway regulating Pi-induced HASMC calcification.[25] We confirmed that type III NPC (Pit-1) was expressed in the HASMC that we used, and its activity was enhanced by Pi treatment. Furthermore, a specific inhibitor of NPC, phosphonoformic acid (PFA), inhibited Ca deposition (reduced by 90.4% at 0.1 μmol/L), indicating that NPC-mediated Pi uptake is also essential for HASMC calcification.

To investigate the mechanisms of these statins, we examined the effect of atorvastatin on apoptosis and NPC activity. Atorvastatin, at concentrations exerting inhibition of calcification, reduced apoptosis in a concentration-dependent manner (Figure 3A). A beneficial effect of statins was also observed in the long-term condition (supplemental Figure II). On the other hand, statins did not inhibit NPC activity induced by Pi treatment (Figure 3B).

Downregulation of Gas6-Axl Interaction Is Associated With Pi-Induced Apoptosis

Immunoblot analysis showed that the expression of Gas6 and Axl was markedly downregulated by 2.6 mmol/L Pi in both short-term (Figure 4A) and long-term (supplemental Figure III) conditions. To further examine whether Pi affects the secretion of Gas6 by HASMC, conditioned medium was collected after Pi treatment. Gas6 production in the medium was reduced by 2.6 mmol/L Pi, along with a reduction in its intracellular expression (Figure 4B). Gas6 production was also reduced in an immunoprecipitation-immunoblotting study on day 10 (Figure 4C). Next, to investigate the role of Gas6-Axl interaction in the process of apoptosis and calcification, rhGas6 and Axl-ECD were supplemented in Pi-treated HASMC. The addition of rhGas6 significantly inhibited both Pi-induced apoptosis and calcification. Addition of Axl-ECD to block the binding of Gas6 to Axl clearly abrogated the inhibitory effect of rhGas6 (Figure 4D and 4E). These results indicate that Pi-induced apoptosis and calcification are associated with downregulation of the Gas6-Axl interaction.

Statin-Mediated Induction of Gas6 Expression Is Dependent on mRNA Stabilization, Not on Transcription

To investigate whether the antiapoptotic effect of statins is dependent on restoration of the Gas6-Axl interaction, we first assessed the effect of statins on Gas6 expression. As shown in Figure 5A, atorvastatin increased Gas6 expression, which was downregulated by Pi at both the mRNA and protein levels. Upregulation of Gas6 expression was also observed in the long-term condition (supplemental Figure IV). Furthermore, to elucidate the mechanism of statins on restoration of Gas6 mRNA, a promoter study was undertaken. Reporter assay using the −1.9 kb Gas6-luciferase DNA construct revealed that atorvastatin did not have a significant effect on Gas6 promoter activity (supplemental Figure V), as well as mRNA expression under the condition in which it was significantly inhibited by PDGF-BB (data not shown). Next, we investigated the effect of atorvastatin on mRNA stabilization using an RNA polymerase inhibitor, actinomycin D (ActD). As shown in Figure 5B, Gas6 mRNA expression was more stable in the presence of atorvastatin than in its absence under Pi and ActD treatment. The half-life was 15.9 hours with atorvastatin and 5 hours without atorvastatin, suggesting the capacity of statins to improve Gas6 mRNA stabilization (Figure 5C). Taken together, these findings suggest that the restoration of Gas6 mRNA by statins appears to be mediated by decreasing the mRNA degradation rate, and not by stimulating transcriptional activity.

Furthermore, to determine whether Gas6 is required for statin-mediated effects, we tried to knock down the action of

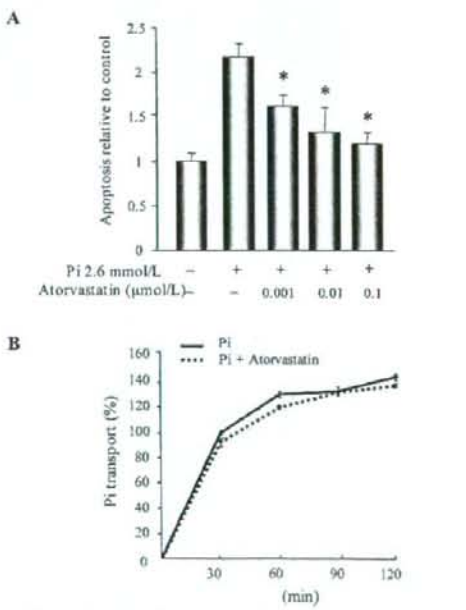

Figure 3. Effect of atorvastatin on Pi-induced apoptosis and NPC activity. A, HASMC were cultured with the indicated concentration of atorvastatin for 12 hours and then incubated with 2.6 mmol/L Pi for an additional 24 hours. All values are presented as mean±SEM (n=3). *$P<0.05$ vs 2.6 mmol/L Pi, statin (-) by Fisher's test. B, HASMC were treated with (dotted line) or without (solid line) 0.1 μmol/L atorvastatin in the presence of 2.6 mmol/L Pi. On day 6, NPC activity was determined in Earl's balanced salt solution containing 0.1 mmol/L $H_3{}^{32}PO_4$ (1 μCi/mL) with 143 mmol/L sodium chloride for the indicated period. All values are presented as mean±SEM (n=6).

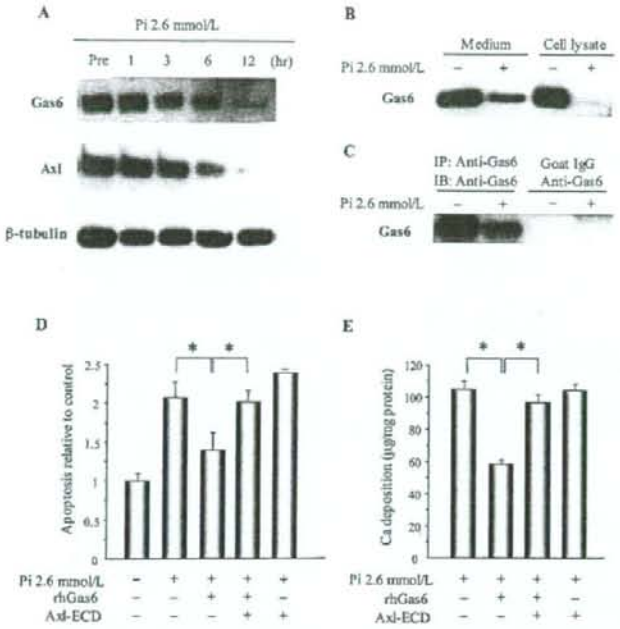

Figure 4. Pi reduces production of Gas6 and Axl, and rhGas6 inhibits Pi-induced apoptosis and calcification via Axl. A, HASMC were cultured in the presence of 2.6 mmol/L Pi for 12 hours. Cell lysates were subjected to SDS-PAGE followed by immunoblotting with antibodies to Gas6, Axl, or β-tubulin. B, Conditioned medium of HASMC in the absence (lane 1) or presence (lane 2) of 2.6 mmol/L Pi at 12 hours was concentrated and separated by SDS-PAGE along with cell lysates. C, Conditioned medium of HASMC on day 10 in the absence (lanes 1 and 3) or presence (lanes 2 and 4) of 2.6 mmol/L Pi was subjected to immunoprecipitation with anti-Gas6 antibody (lanes 1 and 2) or control goat IgG (lanes 3 and 4). Precipitates were immunoblotted with anti-Gas6 antibody. D, After pretreatment with rhGas6 (400 ng/mL) with or without Axl-ECD (1 μg/mL), apoptosis was induced by 2.6 mmol/L Pi. All values are presented as mean±SEM (n=3). *$P<0.05$ by Fisher's test. E, For measurement of Ca deposition, HASMC were cultured with rhGas6 (400 ng/mL) with or without Axl-ECD (1 μg/mL) in the presence of 2.6 mmol/L Pi for 6 days. All values are presented as mean±SEM (n=6). *$P<0.05$ by Fisher's test. Experiments were performed with at least 3 different cell populations.

Gas6 and examined the effect of atorvastatin on Pi-induced apoptosis and calcification. Transfection of Gas6 siRNA markedly decreased Gas6 expression in the short-term and long-term conditions (Figure 6A). The inhibitory effect of atorvastatin on Pi-induced apoptosis and calcification was reversed by Gas6 siRNA (Figure 6B and 6C). Similarly, the beneficial effect of atorvastatin was also abolished by blocking the binding of Gas6 to Axl using Axl-ECD (Figure 6D and 6E). These data support a critical role of Gas6 in the preventive effect of statins on apoptosis and calcification.

Discussion

The present study demonstrated that statins protected HASMC from Pi-induced calcification. The clinical effect of statins on vascular calcification is controversial. Many retrospective clinical studies[6,7,9] and a prospective study[8] have shown beneficial effects, whereas recent prospective studies were unable to show such effects.[12,13] The reason is not yet clear, and the time window of statin use has been raised as an important matter. The discrepancy may also derive from the complex in vivo effects of statins. In this regard, it is important to analyze the detailed regulatory mechanism of statins in a simple model.

In Pi-induced calcification, HASMC undergo apoptosis. A causal link between apoptosis and calcification was evident from the finding that both apoptosis and calcification were inhibited by the general caspase inhibitor, ZVAD.fmk. As reported previously,[25] we confirmed that NPC-mediated Pi uptake is another essential mechanism for HASMC calcification. Given that apoptosis does not always lead to calcification, Pi-induced HASMC calcification is presumably dependent on both an NPC-mediated phenotypic transition from SMC to an osteoblastic phenotype and apoptotic cell death. With respect to the mechanism of action of statins, they clearly inhibited Pi-induced apoptosis, although they did not have an effect on Pi-induced NPC activity or osteoblastic differentiation; Pi-induced upregulation of matrix Gla protein (MGP) mRNA was not inhibited by atorvastatin (supplemental Figure VI). These results suggest that apoptosis is the target of statins in inhibiting HASMC calcification.

Another important signal in Pi-induced calcification is an increase in intracellular Ca ($[Ca^{2+}]_i$). Statins have been shown to inhibit VSMC proliferation[5] and reduce the acute increase of $[Ca^{2+}]_i$ in a mevalonate and isoprenoid pathway–independent manner.[26] On the other hand, $[Ca^{2+}]_i$ is reported to modulate Pi-induced apoptosis of terminally differentiated chondrocytes.[27] Therefore, modulation of $[Ca^{2+}]_i$ is another possible mechanism of the inhibition of apoptosis by statins. In this study, we investigated the association of proliferation with Pi-induced apoptosis and calcification. We found that Pi did not affect proliferation, measured by the incorporation of 5-bromo-2′-deoxyuridine (BrdU) during calcification (data not shown). We also found that the inhibitory effect of statins on calcification was not affected by an inhibitor of Rho kinase (Y-27632), an important modulator of the mevalonate and isoprenoid pathway affecting proliferation and apoptosis (supplemental Figure VII). These results suggest that proliferation is not associated with Pi-induced calcification. The inhibitory effect of statins on calcification was not blocked by mevalonate, farnesylpyrophosphate, geranylgeranylpyrophosphate, or Rho kinase inhibitor, suggesting that the effect of statins is not dependent on the mevalonate and isoprenoid pathways. Indeed, a mevalonate pathway–independent effect of statins has been reported previously,[26,28–30] although the precise mechanism has not been shown. The pleiotropism of statins is of continuing interest.

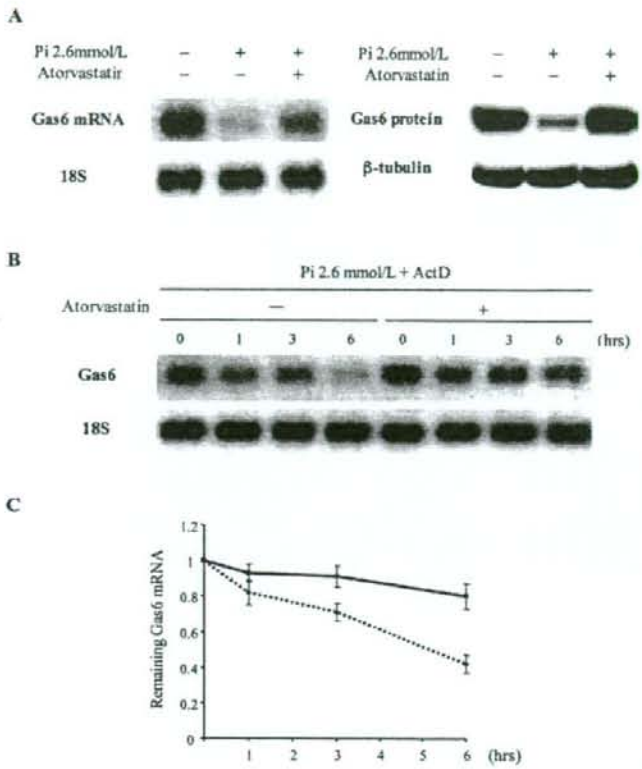

Figure 5. Atorvastatin enhances Gas6 mRNA stabilization, but not transcription. A, After pretreatment with atorvastatin (0.1 μmol/L) for 12 hours, apoptosis was induced by 2.6 mmol/L Pi. At 12 hours, mRNA was isolated and Northern blot analysis for Gas6 and 18S was performed. Simultaneously, cell lysates were collected and subjected to SDS-PAGE followed by immunoblotting with antibodies to Gas6 and β-tubulin. B, Serum-starved HASMC were incubated with actinomycin D (Act D) (5 μg/mL) in the presence of 2.6 mmol/L Pi after 12 hours of atorvastatin (0.1 μmol/L) treatment. Total RNA was harvested at 0, 1, 3, and 6 hours for Northern blot analysis. C, Signal density of Gas6 mRNA with (solid line) or without (dotted line) atorvastatin (0.1 μmol/L) in the presence of 2.6 mmol/L Pi and Act D (5 μg/mL) was normalized to that of 18S RNA at each time point. Gas6 mRNA level at time 0 was given the value 1. Each experiment was performed in triplicate for each condition.

An antiapoptotic effect of statins has been shown in various cell types.[31–34] In cardiomyocytes, apoptosis induced by hypoxia or protein kinase C (PKC) inhibitors was inhibited by 10 μmol/L pravastatin or 0.1 μg/mL atorvastatin, respectively.[31,32] Simvastatin (1 μmol/L) promoted endothelial cell survival.[33] In VSMC, 7-ketocholesterol–induced apoptosis was inhibited by 10 μmol/L pravastatin.[34] However, in contrast to the results of the present and other studies, a proapoptotic effect of statins has also been reported in VSMC,[35] endothelial cells,[36] and cardiac myocytes.[37] Although the precise mechanism is not understood, it can be postulated that statins have biphasic effects on cell survival (an antiapoptotic effect at low concentrations and a proapoptotic effect at high concentrations) depending on the type of cell, statins, and apoptotic stimulus. Indeed, Weis et al showed dose-dependent biphasic effects of statins on apoptotic activity in microvascular endothelial cells.[30] Consistent with these data, we found that 3 different statins displayed an antiapoptotic effect at low concentrations and a proapoptotic effect at high concentrations (>1 μmol/L for atorvastatin and fluvastatin; >100 μmol/L for pravastatin) (data not shown).

During Pi-induced apoptosis, we have shown that Pi downregulates the Gas6-Axl interaction, resulting in blockade of a survival signal, thereby promoting apoptosis and calcification. We previously proposed that Gas6 may allow Axl-expressing phagocytic cells, eg, macrophages and VSMC, to recognize cells exposing phosphatidylserine (PS) on the outer cell membrane, the initial step of the apoptotic process.[38] Proudfoot et al also showed that in vascular calcification, several PS-exposing cells are observed within and on the periphery of the nodules.[16] PS exposure by apoptotic bodies generates a potential Ca-binding site and membrane surface suitable for hydroxyapatite deposition.[39,40] Based on these observations, Gas6-Axl downregulation is presumably involved in decreased cell survival and clearance, both directing cells to apoptosis-mediated mineral deposition.

With regard to the molecular pathway of the restoration of Gas6 by statins, we have shown that statins retarded degradation of Gas6 mRNA, not increasing the transcriptional rate. Indeed, it was reported that statins improve mRNA stability as well as transcription.[41,42] In addition, the result that suppression of the action of Gas6 by siRNA and Axl-ECD abrogated the inhibitory effect of statins on apoptosis and inhibition clearly indicates a pivotal role of Gas6 in the effect of statins.

We conclude that statins inhibit Pi-induced HASMC calcification by preventing apoptosis via restoration of the Gas6-Axl pathway. The regulation of Gas6 by statins occurs at the posttranscriptional level. The present study provides evidence of a preventive role of statins in vascular calcification and further indicates the pleiotropic effects of statins, which could potentially contribute to the treatment of cardiovascular disease.

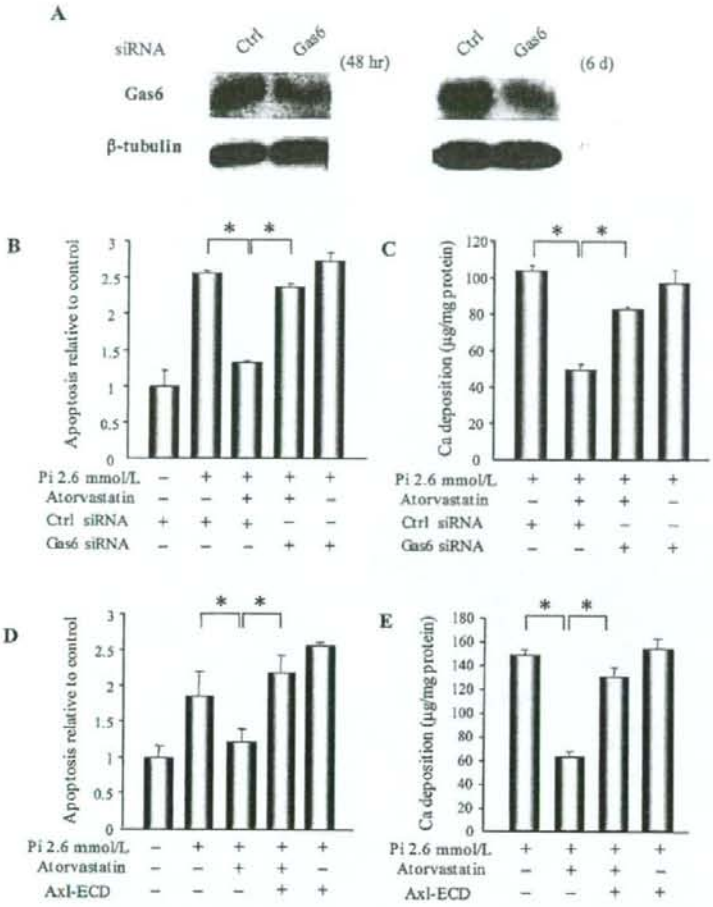

Figure 6. Gas6 knockdown abolishes inhibition of Pi-induced apoptosis and calcification by atorvastatin. A, Gas6-specific siRNA (100 nmol/L) and nonspecific siRNA (Ctrl siRNA) were transfected into HASMC, and immunoblotting was performed at 48 hours and 6 days after transfection. B, Serum-starved HASMC were transfected with 100 nmol/L Gas6 siRNA and control (Ctrl) siRNA. After transfection, cells were treated with atorvastatin (0.1 μmol/L) for 12 hours, then with 2.6 mmol/L Pi for an additional 24 hours before measurement of apoptosis (n=3). C, For measurement of Ca deposition, HASMC were transfected with 100 nmol/L Gas6 siRNA and control siRNA and incubated with atorvastatin (0.1 μmol/L) and 2.6 mmol/L Pi for 6 days (n=3). D, In the case of Axl-ECD, HASMC were pretreated with atorvastatin (0.1 μmol/L) and Axl-ECD (1 μg/mL) for 12 hours, then incubated with 2.6 mmol/L Pi for an additional 24 hours. Thereafter, a quantitative index of apoptosis was determined by ELISA (n=3). E, HASMC were cultured with atorvastatin (0.1 μmol/L) and Axl-ECD (1 μg/mL) in the presence of 2.6 mmol/L Pi for 6 days. Ca content was measured and normalized by cell protein content. All values are presented as mean±SEM (n=6). *$P<0.05$ by Fisher's test. Each panel shows a representative example of 3 independent experiments.

Acknowledgments

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CASE REPORT

Elderly patient presenting with severe thyrotoxic hypercalcemia

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An 81-year-old woman with Graves' disease and osteoporosis was referred to the hospital because of anorexia over one month and impaired consciousness. She also presented with low-grade fever and emaciation. Laboratory tests revealed marked hypercalcemia (corrected serum calcium level of 12.4 mg/dL), which was initially suspected to result from vitamin D toxicity, because she had been taking vitamin D3 (alphacalcidol of 0.5 μg/day) for the treatment of osteoporosis. However, discontinuation of vitamin D3 and fluid infusion did not ameliorate hypercalcemia one week later. After excluding hyperparathyroidism and malignancy-related hypercalcemia, hypercalcemia was considered to be attributable to the exacerbation of hyperthyroidism (free T4 of 6.69 ng/dL, free T3 of 13.27 pg/mL and thyroid stimulating hormone (TSH) <0.015 μIU/mL) with increased bone resorption. Finally, the increased dose of thiamazole (30 mg/day) normalized serum calcium level and thyroid function three months later. Laboratory tests suggested that normal bone formation in spite of increased bone resorption contributed to hypercalcemia in hyperthyroid state.

Keywords: deoxypyridinoline, hypercalcemia, hyperthyroidism, osteoporosis, p-N-telopeptides of collagen cross-links.

Introduction

Hypercalcemia has been associated in approximately 20% of the patients with hyperthyroidism, but is mild in most cases, ranging from the upper normal limit to the slightly elevated level.[1–3] Consequently, we rarely see hyperthyroidism with symptomatic hypercalcemia. Many genotypes have been associated with Graves' disease.[4] Also, a small number of studies have shown that polymorphisms in calcium-regulating genes such as calcium-sensing receptor[5] and vitamin D receptor[6] may influence calcium metabolism in adults. However, no study has reported the association of those polymorphisms with thyrotoxic hypercalcemia. More studies as well as more polymorphisms including haplotype analysis should be performed to clarify the underlying mechanism.

Here, we report an elderly patient presenting with severe symptomatic hypercalcemia resulting from hyperthyroidism.

Case report

An 81-year-old woman was admitted to the Department of Geriatric Medicine, Kyorin University Hospital because of hypercalcemia on February 14 2004. She had Basedow's disease and osteoporosis, and had been taking thiamazole 5 mg/day and alphacalcidol 0.5 μg/day. In January 2004, anorexia had gradually developed followed by gait disturbance. When she was referred to the hospital on February 14, she also presented with confusion and low-grade fever of 37.2°C. Her blood pressure was 122/62 mmHg with a pulse rate of 98 bpm. Physical examination showed a soft diffuse goiter and a systolic ejection murmur of Levine II/VI at the apex, while abdominal and neurological findings were normal.

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Table 1 Laboratory tests on admission

Test	Result
Hb	10.5 g/dL
Ht	32.6%
RBC	$367 \times 10^4/\mu L$
PLT	$22.2 \times 10^4/\mu L$
WBC	3200/μL
Na	144 mEq/L
K	3.1 mEq/L
Cl	100 mEq/L
Ca	11.7 mg/dL
IP	3.4 mg/dL
BUN	19.3 mg/dL
Cr	0.7 mg/dL
TP	6.4 g/dL
Alb	3.3 g/dL
ALP	226 IU/L
AST	37 IU/L
ALT	35 IU/L
LDH	333 U/L
CK	25 IU/L
Glu	126 mg/dL
CRP	0.2 mg/dL

1 Alb, ...; ALP, ...; ALT, ...; AST, ...; BUN, ...; CK, ...; CRP, ...; LDH, ...; PLT, ...; RBC, ...; TP, ...; WBC, ...

Table 2 Results of thyroid function test

Test	Result (normal range)
FreeT4	6.69 ng/dL (0.73–1.53)
FreeT3	13.27 pg/mL (1.63–3.20)
Thyroid stimulating hormone (THS)	0.015 IU/mL (0.41–5.27)
TSH receptor antibody	51.2% (15<)
TSAb (thyroid stimulatory antibody)	540% (180<)
Antithyroid peroxydase antibody	43.8 U/mL (0.3<)
Serum thyroglobulin autoantibodies	0.3 < U/mL (0.3<)

On laboratory tests (Table 1), she showed blood hemoglobin of 10.5 g/dL, white blood cell counts of 3200/μL and serum calcium of 11.7 mg/dL (corrected calcium of 12.4 mg/dL). Other electrolytes as well as liver and kidney function were normal. Thyroid function tests (Table 2) revealed marked hyperthyroidism; free T4 of 6.69 (reference, 0.90–1.70) ng/dL, free T3 of 13.27 (2.3–4.3) pg/mL and thyroid stimulating hormone (TSH) of <0.015 (0.5–5.0) μIU/mL. Plasma levels of TSH receptor antibody, thyroid stimulating antibody and anti-TPO antibody were elevated, compatible with the findings in Graves' disease. Plasma intact PTH was 13 (10–65) pg/mL and PTH-related protein was not detected.

Table 3 Results of markers of bone metabolism

Marker	Result (normal range)
Osteocalcin	9.5 ng/mL (2.5–13)
Bone-specific alkaline phosphatase	24.2 U/L (9.6–35.4)
p-N-telopeptides	43.3 nMBCE/L (10.7–24.0)
Deoxypyridinoline/Cr	43.8 nmol/L/nMCr (2.8–7.6)
calcitonin	33 pg/mL
1–25(OH)VitD_3	6 pg/mL (20–60)

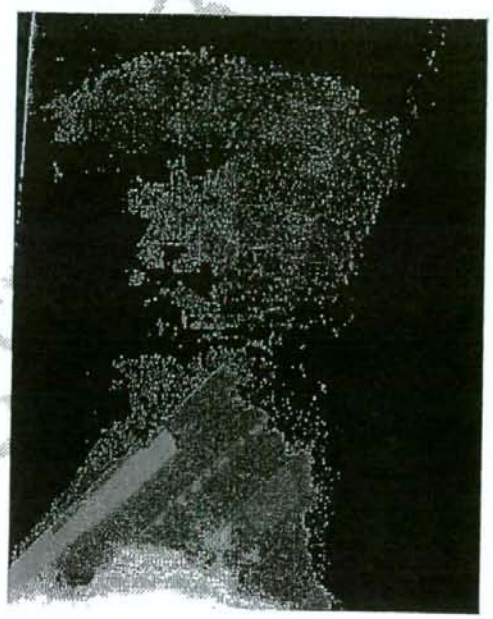

Figure 1 X-ray of lumbar vertebrae.

As shown in Table 3, markers of bone resorption such as deoxypyridinoline (DPD) and N-telopeptides of collagen cross-links (NTx) were elevated, whereas those of bone formation such as osteocalcin and bone-type alkaline phosphatase were not. Bone mineral density of lumbar vertebrae was –3.29 (T score), and that of femur was –3.72 (T score). Multiple compression fractures and remarkable reduction in bone mineral density were found on spinal lateral X-rays and dual energy X-ray absorptiometry, respectively (Fig. 1).

Initially, vitamin D toxicity was suspected as a cause of hypercalcemia; thus, alphacalcidol was ceased with fluid infusion to wash out calcium. However, the

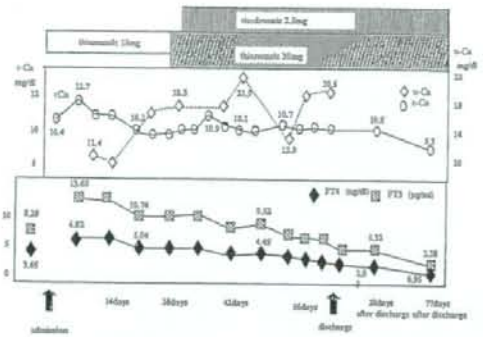

Figure 2 Clinical course of the patient. Thyroid stimulating hormone (TSH) was below the detection limit throughout the clinical course. c-Ca, collected serum calcium; u-Ca, urinary calcium; FT4, free thyroxine; FT3, free triiodothyronine.

hypercalcemia had not improved one week later. Laboratory and imaging tests were carried out to exclude hyperparathyroidism, humoral hypercalcemia of malignancy, osteolytic bone metastases and multiple myeloma. Finally, hypercalcemia was considered to be attributable to the exacerbation of hyperthyroidism with high bone turnover. Consequently, the dose of thiamazole was increased to 30 mg/day to normalize thyroid function. As shown in Figure 2, free T4 and free T3, as well as serum calcium were gradually decreased, and the patient was discharged on May 14 2004. In August 2004, her thyroid function returned to normal (free T4 of 0.95 ng/dL and free T3 of 2.28 pg/mL) with corrected serum calcium concentration of 9.2 mg/dL.

Discussion

Hypercalcemia associated with hyperthyroidism has been reported to occur more frequently in elderly patients than in younger patients; the incidence of hypercalcemia was 2.3% in hyperthyroid patients under 60 years of age and was 18.8% in those over 60 years of age.[2] The severity of hypercalcemia, however, is generally mild, ranging from the upper normal limit to the slightly elevated level,[3] and other complications should be suspected when serum calcium concentration is over 12 mg/dL.[7] Actually, case reports have shown that hyperparathyroidism is uncommonly associated with hypercalcemia in thyrotoxicosis.[8] Only several cases have been reported that hyperthyroidism was considered the only cause of hypercalcemia over 12.0 mg/dL.[9–11] In our case, laboratory tests and diagnostic imaging excluded hyperparathyroidism as well as malignant neoplasms. Furthermore, hypercalcemia was ameliorated in parallel with the improvement of hyperthyroidism, indicating that hypercalcemia resulted from hyperthyroidism.

Thyroid hormones play a critical role in bone development because hypothyroidism in childhood results in the impaired skeletal development.[12] In adults, thyroid hormones are important in the maintenance of bone mass. Thyroid hormone receptors are expressed in bone cells such as osteoblasts and osteoclasts.[12] In adult hyperthyroidism, there is increased bone remodelling, characterized by an increase in both bone resorption and formation, and an imbalance between bone resorption and formation, which results in bone loss and an increased risk for osteoporotic fracture.[12] In our case, however, the markers of bone resorption were elevated but those of bone formation were not. This pattern is consistent with the changes of bone metabolism in older osteoporotic patients,[13] but is different from that in hyperthyroidism as mentioned above. This might be due to the age-related decline in thyroid hormone signaling that leads to bone formation. However, no reports including animal experiments to support this hypothesis can be found so far. This should be investigated in the future.

Anti-thyroid drugs restore not only serum calcium levels[14] but also bone mineral density[15] in patients with thyrotoxic hypercalcemia. It has been also reported that a β blocker, propranolol,[16,17] and radioiodine therapy[10] may ameliorate thyrotoxic hypercalcemia. In our case, an increased dose of thiamazole normalized both thyroid function and serum calcium levels several months later, but bone mineral density was not increased. Longer time periods would be necessary to see the recovery of bone mass if possible.

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〈原　著〉

超高齢者におけるクレアチニンクリアランス推定式の比較検討

平山　俊一[1)]　菊池　令子[2)]　井上慎一郎[2)]　塚原　大輔[2)]　末光　有美[2)]
小林　義雄[2)]　杉山　陽一[2)]　長谷川　浩[2)]　神崎　恒一[3)]　井上　剛輔[3)]
鳥羽　研二[2)]

要　約　**目的**：高齢患者は外来では24時間クレアチニンクリアランスの測定が困難であり，服用薬物数も多いため，クレアチニンクリアランス実測値をできるだけ正確に反映する推定式を利用することは臨床上重要である．**対象**：各種基礎疾患を有する85歳以上の超高齢者67名を含む入院高齢者143名（男性73名　女性70名　平均年齢82.9±8.6歳）．**方法**：4種のクレアチニンクリアランス推定式から得られた推定値と24時間クレアチニンクリアランスの実測値との相関を比較検討した．**結果と結論**：全体として今回の検討では超高齢者においてもCockcroft and Gaultの式による推定値が最もよい相関を示した．85歳以上の女性超高齢者において実測値と推定式の相関が低く，推定式の改定についても今後の検討課題と思われる．

Key words：超高齢者，クレアチニンクリアランス，推定式，Cockcroft and Gaultの式，安田の式

（日老医誌　2007：44：90-94）

緒　言

高齢社会の到来により，外来入院を問わず，高齢患者が増加の一途をたどっている．厚生労働省の推計によると，2004年度において85歳以上の超高齢者は273.4万人と報告されている[1)]．高齢者に腎排泄型薬剤を投与する際，適正な用量を設定するため腎機能を正確に評価する必要がある．腎機能を表す指標として，糸球体濾過量には一般的に内因性クレアチニンクリアランス（以下Ccrと略す）が使われている．クリアランス試験には24時間蓄尿が必要であるが，時間を要することや被験者に排尿，蓄尿という負担があり繁雑であることから外来で測定することは容易ではない．このため血清クレアチニン値（以下Scrと略す）からCcrを推定するいくつかの数式が提案されている．しかしこれらの数式は実際に投薬の必要な諸疾患を有する高齢者に当てはめる際，筋肉量の減少などのためScrによるCcr推定値と実測したCcrがかけ離れた値を取ることがある．外来の超高齢患者においても適切な薬物療法を行うためには腎機能を正確に評価する必要がある．このため種々の推定式による相関を調べどの推定式が最もよく超高齢者に適合するか検討を行った．

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2) R. Kikuchi, S. Inoue, D. Tsukahara, Y. Suemitsu, Y. Kobayashi, Y. Sugiyama, H. Hasegawa, K. Kouzaki, K. Toba：杏林大学病院高齢医学科
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受付日：2006.4.18，採用日：2006.7.12

対象及び方法

杏林大学病院高齢医学科に2004年9月から2006年1月の間に入院した60歳以上の症例のうち，短期入院や，蓄尿不可能症例を除外し，尿道留置カテーテルを使用している患者や蓄尿が可能と判断された症例全例を対象にした．疾患や治療による除外は設けず，脳血管障害，感染症，経口摂取不良，利尿剤，補液などの様々な基礎疾患，治療を有する高齢者（平均年齢82.9±8.6歳（男性82.0±8.8歳　女性83.8±8.3歳））例を対象に行った．男女比及び84歳以下と85歳以上の症例数に偏りはなかった（表1）．対象高齢者全体の平均Scrは1.31±0.87mg/dlであった．身体測定，血液検査，尿検査などを測定し24時間蓄尿によるCcrを計算した．なお，Ccrは未補正のものを使用した．安田の式[2)]，Cockcroft and Gaultの式[3)]（以下C&G式と略す），折田の式[4)]，Walserの式[5)]の推定値を算出し，それぞれ推定値と実測値の相関を回帰分析，相関係数の差の検定により解析し比較検討した．さらに，層別解析として，84歳までの前期及び後期高齢者群76名と，85歳以上の超高齢者67名について男女別に層別解析を行った．

また実測値と推定式からの値との一致を箱ヒゲ図で求

表1　対象年齢分布

Age（歳）	n		
	男性	女性	全体
～84	42	34	76
85～	31	36	67
全体	73	70	143

め，値が外れ値となった症例については，患者の疾患や治療の背景，測定時の問題点について調査した．

本研究は，杏林大学高齢医学の入院に際して，CCr測定値を臨床研究に使用することを口頭で説明し同意を得て試行した．

(1) 安田の式

男性：Ccr（m*l*/min）＝（176－年齢）×体重（kg）÷（100×Scr（mg/100 m*l*））

女性：Ccr（m*l*/min）＝（158－年齢）×体重（kg）÷（100×Scr（mg/100 m*l*））

(2) Cockcroft and Gault の式

男性：Ccr（m*l*/min）＝（140－年齢）×体重（kg）÷（72×Scr（mg/100 m*l*））

女性：Ccr（m*l*/min）＝｛(140－年齢）×体重（kg）÷（72×Scr（mg/100 m*l*））｝×0.85

(3) 折田の式

男性：Ccr（m*l*/min）＝（－0.065×年齢－0.493×BMI＋33）÷（体重（kg）×Scr（mg/100 m*l*））×14.4

女性：Ccr（m*l*/min）＝（－0.052×年齢－0.202×BMI＋21）÷（体重（kg）×Scr（mg/100 m*l*））×14.4

(4) Walser の式

男性：Ccr（m*l*/min）＝7.57÷Scr（mM）－0.103×年齢＋0.096×体重（kg）－6.66

女性：Ccr（m*l*/min）＝6.06÷Scr（mM）－0.08×年齢＋0.08×体重（kg）－4.81

成　績

85歳未満の前期及び後期高齢者群において，安田，C&G，折田，Walser の推定値と24時間蓄尿による実測値の相関係数（r）は安田 r＝0.761，C&G　r＝0.761，折田 r＝0.693，Walser　r＝0.553 と安田の式，C&G 式で強い傾向があった．超高齢者群において，各々の推定式による推定値と実測値の相関係数は安田 r＝0.718，C&G r＝0.739，折田 r＝0.697，Walser r＝0.645 と，安田の式，C&G 式で相関が強い傾向があった（図1，図2）．超高齢者を男女に分け両群で各々の推定値と実測値の相関係数 r を比較したところ，男性で安田 r＝0.840，C&G r＝0.841，折田 r＝0.791，Walser　r＝0.736，女性で安田 r＝0.678，C&G　r＝0.690，折田 r＝0.667，Walser　r＝0.582 となり，男性に強い相関傾向があり，女性の相関係数は低かった（図3，図4）．また，超高齢者群において回帰係数を比較したところ，男性で安田＝0.796，C&G＝0.988，折田＝0.577，Walser＝0.375　女性で安田＝1.088，C&G＝1.262，折田＝0.776，Walser＝0.395 となった．

図5は超高齢者を男女で比較したものである．縦軸は実測値と推定値のずれの割合を示したもの（(実測値－推定値）×100/実測値）である．折田，Walser の式では，男女共に推定値が高く評価される傾向がある．

85歳以上の超高齢者での箱ひげ図における外れ値を検討し，実測値が高値となる6例の患者背景を調べた．輸液4例，利尿剤や Ca 拮抗薬など腎血流量を増加させる薬剤4例，腎不全2例，Scr 高値2例，心不全2例，CRP 高値2例であった．また，推定値が高値となる7例の患者背景を調べた．輸液5例，蓄尿不全または蓄尿少量4例，腎不全4例，癌3例，コントロール不良の糖尿病1例，胸水貯留，腹水貯留1例，肥満1例であった．

考　察

服用薬物数が多いほど薬剤有害作用の発現率は増加する傾向にある．また，加齢によってもその傾向は増加する[6]．その原因には加齢に伴う薬物動態学的・薬力学的な変化，多剤併用による相互作用，日常生活活動度（ADL）・認知機能の低下などが考えられるが，特に重大な原因として，腎機能の低下による相対的過量投与が挙げられる．Scr による腎機能の推定にはいくつか方法があるが高齢者，特に超高齢者になると筋肉量の低下により Scr が腎機能の低下と不相応な低値を示すことがしばしば見られる．Ccr 測定上の更なる問題点として正確な蓄尿の可否がある．加齢に伴う残尿，失禁の増加や患者自身による蓄尿もれなどにより，正確な24時間蓄尿が困難なことがある．1日尿量が少ないとき，Ccr 実測値と推定値のばらつきが大きいとの報告もある．今回は尿道留置カテーテルを使用している患者や蓄尿が可能と判断された患者の症例を対象とし，努めて正確な採尿を試みた．しかしながら，本来行うべきクリアランス法の実施には正確な蓄尿と安静を要し，判定に時間がかかるため実際の外来診療では実施困難なことが多い．従って Scr より Ccr を推定する種々の方法が提案されてきた．今回検討した安田の式，Cockcroft and Gault の式，折田の式，Walser の式は代表的な推定式であり Scr 値，性別，年齢，体重より Ccr を推定できる．C&G 式は欧米で最も広く用いられており欧米人によい相関を示して

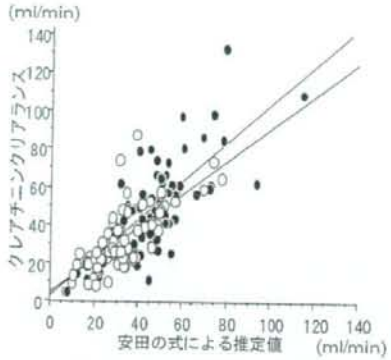

図1　安田の式　84歳以下と85歳以上の比較
○85歳以上：Y = 4.57 + 0.860X（r = 0.718）
●84歳以下：Y = 1.85 + 1.007X（r = 0.761）

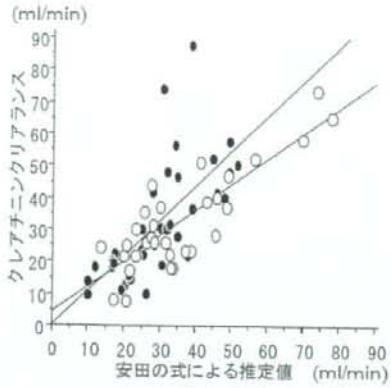

図3　安田の式　85歳以上の性差
○男性：回帰式 Y = 4.09 + 0.796X（r = 0.840）
●女性：回帰式 Y = 0.21 + 1.088X（r = 0.678）

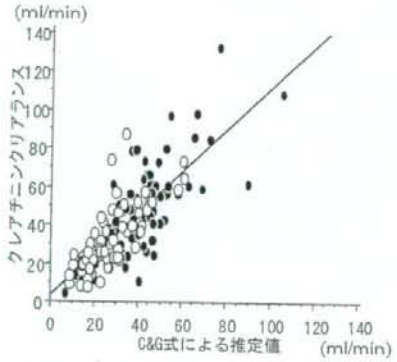

図2　C&G式　84歳以下と85歳以上の比較
○85歳以上：Y = 3.20 + 1.078X（r = 0.739）
●84歳以下：Y = 3.33 + 1.082X（r = 0.761）

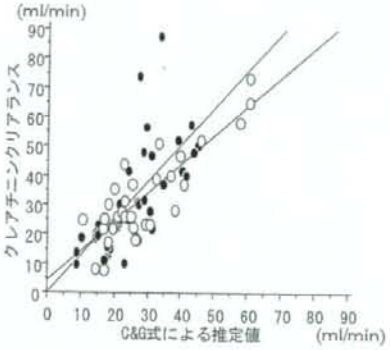

図4　C&G式　85歳以上の性差
○男性；回帰式 Y = 4.07 + 0.988X（r = 0.841）
●女性；回帰式 Y = − 0.09 + 1.262X（r = 0.690）

いる．今回の検討でも超高齢者における相関が0.739と最もよい相関を示した．この原因として日本人の体格が欧米化してきたことやC&G式作成時の対象年齢が18～92歳と超高齢者も含まれていること，作成時の対象症例数が多いことが考えられる．C&Gの式に対して他の3式はいずれもその後に発表されたもので，安田の式は1.4mg/dl以下の血清クレアチニン値を示す高齢者に限定して式を求めたもので，腎不全患者は含めずに高齢者の腎機能を推定しようとしたものである[3]．一方，Walserの式は血清クレアチニン値を2.0mg/dl以上におき，腎不全患者のみを対象としている[5]．堀尾らの式は腎疾患患者を対象として，推定式にBMIの項を加えて肥満の特徴加味して作成された[4]．したがって，今回の対象のように腎機能が広範囲に亘る場合，C-Gの式以外では，いずれもずれが出てしまう結果となったのは，式の作成経緯による要素も大きいと考えられる．

今回，臨床の現場では安定した時期より外来や急性期での腎機能評価を必要とするため，疾患による除外は設けず，脳血管障害，感染症，経口摂取不良，利尿剤，補液などの様々な基礎疾患，治療を有する高齢者を対象に行った．推定式と実測値の乖離に関して，実測値が大きい場合は，輸液や降圧剤など腎血流量を増加させる治療が関与していた場合が多かった．この場合は臨床的には大きな実害は考えられない．一方，実測値が推定式より小さい場合は，相対的な薬物の過量投与など安全管理上

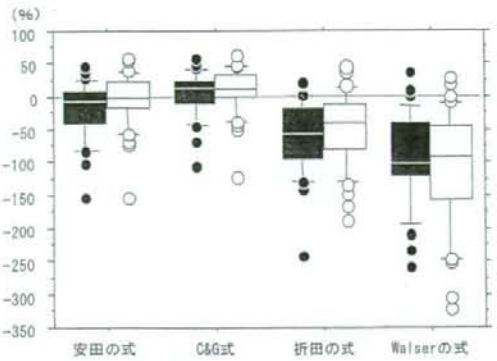

図5　超高齢者男女別において各推定式による推定値と実測値とのずれを箱ひげ図で％表示したもの
縦軸（実測値－推定値）×100/実測値
●男性
○女性

も問題となる．今回の検討では，腎不全，癌，乏尿，コントロール不良の糖尿病，胸水，腹水など複数の病態が重なる重症例で，有効循環血液量も日々変動しうる症例であった．このような症例に救急外来で遭遇した場合，血清クレアチニンから推定されるCcrの精度が低い可能性があることを銘記すべきであろう．Scrについては6.9までの高値も含まれているが，高値を除いた検討を行っても相関に大きな変化は見られなかった．全式において84歳までの前期及び後期高齢者群と85歳以上の超高齢者群に分け，相関を比較したところ，超高齢者群での相関が低い傾向にあり，超高齢者群での合併疾患の増加の影響が示唆される．これらを考慮しても，4種の推定式を比べると相関係数が最も高いC&G式が本邦超高齢者におけるCcr推定式として最適と考えられた．

超高齢者群を男女にわけC&Gの相関係数を比較したところ，男性0.841女性0.690と男性の相関が高い傾向にあった．また，回帰係数を比較したところ男性ではC&G式，女性では安田の式が1に近い値を示した．85歳以上の男性に安田の式を用いると過大評価する可能性があり，85歳以上の女性にC&G式を用いると過小評価する可能性がある．

一方，前期及び後期高齢者群の回帰係数を比較したところ男女ともに安田の式が1に近い値を示した．超高齢者の筋肉量について本邦での正確なデータは少ないが，中島らによれば70歳以降男性では上腕筋周囲，上腕筋面積が急速に減少するが女性ではほとんど変わらない[7]ことから女性の筋肉減少が時代とともに変化し，推定式の再構築が迫られている可能性があり，今後の検討課題と思われた．

本研究の限界として，膀胱留置カテーテルの適応がない蓄尿不可能症例を除外していることがあげられる．具体的には尿失禁症例や，認知症などが含まれるが，これらの症例に対してカテーテル留置を行ってクレアチニンクリアランスを測定し，高齢者全体に対するの推定式の良否を判断する研究は今後の課題であろう．

結　語

超高齢者において，正常値から腎不全を含む範囲の腎機能の判定に，24時間クレアチニンクリアランスの実測値と，すでに発表されている4つの式から求めた推定値とを比較して，超高齢者での推定式の有用性を検討した．4つの推定式のうち，C-Gの式はこの研究の目的にもっとも合致していた．一方，安田の式（高齢者，Scr: 1.4mg/dl以下），Wの式（Scr　2.0mg/dl以上）はいずれもその適用の目的の範囲で，また堀尾の式は腎疾患群内で有用と思われた．

全体として，臨床的に使用するうえでC&G式が最も優れているが，超高齢者への適用に当たっては，10%程度，推定値が低く求まるので，補正が望ましい．

今後超高齢者については，体格，サルコペニアの時代的変遷を考慮して改訂していく必要がある．

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Creatinine clearance estimation in the extremely elderly subjects

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Abstract

Background: It has been reported that elderly outpatients take at least 6 different kinds of medication.

Purpose: To know which formula will best predict creatinine clearance, because 24-hour urine collection is difficult for elderly outpatients.

Patients and Methods: We compared four types of formulae (Cockcroft & Gault, Yasuda, Orita, Walser) to estimate creatinine clearance using serum creatinine of 143 elderly inpatients (73 men, 70 women, mean age 82.9 ± 8.6 years old) including 67 extremely elderly people with various underlying diseases.

Result: The formula of Cockcroft and Gault showed the best correlation with creatinine clearance in the extremely elderly subjects ($r = 0.74$) as well as in people under 85 years ($r = 0.76$). However, the estimated values of the extremely elderly women were lower than actual creatinine clearance.

Conclusion: The formula of Cockcroft and Gault is the best predictive equation of creatinine clearance, except in the extremely elderly women.

Key words: *Extremely elderly, Creatinine clearance, Predicting formula, Cockcroft & Gault's formula, Yasuda's formula*
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