Cystatin C in a composite risk score for mortality in patients with infective endocarditis: a cohort study

Christian Bjurman, Ulrika Snygg-Martin, Lars Olaison, Michael L X Fu, Ola Hammarsten

ABSTRACT

Objective: To develop a multimarker prognostic score for infective endocarditis (IE).

Design: Retrospective case–control.


Participants: 125 patients with definite IE.

Primary outcome measures: 90-day and 5-year mortality.

Results: Mean age was 62.7±17 years. The 90-day and 5-year mortality was 10.4% and 33.6%, respectively. CysC levels at admission and over 20% increases in CysC levels during 2 weeks of treatment were prognostic for 90-day and 5-year mortality independent of creatinine estimated glomerular filtration rate. In multivariate analyses, CysC (OR 5.42, 95% CI 1.90 to 15.5, p=0.002) and age (OR 1.06, 95% CI 1.02 to 1.10, p=0.002) remained prognostic for 5-year mortality. NT-proBNP, TnT, C reactive protein and interleukin 6 were also linked to prognosis. A composite risk scoring system using levels of CysC, NT-proBNP, age and presence of mitral valve insufficiency was able to separate a high-risk and a low-risk group.

Conclusions: CysC levels at admission and increase in CysC after 2 weeks of treatment were independent prognostic markers for both 90-day and 5-year mortality in patients with IE. A multimarker composite risk scoring system including CysC identified a high-risk group.

INTRODUCTION

Infective endocarditis (IE) is an infection localised to the endocardial surface of the heart. IE mostly involves the heart valves, resulting in local valve destruction and abscess formation as well as development of vegetations with the ability to embolise to various organs. Despite major advances in both diagnostic and therapeutic procedures, neither the incidence nor the mortality of the disease have decreased in the past 30 years, with a current in-hospital mortality of 15%–20% and 1-year mortality reaching 40% in developed countries. Several epidemiological studies have identified a number of prognostic factors related to higher mortality including advanced age, Staphylococcus aureus aetiology, cerebral complications and female sex. In addition, biomarkers of inflammation like erythrocyte sedimentation rate, hypoalbuminemia, leucocytosis, C reactive protein (CRP) and procalcitonin can predict poor prognosis but are too non-specific to guide therapy in individual patients. Identification of novel prognostic biomarkers and development of a prognostic score could help to identify IE patients who might benefit from more aggressive therapeutic procedures.
Because IE often influences haemodynamics, biomarkers linked to cardiovascular mortality could have prognostic power in IE. Among these are factors released during cardiovascular stress like NT-proBNP, MR-proANP, copeptin and troponin T (TnT), which are linked to poor prognosis in heart failure, coronary syndromes and sepsis. Markers of renal function like creatinine, estimated glomerular filtration rate (eGFR) and cystatin C (CysC) might also be able to predict prognosis in patients with IE similar to their ability to predict cardiovascular mortality. In this study, we analysed clinical factors and cardiovascular biomarkers in blood samples collected at admission and after 2 weeks of therapy among patients with definite IE and examined their ability to predict 90-day and 5-year mortality. Our primary goal was to develop a prognostic score in IE.

METHODS

In this single-centre retrospective cohort study, patients with IE treated between 1999 and 2005 at the Department of Infectious Diseases, Sahlgrenska University Hospital, University of Gothenburg, Gothenburg, Sweden, were registered between 1 February 1999 and 3 December 2005. During this time, 196 patients were diagnosed with definite IE according to the modified Duke criteria and 125 patients had a blood sample drawn at diagnosis and stored and were therefore included in the study. After 2 weeks of treatment, 120 of the 125 patients had a second blood sample drawn. Of all 196 IE patients recorded from 1999 to 2005, 13 patients died (6.6%) within 90 days and 43 patients died within 5 years (20.9%). Among the 125 patients with an available admission blood sample, the 90-day mortality was 10.4% and the 5-year mortality was 33.6%. Information regarding mortality was collected from the hospital’s registry of administrative data. The study was approved by the Ethical Committee at the University of Gothenburg. All patients were followed for up to 5 years or until death occurred (mean 1449.1±636.8 days).

Clinical data

Demographic and clinical information regarding age, sex, bacterial aetiology, native and prosthetic valve IE, left ventricular ejection fraction (LVEF), comorbidities and surgery during active IE were obtained from the endocarditis database. The study design included analysis of blood samples at admission and after 2 weeks of treatment. The indications for surgery in Sweden are presented elsewhere.

Laboratory analyses

Serial blood samples were obtained during the hospital stay and stored at –70°C until analysis. The first sample was taken at admission and the second sample 2 weeks later. NT-proBNP was analysed by Elecsys proBNP assay (Roche Diagnostics, Rotkreuz, Switzerland). CysC was analysed in serum using reagents from Dako and the Modular P 2551. Creatinine-based eGFR was calculated using ‘The Modification of Diet in Renal Disease’ (MDRD) formula. TnT was analysed by using The Elecsys Troponin T high-sensitivity assay (Roche Diagnostics). All biomarkers were analysed on frozen serum samples in a single run. All other laboratory parameters examined were part of the routine laboratory services provided by the Clinical Chemistry Laboratory, Sahlgrenska University Hospital.

Echocardiography

All patients were examined by transthoracic and transesophageal echocardiography at least once during the study period. Echocardiographic criteria for IE and degrees of valve insufficiency were evaluated. LVEF was calculated from long-axis planes (two-, three- and four-chamber views) of the heart.

Statistical analysis

Multiple logistic regression models were used to evaluate possible associations between serum levels of biomarkers (NT-proBNP, TnT, creatinine and CysC) and clinical variables including age, sex, echocardiographic parameters and infectious agents and underlying diseases. Univariate comparisons between groups were calculated using conventional t tests. Mann–Whitney U tests were used for non-parametric comparisons of medians. Dichotomous variables were analysed using the χ² test. Receiver operating characteristic curves were used to assess the prognostic properties of biomarkers. The log-rank test was used to compare different strata in Kaplan–Meier analyses of survival. Statistical analyses were performed with SPSS V.19. All probabilities were two-tailed, and p values <0.05 were regarded as significant. ORs with CIs were collected from outputs from logistic regression analyses. The coefficient of determination (R²) was calculated in Microsoft Excel 2007 using Spearman’s correlation to assess the strength of the correlation between CysC change and mortality. The add-in Analyse-it was used to compare AUCs between receiver operating characteristic curves. The study population was chosen to get a power of over 90% for detecting clinically relevant associations between CysC, NT-proBNP and mortality (expected OR for mortality of at least 2 for each SD increase in the independent variable at a study population of 125 in logistic regression).

No missing data existed for the variables included in the prognostic score, but for other tested variables, cases sometimes were excluded if data were missing, although no more than two cases in each analysis had to be excluded due to a high degree of data availability.

RESULTS

The mean age among the 125 IE patients was 62.7±16.9 years, 64.8% were men and S aureus infection was seen in 28.0% of the patients (supplementary table 1). Vegetations on aorta, mitralis and tricuspidalis were seen in 50.4%, 44.0% and 4.0%, respectively. Prosthetic valve endocarditis was diagnosed in 28 patients.
(22.4%) of the patients, and 14 (11.2%) had a pacemaker. Vegetations on pacemaker leads were seen in four of these patients. Most of the patients (91.6%) had LVEF over 40%, and 34.5% underwent heart surgery during antibiotic treatment. Clinical parameters correlating with 5-year mortality included age, history of hypertension and mitral valve insufficiency (MI) but not ejection fraction (supplementary table 1). Aminoglycoside use and duration of aminoglycoside therapy were positively correlated with 5-year survival. No associations were found between the presence of emboli and 5-year survival, biomarker levels or clinical variables examined in the study (data not shown).

In the univariate analysis, CysC levels at admission were associated with both 90-day (OR 5.7, 95% CI 2.2 to 14.7, p<0.001) and 5-year mortality (OR 7.1, 95% CI 2.6 to 19.5, p<0.0001, figure 1). CysC increases over 20% between admission and after 2 weeks of treatment (supplementary figure 1) were also associated with increased 5-year mortality (OR 2.8, 95% CI 1.20 to 6.6, p=0.017). The relative and absolute changes of all biomarkers were evaluated, but no significant associations with prognosis were found except for CysC.

All eight patients with CysC over 2.1 mg/l died within 5 years. CysC levels and increase over 20% remained significant prognostic indicators for 5-year mortality with similar ORs when alternative multivariate models, including creatinine eGFR or baseline creatinine, were applied (supplementary table 2).

The area under the receiver operator characteristic curve (AUC) for predicting 5-year mortality was 0.70 (95% CI 0.60 to 0.80, p<0.001) for CysC levels at admission and 0.74 (95% CI 0.65 to 0.83, p<0.0001) for CysC levels after 2 weeks of treatment. CysC had a significantly higher AUC compared with creatinine (0.62, 95% CI 0.51 to 0.73, p=0.0042 for difference between AUC for CysC and creatinine after 2 weeks of treatment). Mean creatinine was significantly higher among patients who died within 5 years (table 1). In contrast, median creatinine was not significantly different among patients who died or lived after 5 years.

In the univariate analysis, log NT-proBNP, GFR, creatinine, age, MI and hypertension were linked to poor prognosis, whereas copeptin and MR-proANP did not reach statistical significance. CRP, interleukin 6 (IL-6) and TnT at 2 weeks, but not at admission, were also linked to prognosis (tables 1 and 2). No sex-based differences were present. There was no association between surgery and prognosis.

The four risk factors with the highest AUC for death within 5 years that appeared to be independent from each other were used to generate a composite risk score where each factor added 1 point. The factors included in the score were CysC over 1.2 mg/l, NT-ProBNP over 2000 ng/l, presence of any grade of MI and aged 70 years or older. The AUC of the risk score was 0.74 (95% CI 0.70 to 0.87, p<0.001). If substituting CysC for eGFR calculated from creatinine levels, the AUC decreased to 0.67 (95% CI 0.57 to 0.78).

Patients with a risk score of 0–2 had a significantly better prognosis (11% (8/71) died within 5 years) compared with those with a score of 3–4 (63% (34/54) died within 5 years, p<0.0001) (figure 2). No significant difference in prognosis could be found between patients differing by 1 point. The score’s ability to separate patient prognosis was improved when the 34.5% of patients that underwent cardiac surgery were excluded (0–2 points 7% (3/41), 3–4 points 66% (22/33) died within 5 years, p<0.0001). The composite risk score also predicted death within 90-days (0–2 points 0% (0/71), 3–4 points 24.1% (13/54) died within 90 days, p<0.0001).

Furthermore, dividing the cohort based on a score of 0–2 or 3–4 predicted 5-year mortality in patients with left-sided IE (OR 14.6, 95% CI 5.55 to 38.2 p<0.001), left-sided IE that did not undergo surgery (OR 25.7, 95% CI 6.35 to 103.7, p<0.001) and S aureus-infected left-sided IE that did not undergo surgery (OR 31.5, 95% CI 2.35 to 422.3, p=0.009). Lastly, the score was also able to predict mortality if the MI parameter was excluded (OR 2.30, 95% CI 1.41 to 3.72, p=0.001) indicating that the composite score was not reliant on the MI parameter and was able to predict mortality in important subgroups of IE.

**DISCUSSION**

CysC levels at admission, CysC levels after 2 weeks and over 20% increases in CysC levels during 2 weeks of treatment were prognostic for mortality in patients with definite IE. The combination of CysC levels and three other risk factors generated a powerful risk score.
CysC is a small 13 kDa cysteine protease inhibitor produced at a constant rate by all nucleated human cells tested. CysC is cleared predominantly by renal filtration and is most often used as a replacement for creatinine as a marker of GFR. CysC is regarded as a more accurate marker of kidney function than creatinine (reviewed in Lassus and Harjola14). CysC also offers superior ability to diagnose acute kidney injury17 and declining GFR18 compared with creatinine. Furthermore, several studies have shown that elevated CysC is a strong risk factor for adverse cardiovascular prognosis in older people even when creatinine levels are normal.19 Increased CysC levels indicate a future risk of developing heart failure,20 as well as a poor prognosis among patients with already established heart failure,21 independent of creatinine levels. Therefore, CysC is a marker of kidney function and prognosis that outperforms creatinine in most studies.

The associations between CysC levels and prognosis in our study might reflect that IE itself or nephrotoxic agents used during treatment of IE impairs kidney function. The ability of CysC to more correctly predict

Table 1 Laboratory characteristics of IE patients

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total</th>
<th>Dead*</th>
<th>Alive*</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRP (mg/l) (at admission)</td>
<td>58.6±57.9</td>
<td>61.1±54.7</td>
<td>57.3±64.3</td>
<td>0.72</td>
</tr>
<tr>
<td>CRP (mg/l) (after 2 weeks)</td>
<td>28.0±49.3</td>
<td>45.0±26.7</td>
<td>20.7±78.2</td>
<td>0.013</td>
</tr>
<tr>
<td>CRP (mg/l) (peak level)</td>
<td>139.9±94.1</td>
<td>160.8±86.5</td>
<td>130.5±107.3</td>
<td>0.12</td>
</tr>
<tr>
<td>IL-6 (ng/l) (at admission)</td>
<td>45.3±112.1</td>
<td>43.5±134.5</td>
<td>46.3±42.2</td>
<td>0.90</td>
</tr>
<tr>
<td>IL-6 (ng/l) (after 2 weeks)</td>
<td>24.1±42.5</td>
<td>39.1±25.4</td>
<td>17.9±65.2</td>
<td>0.011</td>
</tr>
<tr>
<td>Hb (g/l)</td>
<td>112.2±17.3</td>
<td>109.8±17.5</td>
<td>113.2±16.9</td>
<td>0.48</td>
</tr>
<tr>
<td>Creatinine (µmol/l)</td>
<td>95.3±66.6</td>
<td>123.2±26.7</td>
<td>81.4±104.1</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>eGFR (ml/min/1.73m²) (MDRD)</td>
<td>81.0±41.2</td>
<td>67.3±44.1</td>
<td>87.0±29.6</td>
<td>0.016</td>
</tr>
<tr>
<td>NT-proBNP (ng/l) (at admission)</td>
<td>106.9±226.1</td>
<td>156.1±204.7</td>
<td>82.3±259.3</td>
<td>0.083</td>
</tr>
<tr>
<td>NT-proBNP (ng/l) (after 2 weeks)</td>
<td>75.7±124.2</td>
<td>109.7±104.4</td>
<td>61.1±157.6</td>
<td>0.048</td>
</tr>
<tr>
<td>Incremental NTnT (%)</td>
<td>40.8%</td>
<td>44.4%</td>
<td>39.3%</td>
<td>0.60</td>
</tr>
<tr>
<td>NT-proANP (pmol/l) (at admission)</td>
<td>327.6±3363.6</td>
<td>4782.3±2042.7</td>
<td>1660.8±4633.1</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>NT-proANP (pmol/l) (after 2 weeks)</td>
<td>29.0±21.2</td>
<td>0.42</td>
<td>59.2±0.17</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>CysC (mg/l) (at admission)</td>
<td>1.34±0.67</td>
<td>1.73±0.35</td>
<td>1.15±0.94</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>CysC (mg/l) (after 2 weeks)</td>
<td>1.45±0.81</td>
<td>0.99±0.65</td>
<td>0.66±0.99</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>CysC (&gt;20% increase) (%)</td>
<td>26.7%</td>
<td>41.7%</td>
<td>20.2%</td>
<td>0.015</td>
</tr>
<tr>
<td>MR-proANP (pmol/l) (at admission)</td>
<td>327.6±199.3</td>
<td>378.8±227.0</td>
<td>302.0±452.7</td>
<td>0.21</td>
</tr>
<tr>
<td>MR-proANP (pmol/l) (after 2 weeks)</td>
<td>290.2±39.6</td>
<td>249.2±219.0</td>
<td>218.8±135.1</td>
<td>0.15</td>
</tr>
<tr>
<td>Copeptin (pmol/L) (at admission)</td>
<td>23.3±29.0</td>
<td>30.1±24.3</td>
<td>19.9±59.2</td>
<td>0.17</td>
</tr>
<tr>
<td>Copeptin (pmol/L) (after 2 weeks)</td>
<td>29.0±123.2</td>
<td>31.7±21.2</td>
<td>0.42</td>
<td></td>
</tr>
</tbody>
</table>

*After 5 years follow-up.

Table 2 ORs* for mortality among IE patients

<table>
<thead>
<tr>
<th>Variable†</th>
<th>OR (all patients)</th>
<th>p Value</th>
<th>OR (no surgery‡)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>1.06 (1.03–1.10)</td>
<td>&lt;0.001</td>
<td>1.09 (1.03–1.14)</td>
<td>0.001</td>
</tr>
<tr>
<td>MI (all degrees)</td>
<td>2.94 (1.30–6.67)</td>
<td>0.010</td>
<td>5.45 (1.84–16.2)</td>
<td>0.002</td>
</tr>
<tr>
<td>Hypertension</td>
<td>3.12 (1.37–7.10)</td>
<td>0.007</td>
<td>2.81 (1.03–7.62)</td>
<td>0.043</td>
</tr>
<tr>
<td>CRP (mg/l) (after 2 weeks)</td>
<td>1.01 (1.00–1.02)</td>
<td>0.006</td>
<td>1.02 (1.00–1.04)</td>
<td>0.025</td>
</tr>
<tr>
<td>Creatinine (µmol/l)</td>
<td>1.02 (1.00–1.02)</td>
<td>0.006</td>
<td>1.02 (1.00–1.04)</td>
<td>0.025</td>
</tr>
<tr>
<td>GFR (MDRD)</td>
<td>0.98 (0.97–1.00)</td>
<td>0.012</td>
<td>0.98 (0.96–1.00)</td>
<td>0.041</td>
</tr>
<tr>
<td>logNT-proBNP (ng/l) (at admission)</td>
<td>12.2 (4.28–34.9)</td>
<td>0.001</td>
<td>23.2 (4.68–115.0)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>logNT-proBNP (ng/l) (after 2 weeks)</td>
<td>5.91 (2.43–14.4)</td>
<td>0.001</td>
<td>9.44 (2.83–31.5)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>CysC (mg/l) (at admission)</td>
<td>7.11 (2.59–19.5)</td>
<td>0.001</td>
<td>37.5 (4.58–308.1)</td>
<td>0.001</td>
</tr>
<tr>
<td>CysC (mg/l) (after 2 weeks)</td>
<td>2.55 (1.37–4.76)</td>
<td>0.003</td>
<td>41.7 (5.43–320.6)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>CysC (mg/l) (&gt;20% increase)</td>
<td>2.82 (1.20–6.59)</td>
<td>0.017</td>
<td>2.60 (0.90–7.50)</td>
<td>0.080</td>
</tr>
<tr>
<td>TNnT (ng/l) (after 2 weeks)</td>
<td>1.00 (1.00–1.01)</td>
<td>0.059</td>
<td>1.03 (1.01–1.05)</td>
<td>0.008</td>
</tr>
<tr>
<td>IL-6 (ng/l) (after 2 weeks)</td>
<td>1.02 (1.00–1.03)</td>
<td>0.044</td>
<td>1.10 (1.04–1.17)</td>
<td>0.002</td>
</tr>
</tbody>
</table>

*From multiple logistic regression.
†Insignificant predictors excluded from the table.
‡Subgroup analysis of patients who did not undergo surgery.

CRP, C reactive protein; GFR, glomerular filtration rate; IL-6, interleukin 6; MI, mitral valve insufficiency.
GFR among older people and to respond to rapid changes in GFR compared with creatinine could explain the stronger association between CysC levels and IE prognosis compared with creatinine levels.

There are different conceivable explanations for decreased kidney function in IE. One factor could be decreased cardiac output during the acute phase of IE. Although there was no correlation between LVEF and prognosis (supplementary table 1), levels of the heart failure biomarker, NT-proBNP and prevalence of MI were significantly higher among patients with poor prognosis. In addition, levels of TnT after 2 weeks of treatment were associated with prognosis. TnT levels are prognostic and therapeutic procedures, and we still have limited ability to find the patients that should be considered for more aggressive treatment. In this light, this novel risk score could add decisional information and allow for a multifactorial judgement of patients and consideration for more active intervention like heart valve replacement or surgical removal of vegetations.

A potential problem with the current study was that 36.2% of the patients treated for IE during the study period (71/196) lacked stored blood samples. In addition, there was a bias for patients with a worse prognosis in the study group. On the other hand, the study group of 125 IE patients had a 5-year prognosis (66.4% 5-year survival) closer to the 60% 5-year survival reported in other studies. Furthermore, data on haemodynamic parameters on admission and during the hospital stay were not recorded. As this was a single-centre study, our findings must be validated before the risk score can be included in clinical routine.
In summary, a prognostic score including CysC over 1.2 mg/l, NT-proBNP over 2000 ng/l, presence of any grade of MI and aged 70 years or older could identify a high-risk and low-risk group in IE.

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**Competing interests** None.

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**Provenance and peer review** Not commissioned; externally peer reviewed.

**Data sharing statement** There are no additional data available.

**REFERENCES**


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