

BMJ Open Genome-wide association study of perioperative myocardial infarction after coronary artery bypass surgery

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ABSTRACT

Objectives: Identification of patient subpopulations susceptible to develop myocardial infarction (MI) or, conversely, those displaying either intrinsic cardioprotective phenotypes or highly responsive to protective interventions remain high-priority knowledge gaps. We sought to identify novel common genetic variants associated with perioperative MI in patients undergoing coronary artery bypass grafting using genome-wide association methodology.

Setting: 107 secondary and tertiary cardiac surgery centres across the USA.

Participants: We conducted a stage I genome-wide association study (GWAS) in 1433 ethnically diverse patients of both genders (112 cases/1321 controls) from the Genetics of Myocardial Adverse Outcomes and Graft Failure (GeneMAGIC) study, and a stage II analysis in an expanded population of 2055 patients (225 cases/1830 controls) combined from the GeneMAGIC and Duke Perioperative Genetics and Safety Outcomes (PEGASUS) studies. Patients undergoing primary non-emergent coronary bypass grafting were included.

Primary and secondary outcome measures:

The primary outcome variable was perioperative MI, defined as creatine kinase MB isoenzyme (CK-MB) values $\geq 10\times$ upper limit of normal during the first postoperative day, and not attributable to preoperative MI. Secondary outcomes included postoperative CK-MB as a quantitative trait, or a dichotomised phenotype based on extreme quartiles of the CK-MB distribution.

Results: Following quality control and adjustment for clinical covariates, we identified 521 single nucleotide polymorphisms in the stage I GWAS analysis. Among these, 8 common variants in 3 genes or intergenic regions met $p < 10^{-5}$ in stage II. A secondary analysis using CK-MB as a quantitative trait (minimum $p = 1.26 \times 10^{-3}$ for rs609418), or a dichotomised phenotype based on extreme CK-MB values (minimum $p = 7.72 \times 10^{-6}$ for rs4834703) supported these findings. Pathway analysis revealed that genes harbouring top-scoring variants cluster in pathways of biological relevance to extracellular matrix remodelling, endoplasmic reticulum-to-Golgi transport and inflammation.

Strengths and limitations of this study

- This is the first genome-wide association study of perioperative myocardial infarction, using prospective cohorts of cardiac surgical patients, standard definitions of the primary phenotype and full adjustment for non-genetic risk factors.
- We conducted comprehensive and complementary single marker and pathway-based genome-wide association analyses.
- The study is powered to detect relatively large effect sizes.
- Rare genetic variant effects not analysed.
- Predominantly Caucasian cohort, thus findings cannot be generalised to other populations.

Conclusions: Using a two-stage GWAS and pathway analysis, we identified and prioritised several potential susceptibility loci for perioperative MI.

INTRODUCTION

Despite advances in surgical techniques and pharmacological therapy, the incidence of myocardial infarction (MI) after coronary artery bypass grafting (CABG) remains as high as 19%, and is associated with increased mortality and long-term morbidity.¹ Strategies to identify subpopulations of patients at risk for developing large myocardial infarcts on the one hand, or those displaying an intrinsic cardioprotective state on the other hand, remain high-priority knowledge gaps and could inform selection of more specific protective agents.²

The evidence for heritability of MI is striking, supported both by family studies and, recently, by a number of well powered and replicated genome-wide association studies (GWAS), which primarily implicate common genetic variants at the 9p21 locus in multiple racial groups.^{3–6} However, although family-



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based methods are not practical for studying perioperative MI (PMI), its genetic basis is strongly suggested by several observations, including wide variability in incidence and severity that is poorly explained by clinical and procedural risk factors, different racial susceptibility profiles and results from preclinical animal models. Indeed, extensive genetic variability has been found in biological pathways implicated in the pathophysiology of postoperative MI, such as the complex acute inflammatory response to cardiac surgery. Mounting evidence for heritability of a proinflammatory state suggests that individual genetic history may also significantly modulate the magnitude of postoperative inflammatory response after cardiac surgery.⁷ Yet only a few studies have identified allelic associations with altered susceptibility to myocardial ischaemia-reperfusion injury in cardiac surgical populations, all based on a candidate gene association approach.^{8–12} Thus, the overall influence of common genetic variation on the incidence of PMI remains poorly understood.

Recently, integrated testing of genes involved in the same biological pathway has emerged as an alternative strategy for evaluating the combined effects of multiple genetic variants with small effect size on a disease phenotype.^{13–15} Given the polygenic nature of disease susceptibility, this approach is increasingly being used to identify groups of gene variants with shared cellular function that are enriched for disease, while also improving the statistical power of GWAS. In this study, we adopted this strategy by first employing genome-wide association methodology to identify common genetic variants associated with PMI after CABG, followed by pathway-based analyses to uncover biological mechanisms of relevance to PMI.

METHODS

The study design and reporting of the results follow the recommendations by 'Strengthening the Reporting of Genetic Association Studies' (STREGA).¹⁶ We performed a joint two-stage¹⁷ GWAS combined with a pathway analysis approach.

Patient populations

The stage I cohort (discovery cohort) comprised 1493 ethnically diverse subjects who underwent an isolated CABG with cardiopulmonary bypass for the first time and were enrolled between 2002 and 2003 in the Institutional Review Board (IRB) approved Genetics of Myocardial Outcomes and Graft Failure (GeneMAGIC) ancillary substudy of the multicentre Project of Ex-vivo Vein Graft Engineering via Transfection (PREVENT-IV).¹⁸ Of those, 1433 patients met eligibility requirements after applying quality control criteria and excluding patients with missing genotypes or phenotypic information.

In stage II, we tested the top genetic variants in an expanded data set in which an additional 622 patients of self-reported European ancestry were added to the

discovery data set, leading to a total of 2055 patients. The additional patients underwent CABG with cardiopulmonary bypass between 1997 and 2006 as part of the Perioperative Genetics and Safety Outcomes Study, an IRB-approved longitudinal study at the Duke University Medical Center.^{11 12}

Definition of PMI

PMI was defined according to the universal definition of MI¹⁹ as an elevation in the plasma level of creatine kinase MB isoenzyme (CK-MB) that was >10 times the upper limit of normal, as measured by a core laboratory within 24 h after surgery, and that was not attributable to an intervening clinical event or preoperative MI (adjudicated by the PREVENT-IV Clinical Events Committee).¹⁸

Genotyping and quality controls

Genomic DNA was isolated from whole blood or saliva using standard procedures. Genotyping in both cohorts was performed on the Illumina Human610-Quad BeadChip at the Duke Genomic Analysis Facility. Sample and genotype quality control of data flow included assessment of call rates, gender check, cryptic relatedness, SNP missingness and the Hardy-Weinberg equilibrium, as previously described.²⁰ We used principal components derived from the EIGENSTRAT²¹ method to control for population stratification (see online supplementary methods).

Statistical analysis

Univariate regression analysis was performed to test differences in demographic, clinical and procedural characteristics between patients with and without postoperative MI; statistically significant covariates were subsequently used to adjust genetic association tests. Genome-wide association analyses performed in the stage I cohort used multivariable logistic regression models implemented in PLINK 1.07, assuming an additive genetic model, and including significant clinical covariates and the top 10 principal components to adjust for population stratification (see online supplementary table S1). Statistical significance for stage I analyses was a priori arbitrarily defined as a two-tailed $p < 0.001$, to balance between the overly conservative Bonferroni correction and type II error, given that we had an a priori defined replication data set to obviate type I error. In stage II analyses, the same clinical covariate and principal component adjustments (re-estimated for the expanded data set) were applied, with statistical significance defined as a Bonferroni adjusted p value of 0.05/number of SNPs identified in stage I, to control the overall type I error rate. Haplotype association analysis was performed in the stage II cohort for genes tagged by the significant SNPs, adjusting for the same clinical covariates and principal components. Secondary analyses were performed for the top SNPs identified in the stage II cohort, using the continuous phenotype of CK-MB values and a dichotomised extreme CK-MB

phenotype, which included participants within the first and fourth quartiles of the CK-MB distribution. For CK-MB, a linear regression model was applied with adjustment for the same set of covariates as in the primary analysis. For the extreme CK-MB subset, we re-assigned trait status as '0' for participants within the first CK-MB quartile, and '1' for participants within the fourth CK-MB quartile from the stage II cohort. Logistic regression with the same set of covariates was performed. Finally, we employed pathway analysis to prioritise association results and provide biological interpretation, using functional ontology enrichment analysis tools implemented in MetaCore (GeneGO, St. Joseph, MI; see online supplementary methods).

RESULTS

PMI was observed in 112 of 1433 patients (7.8%) and in 225 of 2055 patients (10.9%) in stage I and II cohorts, respectively (see online supplementary table S2). Aortic cross-clamp time, number of coronary artery grafts, and procedures in addition to CABG were significantly associated with PMI in stage I analyses. Stage II analyses showed that extracardiac arteriopathy and year of surgery also played significant roles. All the clinical variables identified above were included in multivariable logistic regression models to adjust the genetic association tests for potential confounders (see online supplementary table S2).

After applying quality control criteria (see online supplementary methods: A.1. Quality control of data flow), 534 390 markers were analysed for association with PMI in stage I. While none of the SNPs reached genome-wide significance (figure 1), 521 SNPs met the a priori defined discovery threshold of $p < 0.001$ (minimum $p = 2.76 \times 10^{-6}$, rs2044061 on chromosome 8) and were subsequently analysed in stage II (see online supplementary table S10). A quantile-quantile (Q-Q) plot of

observed versus expected p values showed that the population substructure was well adjusted for (see online supplementary figure S2).

In stage II analyses, eight of the 521 SNPs met the Bonferroni correction threshold ($p < 9.6 \times 10^{-5}$ for 521 SNPs). The top 2 SNPs (rs10454444 and rs10913237), located in the pregnancy-associated plasma protein A2 gene (*PAPPA2*), were in high linkage disequilibrium, with p values for stage II of 2.43×10^{-6} (OR 0.46; 95% CI 0.33 to 0.63) and 2.47×10^{-6} (OR 0.46; 95% CI 0.33 to 0.63), respectively. In addition, one intronic SNP in histone deacetylase-4 (*HDAC4*), two in the SEC24 family, member D (*SEC24D*, a member of the cytoplasmic coat protein complex II, COPII), and two located in intergenic regions were associated with PMI (table 1).

When CK-MB was tested as a quantitative trait, all eight SNPs remained significantly associated with plasma levels of CK-MB. However, rs4834703 in *SEC24D* ($p = 7.72 \times 10^{-6}$) and rs10200850 in *HDAC4* ($p = 8.26 \times 10^{-5}$) showed the strongest association, followed by the 2 SNPs in *PAPPA2* ($p = 0.0001$; table 2). When the dichotomised extreme CK-MB phenotype was studied in the stage II cohort, only the 2 SNPs located in *SEC24D* (rs4834703 and rs6822035, $p = 0.002$) and rs609418 in the intergenic region between *RFXAP* and *SMAD9* ($p = 0.001$) remained nominally significant (table 2). Overall, the rs4834703 SNP in *SEC24D* consistently showed strong association signals across postoperative MI, quantitative CK-MB and the extreme CK-MB traits.

The haplotype structures of genic regions surrounding the significant SNPs in *PAPPA2*, *HDAC4* and *SEC24D* are shown in online supplementary figure S3, and the results of haplotype analysis are shown in table 3 and online supplemental table S3. Haplotype analysis performed for the linkage disequilibrium blocks containing the significant markers showed that the A-A haplotype (rs6822035, rs10518325) in *SEC24D* had the most

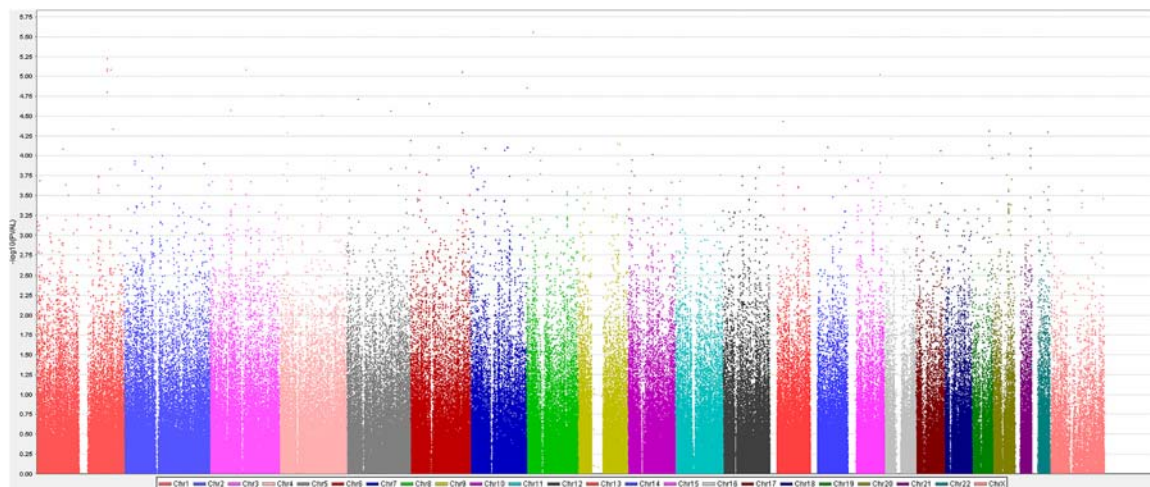


Figure 1 Manhattan plot of genome-wide association with perioperative myocardial infarction in stage I analysis. The x axis represents the genome in physical order (coloured by chromosome); the y axis showing $-\log_{10}(p)$ for all single nucleotide polymorphisms (SNPs). None of the SNPs reached genome-wide significance ($p < 9.09 \times 10^{-8}$), but 521 SNPs met the prespecified discovery threshold $p < 0.001$ for inclusion in stage II analyses (minimum $p = 2.76 \times 10^{-6}$, rs2044061 on chromosome 8).

Table 1 Top eight SNP associated with postoperative myocardial infarction

Chr	SNP	Base pair	Gene symbol	Stage I: discovery data set*				Stage II: expanded data set*			
				MAF		p Value	OR (95% CI)	MAF		p Value	OR (95% CI)
				Controls N=1321	Cases N=112			Controls N=1830	Cases N=225		
1	rs10489478	176 566 350	PAPPA2	0.18	0.09	2.67×10 ⁻⁴	0.41 (0.25 to 0.66)	0.18	0.11	0.47 (0.34 to 0.65)	4.70×10 ⁻⁶
1	rs10913237	176 630 416	PAPPA2	0.18	0.09	1.85×10 ⁻⁴	0.39 (0.24 to 0.64)	0.19	0.11	0.46 (0.33 to 0.63)	2.47×10 ⁻⁶
1	rs10454444	176 649 181	PAPPA2	0.18	0.09	1.81×10 ⁻⁴	0.39 (0.24 to 0.64)1	0.19	0.11	0.46 (0.33 to 0.63)	2.43×10 ⁻⁶
2	rs10 200 850	240 234 901	HDAC4	0.06	0.13	4.34×10 ⁻⁴	2.22 (1.42 to 3.46)	0.06	0.11	2.23 (1.57 to 3.17)	8.18×10 ⁻⁶
4	rs4834703	119 691 624	SEC24D	0.09	0.18	3.13×10 ⁻⁵	2.27 (1.54 to 3.34)	0.09	0.16	1.98 (1.47 to 2.66)	6.80×10 ⁻⁶
4	rs6822035	119 710 421	SEC24D	0.29	0.40	2.59×10 ⁻⁴	1.73 (1.29 to 2.33)	0.28	0.36	1.65 (1.32 to 2.05)	9.55×10 ⁻⁶
12	rs2303970	74 471 340	TRHDE LOC552889	0.48	0.35	3.51×10 ⁻⁴	0.58 (0.43 to 0.78)	0.48	0.36	0.62 (0.50 to 0.76)	8.89×10 ⁻⁶
13	rs609418	37 417 427	RFXPAP SMAD9	0.25	0.35	3.14×10 ⁻⁴	1.73 (1.28 to 2.33)	0.25	0.33	1.67 (1.34 to 2.09)	5.81×10 ⁻⁶

*Adjusted for clinical characteristics including extracardiac arteriopathy, recent myocardial infarction, procedure other than CABG only, year of surgery, number of diseased vessels and aortic cross-clamp time.

HDAC4, histone deacetylase-4; PAPPA2, pregnancy-associated plasma protein A2; RFXAP, regulatory factor X-associated protein; SEC24D, SEC24-related protein D; SMAD9, mother against decapentaplegic homolog 9; TRHDE, thyrotropin-releasing hormone-degrading ectoenzyme; intergenic region is expressed by two flanking genes with 'I' in between. CABG, coronary artery bypass grafting; Chr, chromosome; MAF, minor allele frequency (based on the discovery data set); SNP, single nucleotide polymorphisms.

significant association with postoperative MI ($p=5.54\times 10^{-7}$, OR 1.87; 95% CI 1.46 to 2.39, table 3).

In multivariate risk factor-adjusted stage I and II analyses, we found no evidence for association between genetic variation at the 9p21 locus and incident postoperative MI, including the rs10116277 SNP previously associated with MI and mortality in non-surgical²⁰ and cardiac surgical^{8 9} cohorts (see online supplementary figure S4).

The top 10 enriched pathway maps for the stage I analysis SNPs are shown in online supplementary figure S5. The most significant were 'Cell adhesion: extracellular matrix remodelling' and 'Cytoskeleton remodelling: TGF, WNT, and cytoskeletal remodelling' (enrichment p value= 1.9×10^{-8} and 7.3×10^{-6} , respectively). The most significant canonical pathway maps in stage I and II comparative analyses were 'Immune response: NFAT signalling and leucocyte interaction' and 'Cell adhesion: extracellular matrix remodelling' ($p=7.2\times 10^{-4}$ and 1.1×10^{-3} , respectively; see online supplementary tables S4 and 5).

DISCUSSION

We present the first report of a two-stage GWAS involving 225 PMI cases and 1830 controls. After accounting for clinical and procedural covariates, we identified eight significant SNPs mapped to three genes (*PAPPA2*, *HDAC4*, *SEC24D*) and two intergenic regions. The most significant association with PMI was exhibited by rs10454444 in *PAPPA2* ($p=2.43\times 10^{-6}$) in single-marker analyses, by *SEC24D* A-A (rs6822035, rs10518325, $p=5.54\times 10^{-7}$) in haplotype analyses, and by *SEC24D* SNPs in secondary analyses when CK-MB was evaluated as a quantitative trait (rs4834703, $p=2.43\times 10^{-6}$) or as an extreme CK-MB phenotype (rs4834703 and rs6822035, $p=0.002$).

Among these eight SNPs, rs4834703 in *SEC24D* showed the most consistently strong association with all three phenotypes evaluated in this study. The transport protein *SEC24D* is an integral component of cytoplasmic COPII transport machinery, a key player in vesicle trafficking of secretory proteins from the endoplasmic reticulum (ER) to the Golgi apparatus for delivery to downstream compartments. COPII is responsible for cargo sorting and vesicle morphogenesis, with roles in modulating ER exit, cell surface transport, lipid secretion and cholesterol biosynthesis, and function of G protein-coupled receptors. Conditions of ischaemia, oxidative injury or acute phase-response result in ER stress through accumulation of misfolded proteins, which leads to activation of the unfolded protein response (UPR) signalling pathway. If the protective mechanisms activated by the UPR are insufficient, cells die by apoptosis and autophagy. However, altered expression or function of SEC24 proteins could also explain ER trapping of misfolded proteins under conditions of ER stress,^{22 23} with SEC24D being the only isoform implicated in extracellular matrix secretion.²⁴ Animal

Table 2 Association of the top eight SNP with CK-MB as a quantitative trait and as an extreme phenotype in the joint analysis data set

Chr	SNP	Base pair	Gene symbol	MAF (Overall)	CK-MB as a quantitative trait*		CK-MB as an extreme phenotype*	
					β -Coefficient	p Value	OR (95% CI)	p Value
1	rs10489478	176 566 350	<i>PAPPA2</i>	0.17	-5.40	2.27×10^{-4}	0.77 (0.574 to 1.047)	0.1
1	rs10913237	176 630 416	<i>PAPPA2</i>	0.18	-5.58	1.30×10^{-4}	0.78 (0.578 to 1.052)	0.1
1	rs10454444	176 649 181	<i>PAPPA2</i>	0.18	-5.59	1.21×10^{-4}	0.77 (0.575 to 1.043)	0.09
2	rs10200850	240 234 901	<i>HDAC4</i>	0.07	9.26	8.26×10^{-5}	1.49 (0.950 to 2.326)	0.08
4	rs4834703	119 691 624	<i>SEC24D</i>	0.10	8.54	7.72×10^{-6}	1.82 (1.242 to 2.654)	0.002
4	rs6822035	119 710 421	<i>SEC24D</i>	0.30	4.42	4.81×10^{-4}	1.48 (1.152 to 1.903)	0.002
12	rs2303970	74 471 340	<i>TRHDE</i>	0.47	-2.93	0.01	0.84 (0.669 to 1.047)	0.12
13	rs609418	37 417 427	<i>LOC552889</i> <i>RFXAP/SMAD9</i>	0.26	4.80	2.26×10^{-4}	1.56 (1.189 to 2.034)	0.001

*Adjusted for clinical characteristics including extracardiac arteriopathy, recent myocardial infarction, procedure other than CABG only, year of surgery, number of diseased vessels, and aortic cross-clamp time using either linear regression (β -coefficient) or logistic regression (OR, 95% CI) analyses.

HDAC4, histone deacetylase-4; *PAPPA2*, pregnancy-associated plasma protein A2; *RFXAP*, regulatory factor X-associated protein; *SEC24D*, SEC24-related protein D; *SMAD9*, mother against decapentaplegic homolog 9; *TRHDE*, thyrotropin-releasing hormone-degrading ectoenzyme.

CABG, coronary artery bypass grafting; Chr, chromosome; CK-MB, creatine kinase MB isoenzyme; MAF, minor allele frequency (based on the expanded data set); SNP, single nucleotide polymorphisms.

models of defects in *SEC24D* involve characteristic skeletal malformations, whereas its complete disruption results in early-embryonic lethality.²⁵ However, there are no reports of human diseases associated with genetic variation in *SEC24D*.

PAPPA2 is a metalloproteinase that regulates local insulin-like growth factor (IGF) bioavailability by specifically cleaving IGF-binding protein 5 (IGFBP-5). In experimental models of myocardial ischaemia, IGFBP-5 inhibits both myocardial IGF-1, with implications for inflammation-linked angiogenesis and repair processes,²⁶ and IGF-2, limiting its cardioprotective effects following ischaemia reperfusion.^{27–28} The related protein *PAPPA1* cleaves IGFBP-4 and is activated and released from vulnerable atherosclerotic plaques. *PAPPA1* has been extensively studied as a cardiovascular risk biomarker for the diagnosis and prognosis of acute

coronary syndrome;^{29–30} however, the role of *PAPPA2* in cardiovascular biology has not been previously reported. Consistent with our single-marker analysis findings, the GWAS pathway analysis identified significant contributions of variants in other IGF system component genes, namely IGF-2 and the IGF-1 receptor (see online supplementary figure S6 and table S5).

HDAC4, a member of the HDAC family, mediates changes in the chromatin structure by removing acetyl groups from the core histones, resulting in transcriptional repression. *HDAC4* is highly expressed in the myocardium, where it plays an important role in the regulation of gene expression and is involved in myocardial cell cycle progression, differentiation and apoptosis.³¹ Experimental HDAC inhibition is associated with a profound reduction in ischaemia-induced myocardial cell death,³¹ by triggering preconditioning effects and

Table 3 Estimated haplotype frequencies in the *SEC24D* gene and results of association tests with incidence of PMI in the stage II analysis cohort (n=2055)

SNP1	SNP2	Haplotype	Haplotype frequency		OR (95% CI)	p Value
			Patients with PMI (n=225)	Patients without PMI (n=1830)		
rs6828577	rs6822035	A-A	0.3956	0.2874	1.65 (1.33 to 2.06)	8.84×10^{-6}
rs6828577	rs6822035	G-C	0.6044	0.7126	Reference	
rs6822035	rs10518325	A-G	0.03516	0.0528	0.86 (0.43 to 1.70)	0.657
rs6822035	rs10518325	C-G	0.009083	0.02636	1.39 (0.67 to 2.90)	0.378
rs6822035	rs10518325	A-A	0.3631	0.2358	1.87 (1.46 to 2.39)	5.54×10^{-7}
rs6822035	rs10518325	C-A	0.5927	0.685	Reference	
rs10518325	rs11098451	A-A	0.03097	0.06231	0.76 (0.48 to 1.19)	0.225
rs10518325	rs11098451	G-G	0.04425	0.07845	0.87 (0.58 to 1.31)	0.509
rs10518325	rs11098451	A-G	0.9248	0.8592	Reference	

Adjusted for clinical characteristics including extracardiac arteriopathy, recent myocardial infarction, procedure other than CABG only, year of surgery, number of diseased vessels, aortic cross-clamp time.

CABG, coronary artery bypass grafting; PMI, perioperative myocardial infarction; SNP, single nucleotide polymorphism.

promoting myocardial repair. Genetic variants in HDACs are important determinants of susceptibility to cardiovascular diseases,³² suggesting functional roles for HDAC4 in modulating perioperative myonecrosis, and their potential use in predicting individual patient responsiveness to HDAC inhibition.

One of the intergenic SNPs associated with PMI (rs609418) is located near the mother against the decapentaplegic homologue 9 (*SMAD9*) gene, part of the transforming growth factor β (TGF- β) signalling pathway, which is markedly activated in the infarcted myocardium. Members of the TGF- β superfamily transduce their signal from the membrane to the nucleus via a distinct combination of transmembrane receptors and downstream effectors—the SMAD proteins.³³ TGF- β plays important and complex roles in regulating postinfarction inflammatory responses. In animal models, signalling through the SMAD transcription factors is associated with resolution of inflammation, repression of cytokine and chemokine gene synthesis, and protection against myocardial ischaemia-reperfusion injury.³⁴ Consistent with this single-locus gene association result, the bone morphogenetic protein pathway, which also transduces its signals via a SMAD9-dependent cascade, was identified as one of the top-scoring pathways in our GWAS pathway analysis ($p=5.2\times 10^{-3}$, see online supplementary table S7). Although no direct functional roles are currently attributed to this intergenic region, a query of the Regulome and Haploreg databases reports that rs609418 is located within active regulatory elements (GATA2 transcription factor binding site by ENCODE ChIP-seq and altering regulatory motifs in Gfi1 and Mef2 by the Position-Weight Matrix, see online supplementary figure S7).

Surprisingly, we have been unable to replicate previously reported associations between common genetic variants at the 9p21 locus and risk for PMI or mortality after CABG.^{8–9} Many different reasons may account for this, including inadequate sample size, variation in study design, differences in allele frequencies or variability in the definition of PMI phenotype.³⁵ Indeed, our observation is consistent with other studies showing that, although genetic variants at the 9p21 locus are associated with incident coronary artery disease (CAD), they may not be associated with the actual risk of MI.³⁶ This discrepancy between convincing associations of 9p21 with a greater burden of CAD but not with MI in the presence of underlying CAD has been further confirmed by nested case-control studies³⁷ as well as meta-analyses.^{5 38 39} Taken together, in subjects with established CAD, such as those included in our study, any lack of association of the 9p21 locus with subsequent MI could have resulted from the presence of CAD in carriers and non-carriers of the risk variants at the 9p21 locus, which seems to primarily mediate an atherosclerotic phenotype.

The strengths of our study are (1) a relatively large population of cardiac surgery patients, (2) a prospective cohort design and (3) a combination of complementary

single-marker and pathway-based genome-wide association analyses. This approach allowed us to identify genetic variants that carry only a small disease risk individually, but that jointly can contribute relatively large effects on PMI susceptibility. Furthermore, an application of results from pathway-based analysis may add structure to interpreting genomic data and allow exploration of cellular processes that functionally underpin the observed associations. Finally, by using this approach, replication of association findings at the gene and pathway level is much easier compared to replication at the individual SNP level.¹³ Of note, most of the genes identified through pathway enrichment analysis in this study encode targets for therapeutic drugs that have already been developed. Thus, by improving risk assessment and identifying allele-specific therapeutic responses, further investigation of loci and pathways prioritised in this study could yield actionable results for enhancing perioperative cardioprotection.

Several limitations are worth mentioning. Power calculations (see online supplementary results B.6.) show that, based on the current sample size and incidence of PMI, our study can detect a genotypic relative risk approximately 2 with 80% power (assuming a variant with a 10% minor allele frequency and a realistic linkage disequilibrium between the tested marker and the causal locus $D'=0.8$). Thus, although our study is the largest genetic association study of PMI conducted to date, it is powered to detect only common variants with relatively large effect sizes. Most published genetic association studies of PMI have reported larger effect sizes compared with ambulatory populations (OR range 1.79–3.97).^{8 10 11} The possibility of rare genetic variants that drive a pronounced clinical phenotype was not explored in this study, because only variants with minor allele frequencies >0.05 were assessed. Also, functional studies to further elucidate the potential biological effects of the SNPs identified were not feasible due to lack of plasma or tissue availability in the GeneMAGIC study. Finally, patients enrolled in our cohorts were predominantly Caucasian, and therefore our findings cannot be generalised to other ethnic groups.

In conclusion, we report the first GWAS in a cohort of patients at risk for MI after CABG surgery. On the basis of our integrated approach utilising primary (PMI) and secondary phenotypes (quantitative CK-MB, extreme CK-MB), single-marker analysis and pathway analysis, we identified several polymorphisms in the insulin growth factor system implicated in the regulation of extracellular matrix remodelling, as well as the ER-to-Golgi secretory pathway potentially involved in adaptive responses to ER stress. As other GWAS of PMI cohorts publish their results, we intend to collaborate on conducting a meta-analysis for this particular phenotype. While our GWAS results are intriguing, follow-up studies are needed to translate these initial findings into biological insights that could lead to predictive and therapeutic advances in perioperative care. For instance, in the

regions of confirmed associations, causal variants will only occasionally be among those directly genotyped. Moreover, GWAS detect almost exclusively the effects of common SNPs, offering limited power to capture any rare and structural variants, such as insertions, deletions, inversions and translocations. Detailed sequencing may be necessary to further characterise the genetic variations in the PMI-associated regions to enhance the identification of causal variants. Furthermore, as in most cases, the functions of identified genes and their variants, as well as the mechanisms by which they may contribute to PMI pathophysiology, are largely unknown. Currently, very few existing groups can bridge from genetics to molecular biology or cell physiology and to disease or novel therapy; we propose to examine the mechanisms by which variation in the observed genes is involved in myocardial ischaemia-reperfusion injury by examining their functional effects in the human myocardium from patients undergoing cardiac surgery, as well in our previously described preclinical rodent and swine models of cardioplegic arrest and cardiopulmonary bypass.⁴⁰ The use of such animal models would allow pharmacological studies targeting the identified pathways to explore the mechanism by which novel cardioprotective drugs would attenuate myocardial ischaemia-reperfusion injury, with the ultimate goal of developing personalised cardioprotective strategies.

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SUPPLEMENTAL MATERIAL

Table of Contents

PEGASUS Investigative Team Members	Page 2
Supplemental Methods	Page 3
A.1. Quality control of data flow	Page 3
A.2. Controlling for population stratification	Page 4
A.3. Haplotype analysis	Page 6
A.4. GWAS pathway analysis	Page 6
Supplemental Results	Page 7
B.1. Patient characteristics	Page 7
B.2. Single-locus GWAS analysis	Page 8
B.3. Haplotype analysis	Page 8
B.4. Chromosome 9p21 locus analysis	Page 14
B.5. GWAS pathway analysis results	Page 15
B.6. Power calculation	Page 21
B.7. Details of the top 521 SNPs identified in stage I GWAS analyses	Page 22
Supplemental References	Page 25

Perioperative Genetics and Safety Outcomes Study (PEGASUS) Investigative Team Members

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A. SUPPLEMENTAL METHODS

A.1. Quality control of data flow

The following quality control steps were taken to make sure that genotypes were correctly called.

- Infinium BeadStudio raw data analysis: Any sample that had a very low intensity or a very low call rate using the standard Illumina cluster ($< 95\%$) was deleted. All SNPs that had a call frequency below 100% were then reclustered. Any sample that was below a 98% call rate after reclustering was deleted. Next, all SNPs that had a call frequency below 99% were deleted. Any SNPs for which $>1\%$ of samples were not called or were ambiguously called were deleted. A total of 35 samples (13 in GeneMagic and 22 in PEGASUS cohort) were deleted during this procedure.
- Minor allele frequency (MAF) check for data handling accuracy: This step performs a basic check of the data accuracy on the data flow pipeline from the output of the Illumina genotyping facility to the analytical process. We checked the MAF report from PLINK software against the original locus report generated by the genotyping facility, and ensured that the 2 matched exactly.
- Gender specification: This step compares the observed genotypes on chromosomes X and Y to the gender specification obtained from the phenotype database. Samples with X-chromosomal heterozygosity that was inconsistent with reported gender were individually inspected against the original data source. A total of 11 samples could not be reconciled and were excluded at this step (8 in GeneMagic and 3 in PEGASUS cohort)
- Cryptic relatedness: We estimated the sharing of genetic information between cohort participants by calculating identity by descent (IBD) using PLINK software. All pairs with DNA samples showing ≥ 0.125 estimated proportion of alleles IBD were inspected, and one sample from each pair was excluded from further analyses. A total of 9 samples (all in PEGASUS cohort) were excluded at this step.
- Genotype missing: This step assesses whether the genotype missing is skewed toward cases or controls, which could give rise to spurious association p-values. We used PLINK software to perform this check on the top SNPs discussed in the paper.

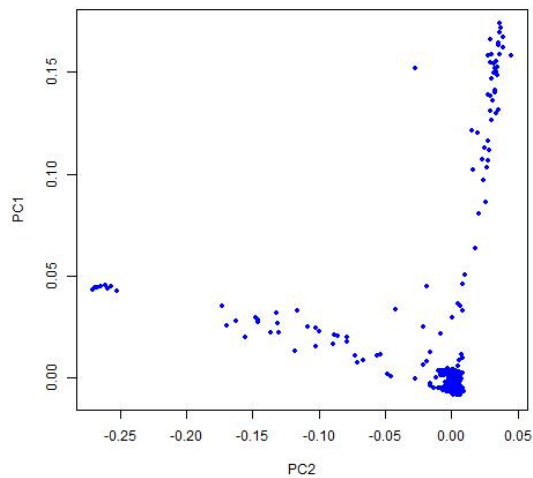
- Low MAF: We removed all SNPs with $MAF < 0.01$ in order to control for error in the estimation of asymptotic p-values, as alleles with such a low MAF would have no chance of approaching significance based on our sample size and perioperative MI incidence.
- Hardy-Weinberg Equilibrium (HWE): We used PLINK software to identify any observed genotypes that deviated from HWE. All markers that significantly deviated from HWE ($p < 10^{-6}$) were excluded.

Analyses were performed using PLINK 1.07, SAS/Genetics version 9.2, and R version 2.15.1.

A.2. Controlling for population stratification

We used a modified EIGENSTRAT method to control for population stratification.¹ This method derives the principal components of the correlations among the gene variants, and corrects for those correlations in the association tests. Population structure was investigated using the EigenSoft program. All 15 principal components (PCs) were computed for both datasets. Plots between pairwise PCs, particularly PC1 vs PC2, were generated to determine whether any obvious outliers deviated from the main cluster, and hence, had to be excluded from subsequent analyses (**Supplemental Figure S1**).

Supplemental Figure S1. Comparison of PC1 vs PC2 reveals potential population stratification in the discovery (Gene-Magic) dataset.



In addition, we performed multivariate regression analyses using a strategy to keep all PCs up to the last PC with $p < 0.05$ in each step, to determine the number of PCs to be used for correction in the final analysis. For instance, starting with 15 PCs in the model, if PC(i) is the last PC with $p < 0.05$, we included PC(1) to PC(i) in the next multivariate model, and then repeated the process until the last PC remained nominally significant. Using this iterative multivariate analysis, we found that the top 10 PCs were a reasonable set for the Gene-Magic dataset ($p = 0.032$), and were subsequently re-estimated and used for stage II analysis (**Supplemental Table S1**). This final set of 10 PCs was then used as covariates to adjust for ancestry, along with clinical variables, in multivariate logistic regression analysis of perioperative MI.

Supplemental Table S1: Principal component analysis of the study populations

Parameter	ANALYSIS OF MAXIMUM LIKELIHOOD ESTIMATES									
	DISCOVERY DATASET					REPLICATION DATASET				
	DF	Estimate	Standard error	Wald chi-square test	P-value	DF	Estimate	Standard error	Wald chi-square test	P-value
Intercept	1	-2.635	0.127	434.325	<0.0001	1	-2.153	0.076	798.277	<0.0001
Principal component 1	1	-31.474	14.214	4.903	0.027	1	18.429	8.413	4.798	0.029
Principal component 2	1	-5.486	3.826	2.056	0.152	1	-4.009	3.338	1.443	0.230
Principal component 3	1	-7.575	3.497	4.691	0.03	1	-3.239	3.230	1.006	0.316
Principal component 4	1	-0.431	3.479	0.015	0.901	1	-1.266	3.119	0.165	0.685
Principal component 5	1	18.941	9.623	3.874	0.049	1	-1.642	4.828	0.116	0.734
Principal component 6	1	0.519	7.944	0.004	0.948	1	-15.494	7.678	4.073	0.044
Principal component 7	1	-2.231	10.001	0.049	0.824	1	12.985	6.873	3.569	0.059
Principal component 8	1	-10.793	9.043	1.424	0.233	1	2.244	4.825	0.216	0.642
Principal component 9	1	29.876	11.661	6.564	0.01	1	-8.120	5.366	2.289	0.130
Principal component 10	1	-22.775	10.593	4.623	0.032	1	7.487	4.650	2.592	0.107

DF, degrees of freedom

A.3. Haplotype analysis

For the final candidate genes prioritized based on the significance of SNP association tests, we first identified the linkage disequilibrium (LD) blocks harboring the significant SNPs. Within each LD block, we performed haplotype association analysis using sliding windows of 3 markers across the region. This was conducted for the expanded dataset, by constructing multivariable logistic regression models adjusting for the same clinical covariates and PCs used for single marker analyses.

A.4. GWAS pathway analysis

SNPs with a covariate-adjusted association p-value < 0.01 in stage I GWAS were subjected to functional ontology enrichment analyses using tools implemented in the MetaCore software suite (GeneGO, St. Joseph, MI). Enrichment analysis begins by assigning SNPs to genes, and matching these geneIDs with geneIDs in functional ontologies in highly curated canonical pathway maps in MetaCore. The aggregation of GWAS associations for the genes in tested pathways, ie, the significance of enrichment, is computed as the p-value of a hypergeometric model.² Canonical pathways enriched in stage I and stage II analyses were further compared; and the probability of a random intersection between the set of genes in common in the 2 cohorts, and functional ontology entities was estimated as p-value of a hypergeometric distribution in MetaCore.

B. SUPPLEMENTAL RESULTS

B.1. Patient characteristics

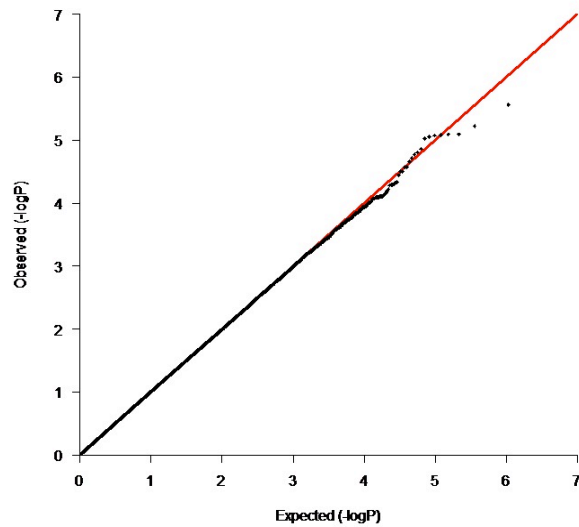
Supplemental Table S2. Clinical characteristics of the study populations

Characteristics	STAGE I ANALYSIS (N=1433)				STAGE II ANALYSIS (N=2055)			
	No PMI, (n=1321)	PMI (n=112)	OR (95%CI)	P-value*	No PMI (n=1830)	PMI (n=225)	OR (95%CI)	P-value*
Extracardiac arteriopathy	251 (19.0)	20 (17.9)	0.93 (0.56-1.53)	0.77	754 (41.2)	128 (56.9)	1.88 (1.42-2.49)	<0.0001
Recent myocardial infarction	256 (19.4)	23 (20.5)	1.08 (0.67-1.74)	0.77	393 (21.5)	39 (17.3)	0.77 (0.53-1.10)	0.15
Procedure other than CABG only	126 (9.5)	23 (20.5)	2.45 (1.50-4.02)	0.0004	153 (8.4)	51 (22.7)	3.21 (2.26-4.58)	<0.0001
Year of surgery by year								
1997					26 (1.4)	3 (1.3)	1.0	
1998					70 (3.8)	8 (3.6)	0.99 (0.24-4.02)	0.98
1999					87 (4.8)	3 (1.3)	0.30 (0.06-1.57)	0.15
2000					77 (4.2)	14 (6.2)	1.58 (0.42-5.92)	0.50
2001					49 (2.7)	12 (5.3)	2.12 (0.55-8.20)	0.28
2002	146 (11.1)	9 (8.0)	1.0		188 (10.3)	20 (8.9)	0.92 (0.26-3.32)	0.90
2003	1175 (88.9)	103 (92.0)	1.42 (0.70-2.87)	0.33	1189 (65.0)	109 (48.4)	0.80 (0.24-2.67)	0.71
2004					32 (1.8)	8 (3.6)	2.17 (0.52-9.0)	0.29
2005					80 (4.4)	36 (16.0)	3.90 (1.11-13.72)	0.03
2006					32 (1.8)	12 (5.3)	3.25 (0.83-12.75)	0.09
Number of diseased vessels								
0	67 (5.1)	6 (5.3)	1.0		69 (3.8)	6 (2.7)	1.0	
1	259 (19.6)	29 (25.9)	1.25 (0.50-3.14)	0.63	276 (15.0)	32 (14.2)	1.33 (0.54-3.32)	0.54
2	519 (39.3)	43 (38.4)	0.93 (0.38-2.26)	0.86	595 (32.5)	52 (23.1)	1.01 (0.42-2.43)	0.99
3	476 (36.0)	34 (30.4)	0.80 (0.32-1.97)	0.62	885 (48.4)	130 (57.8)	1.69 (0.72-3.97)	0.22
4					5 (0.3)	5 (2.2)	11.5 (2.58-51.24)	0.0014
Aortic cross clamp time, min	51.2±36.8	71.9±32.4	1.015 (1.01-1.02)	<0.0001	55.0±35.2	80.5±36.7	1.019 (1.015-1.023)	<0.0001

Descriptive statistics of clinical variables are presented as count (percent frequency) for categorical variables and mean \pm SD for continuous variables. PMI, postoperative myocardial infarction; CABG, coronary artery bypass surgery; extracardiac arteriopathy, defined as any one or more of the following: claudication, carotid occlusion or $> 50\%$ stenosis, and/or previous or planned intervention on the abdominal aorta, limb arteries or carotids; OR (95%CI), univariate odds ratio (95% confidence interval). *Comparisons made using the *t*-test or Wald chi-square test, as appropriate. Clinical variables were included in the final multivariate logistic regression analysis if significant ($p < 0.05$) in univariate analyses.

B.2. Single-locus GWAS analysis - population structure adjustment

Supplemental Figure S2. Quantile - Quantile (Q-Q) plot representation of the GWAS association results in the discovery dataset

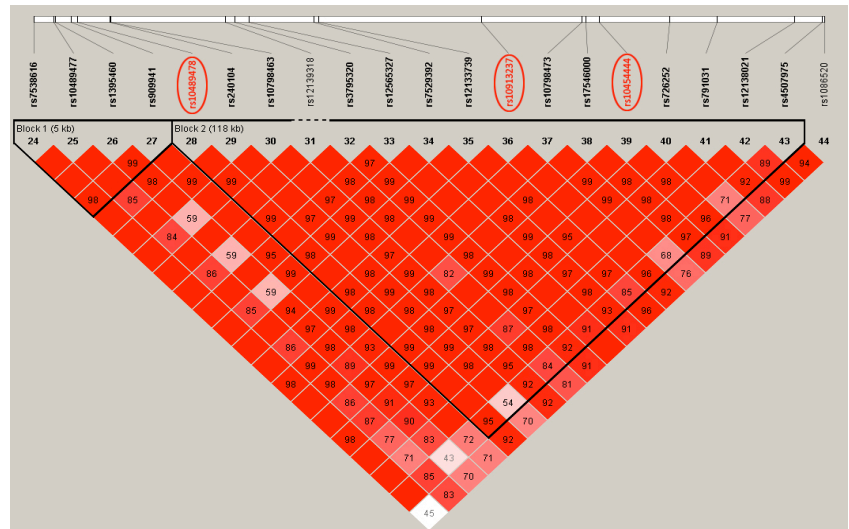


Distribution of expected (under the null hypothesis) vs observed p-values for single nucleotide polymorphisms that are associated with perioperative myocardial infarction, based on a whole genome-wide analysis. The red diagonal line represents the line obtained if the observed distribution did not deviate from the expected distribution. All p-values were corrected for the inflation factor ($\lambda = 1.0073$).

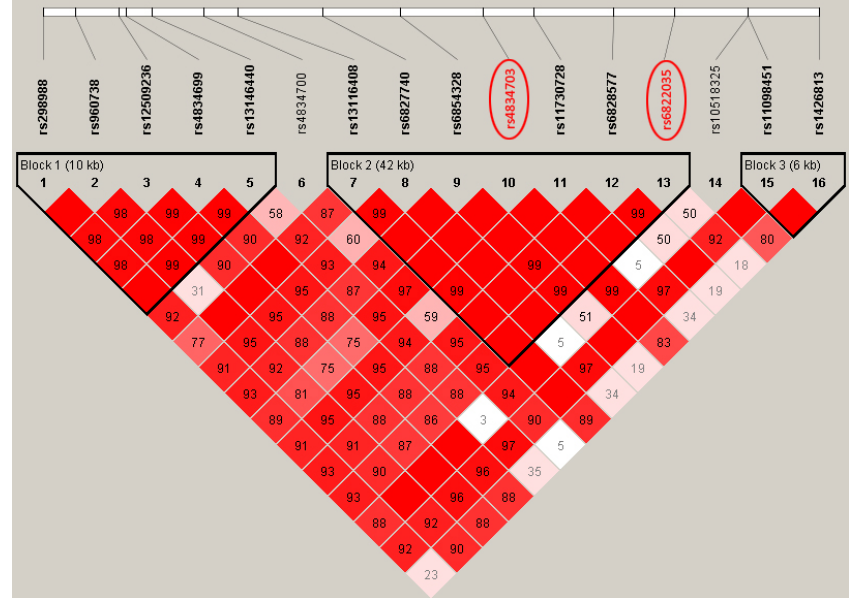
B.3. Haplotype analysis of genes harboring top scoring SNPs

Supplemental Figure S3. Linkage disequilibrium (LD) structures of [A] *PAPPA2* (1q23-q25 chromosome region), [B] *SEC24D* (4q26 chromosome region), and [C] *HDAC4* (2q37.3 chromosome region), and displayed as pairwise correlation plots using HapMap database (CEU European ancestry) (Haploview). Regions of LD are shaded in bright red (strong LD) and lighter for moderate or weak LD. The physical location of the individual SNPs associated with perioperative myocardial infarction in 2-stage analyses is circled in red. True haplotype blocks in the population are marked with black lines in the correlation plot.

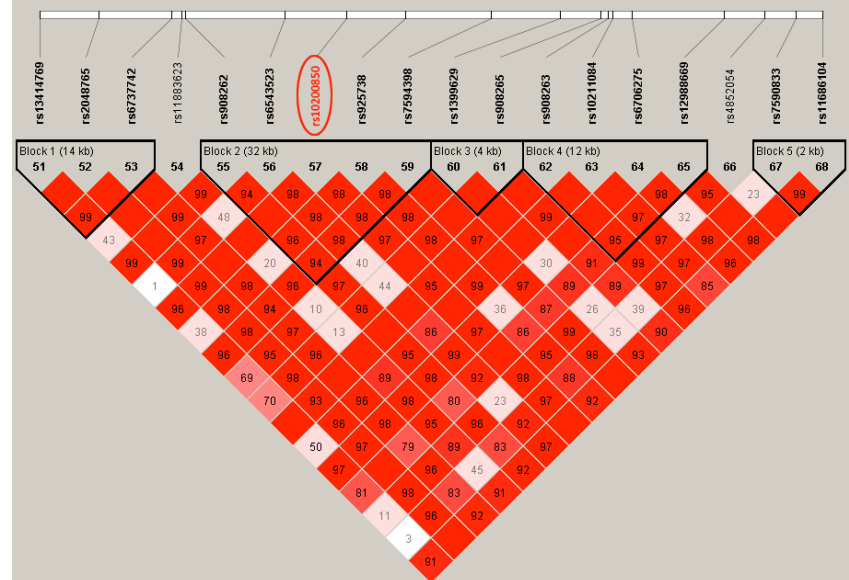
A. *PAPPA2* gene



B. *SEC24D* gene



C. *HDAC4* gene



Supplemental Table S3. Results of the haplotype analyses for *PAPPA2* and *HDAC4*

CHR	GENESYMBOL	BPI	BP2	SNP1	SNP2	HAPLOTYPE	F	OR	STAT	P
1	PAPPA2	176562608	176562796	RS10489477	RS1395460	AA	0.166	0.464	19.5	1.01E-05
1	PAPPA2	176562608	176562796	RS10489477	RS1395460	GG	0.655	1.43	9.56	0.00199
1	PAPPA2	176562608	176562796	RS10489477	RS1395460	GA	0.179	1.08	0.292	0.589
1	PAPPA2	176562796	176565307	RS1395460	RS909941	AG	0.344	0.698	9.56	0.00198
1	PAPPA2	176562796	176565307	RS1395460	RS909941	GA	0.576	1.29	5.58	0.0182
1	PAPPA2	176562796	176565307	RS1395460	RS909941	GG	0.0786	1.22	1.16	0.282
1	PAPPA2	176565307	176566350	RS909941	RS10489478	GA	0.175	0.474	20.8	4.98E-06
1	PAPPA2	176565307	176566350	RS909941	RS10489478	AG	0.578	1.29	5.55	0.0184
1	PAPPA2	176565307	176566350	RS909941	RS10489478	GG	0.248	1.19	2.17	0.141
1	PAPPA2	176566350	176571431	RS10489478	RS240104	AG	0.175	0.474	20.8	4.98E-06
1	PAPPA2	176566350	176571431	RS10489478	RS240104	GG	0.589	1.25	4.47	0.0345
1	PAPPA2	176566350	176571431	RS10489478	RS240104	GA	0.237	1.23	3.16	0.0754
1	PAPPA2	176571431	176571578	RS240104	RS10798463	GG	0.241	0.631	12.2	0.000477
1	PAPPA2	176571431	176571578	RS240104	RS10798463	AA	0.237	1.23	3.16	0.0754
1	PAPPA2	176571431	176571578	RS240104	RS10798463	GA	0.522	1.17	2.38	0.123
1	PAPPA2	176571578	176589732	RS10798463	RS12139318	GC	0.193	0.515	18.8	1.45E-05
1	PAPPA2	176571578	176589732	RS10798463	RS12139318	AC	0.759	1.58	12.2	0.000477
1	PAPPA2	176571578	176589732	RS10798463	RS12139318	GA	0.0485	1.28	1.24	0.266
1	PAPPA2	176589732	176591291	RS12139318	RS3795320	CC	0.197	0.5	20.3	6.47E-06
1	PAPPA2	176589732	176591291	RS12139318	RS3795320	CA	0.755	1.62	13.4	0.000248
1	PAPPA2	176589732	176591291	RS12139318	RS3795320	AC	0.0485	1.28	1.24	0.266
1	PAPPA2	176591291	176593524	RS3795320	RS12565327	CG	0.245	0.616	13.4	0.000256
1	PAPPA2	176591291	176593524	RS3795320	RS12565327	AG	0.675	1.49	11.4	0.00075
1	PAPPA2	176591291	176593524	RS3795320	RS12565327	AA	0.0795	1.02	0.0109	0.917
1	PAPPA2	176593524	176603840	RS12565327	RS7529392	GA	0.244	0.618	13.2	0.000274
1	PAPPA2	176593524	176603840	RS12565327	RS7529392	GG	0.676	1.49	11.3	0.000796
1	PAPPA2	176593524	176603840	RS12565327	RS7529392	AG	0.0801	1.02	0.00645	0.936

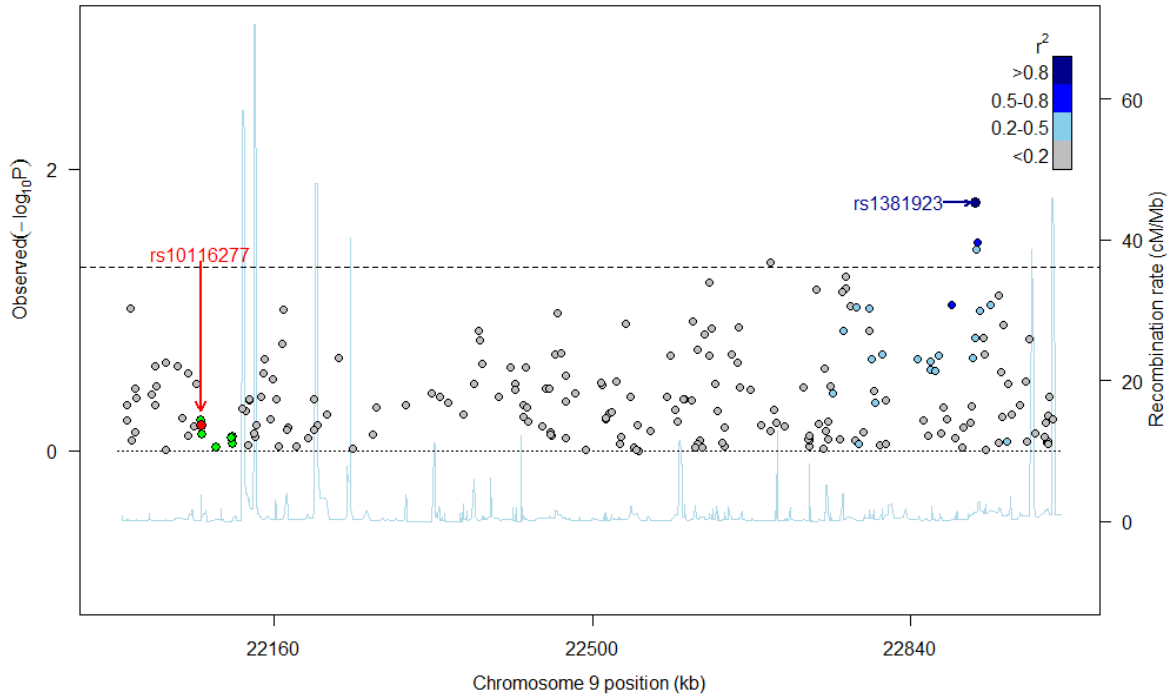
1	PAPPA2	176603840	176604564	RS7529392	RS12133739	AA	0.177	0.46	22.2	2.52E-06
1	PAPPA2	176603840	176604564	RS7529392	RS12133739	GA	0.756	1.62	13.3	0.000264
1	PAPPA2	176603840	176604564	RS7529392	RS12133739	AG	0.0675	1.23	1.13	0.288
1	PAPPA2	176604564	176630416	RS12133739	RS10913237	AA	0.176	0.46	22.1	2.56E-06
1	PAPPA2	176604564	176630416	RS12133739	RS10913237	AG	0.756	1.62	13.3	0.000269
1	PAPPA2	176604564	176630416	RS12133739	RS10913237	GG	0.0674	1.23	1.13	0.288
1	PAPPA2	176630416	176646383	RS10913237	RS10798473	AG	0.176	0.461	22.1	2.65E-06
1	PAPPA2	176630416	176646383	RS10913237	RS10798473	GA	0.489	1.29	5.98	0.0145
1	PAPPA2	176630416	176646383	RS10913237	RS10798473	GG	0.336	1.16	1.85	0.174
1	PAPPA2	176646383	176647000	RS10798473	RS17546000	GA	0.351	0.665	12.2	0.000484
1	PAPPA2	176646383	176647000	RS10798473	RS17546000	AA	0.489	1.29	5.98	0.0145
1	PAPPA2	176646383	176647000	RS10798473	RS17546000	GG	0.161	1.17	1.39	0.239
1	PAPPA2	176647000	176649181	RS17546000	RS10454444	AG	0.176	0.461	22.1	2.60E-06
1	PAPPA2	176647000	176649181	RS17546000	RS10454444	AA	0.663	1.42	9.13	0.00252
1	PAPPA2	176647000	176649181	RS17546000	RS10454444	GA	0.161	1.17	1.39	0.239
1	PAPPA2	176649181	176660247	RS10454444	RS726252	GG	0.176	0.461	22.1	2.59E-06
1	PAPPA2	176649181	176660247	RS10454444	RS726252	AA	0.591	1.28	5.11	0.0238
1	PAPPA2	176649181	176660247	RS10454444	RS726252	AG	0.232	1.23	3.09	0.0787
1	PAPPA2	176660247	176667810	RS726252	RS791031	GA	0.245	0.625	12.7	0.000371
1	PAPPA2	176660247	176667810	RS726252	RS791031	AA	0.591	1.28	5.11	0.0238
1	PAPPA2	176660247	176667810	RS726252	RS791031	GC	0.164	1.18	1.44	0.231
1	PAPPA2	176667810	176680137	RS791031	RS12138021	AA	0.769	0.832	2.43	0.119
1	PAPPA2	176667810	176680137	RS791031	RS12138021	CA	0.164	1.18	1.42	0.234
1	PAPPA2	176667810	176680137	RS791031	RS12138021	AG	0.0665	1.2	0.831	0.362
1	PAPPA2	176680137	176684432	RS12138021	RS4507975	AG	0.227	0.721	5.97	0.0146
1	PAPPA2	176680137	176684432	RS12138021	RS4507975	AA	0.706	1.23	3.05	0.0806
1	PAPPA2	176680137	176684432	RS12138021	RS4507975	GG	0.0615	1.17	0.537	0.464
2	HDAC4	240201797	240208154	RS13414769	RS2048765	GG	0.061	2.18	18.4	1.79E-05
2	HDAC4	240201797	240208154	RS13414769	RS2048765	AA	0.663	0.804	3.83	0.0503
2	HDAC4	240201797	240208154	RS13414769	RS2048765	GA	0.276	0.962	0.102	0.749
2	HDAC4	240208154	240216021	RS2048765	RS6737742	GG	0.061	2.19	18.6	1.58E-05

2	HDAC4	240208154	240216021	RS2048765	RS6737742	AG	0.718	0.773	5.06	0.0244
2	HDAC4	240208154	240216021	RS2048765	RS6737742	AA	0.221	0.986	0.012	0.913
2	HDAC4	240216021	240217116	RS6737742	RS11883623	AG	0.221	0.986	0.0128	0.91
2	HDAC4	240216021	240217116	RS6737742	RS11883623	GG	0.185	1.01	0.00304	0.956
2	HDAC4	240216021	240217116	RS6737742	RS11883623	GA	0.594	1.01	0.00252	0.96
2	HDAC4	240217116	240217522	RS11883623	RS908262	GC	0.182	1.01	0.00393	0.95
2	HDAC4	240217116	240217522	RS11883623	RS908262	AC	0.594	0.995	0.0024	0.961
2	HDAC4	240217116	240217522	RS11883623	RS908262	GA	0.224	1	0.00029	0.986
2	HDAC4	240217522	240228263	RS908262	RS6543523	CG	0.266	1.32	5.92	0.015
2	HDAC4	240217522	240228263	RS908262	RS6543523	CA	0.51	0.8	4.6	0.032
2	HDAC4	240217522	240228263	RS908262	RS6543523	AA	0.221	0.978	0.0301	0.862
2	HDAC4	240228263	240234901	RS6543523	RS10200850	GA	0.0614	2.21	19.6	9.58E-06
2	HDAC4	240228263	240234901	RS6543523	RS10200850	AG	0.73	0.75	6.47	0.011
2	HDAC4	240228263	240234901	RS6543523	RS10200850	GG	0.208	1.02	0.0282	0.867
2	HDAC4	240234901	240241255	RS10200850	RS925738	AG	0.0615	2.14	17.7	0.000026
2	HDAC4	240234901	240241255	RS10200850	RS925738	GA	0.414	0.812	3.61	0.0575
2	HDAC4	240241255	240250456	RS925738	RS7594398	GA	0.524	0.968	0.0946	0.758
2	HDAC4	240241255	240250456	RS925738	RS7594398	AG	0.0645	2.13	17.9	2.32E-05
2	HDAC4	240241255	240250456	RS925738	RS7594398	GG	0.415	0.819	3.31	0.0689
2	HDAC4	240241255	240250456	RS925738	RS7594398	GG	0.52	0.965	0.112	0.737
2	HDAC4	240250456	240257958	RS7594398	RS1399629	AA	0.0649	2.12	17.8	2.43E-05
2	HDAC4	240250456	240257958	RS7594398	RS1399629	GA	0.423	0.84	2.58	0.108
2	HDAC4	240250456	240257958	RS7594398	RS1399629	GG	0.512	0.945	0.286	0.593
2	HDAC4	240257958	240262287	RS1399629	RS908265	GG	0.13	0.905	0.388	0.533
2	HDAC4	240257958	240262287	RS1399629	RS908265	AG	0.488	1.06	0.301	0.583
2	HDAC4	240257958	240262287	RS1399629	RS908265	GA	0.382	0.986	0.0174	0.895
2	HDAC4	240262287	240263103	RS908265	RS908263	GA	0.0721	0.827	0.819	0.365
2	HDAC4	240262287	240263103	RS908265	RS908263	GG	0.546	1.07	0.387	0.534
2	HDAC4	240262287	240263103	RS908265	RS908263	AG	0.382	0.986	0.0174	0.895
2	HDAC4	240263103	240263584	RS908263	RS10211084	AG	0.0721	0.827	0.823	0.364
2	HDAC4	240263103	240263584	RS908263	RS10211084	GG	0.723	1.09	0.482	0.487

2	HDAC4	240263103	240263584	RS908263	RS10211084	GA	0.205	0.978	0.0302	0.862
2	HDAC4	240263584	240265617	RS10211084	RS6706275	GA	0.31	0.747	6.34	0.0118
2	HDAC4	240263584	240265617	RS10211084	RS6706275	GG	0.485	1.29	6.18	0.0129
2	HDAC4	240263584	240265617	RS10211084	RS6706275	AG	0.205	0.978	0.0302	0.862
2	HDAC4	240265617	240275570	RS6706275	RS12988669	AA	0.309	0.748	6.28	0.0122
2	HDAC4	240265617	240275570	RS6706275	RS12988669	GA	0.52	1.27	5.11	0.0238
2	HDAC4	240265617	240275570	RS6706275	RS12988669	GG	0.17	1.02	0.0248	0.875

B.4. Chromosome 9p21 locus and perioperative MI

Supplemental Figure S4. Single nucleotide polymorphisms at 9p21 locus previously associated with incident myocardial infarction³ and mortality⁴ after CABG.

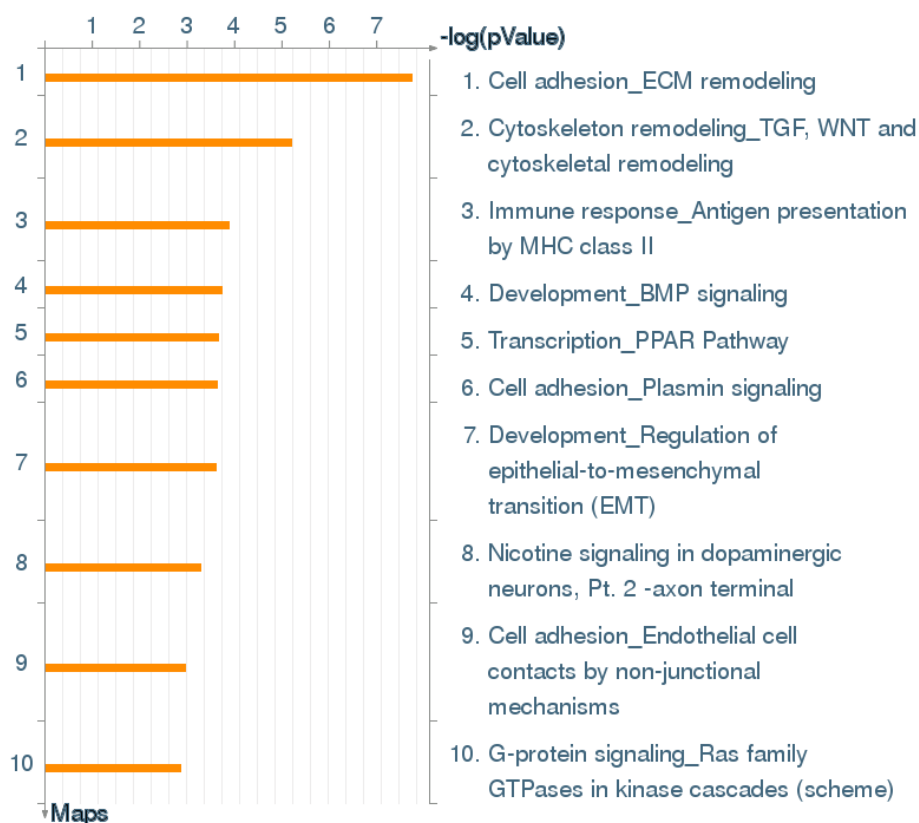


The dashed horizontal line indicates the nominal significance threshold, $p = 0.05$. The green dots represent single nucleotide polymorphisms (base pair) at the 9p21 locus previously identified as predictors of perioperative MI: rs1547705 (22082375, intron); rs1333040 (22083404, intron); rs4977574 (22098574, intron); rs944797 (22115286, intron); rs2383207 (22115959, intron); rs1537375 (22116071, intron). The red dot represents rs10116277 (22081397) variant, which was previously associated with myocardial infarction in both non-surgical and cardiac surgical cohorts. The dark blue point rs1381923 (22909438, unknown function) is the most significant variant in this plotted region. All p-values are the results of multivariate risk factor-adjusted analyses.

B.5. GWAS pathway analysis results

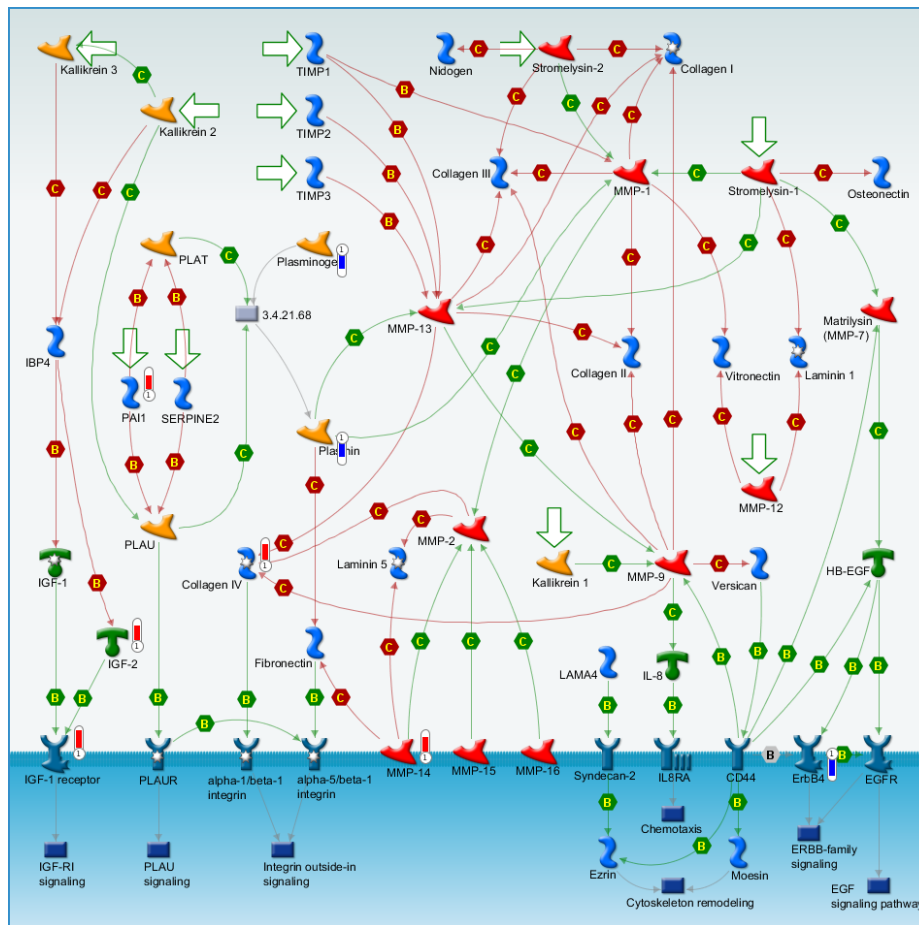
Of the 534,350 SNPs included in analysis, 250,740 were recognized, and 66,893 were mapped to 19,163 genes within MetaCore. Stage I cohort analysis in MetaCore identified several canonical pathways after functional enrichment analysis with SNPs that passed the p-value and odds-ratio filters ($p < 0.01$, $0.9 < OR < 1.1$).

Supplemental Figure S5. GenGo Canonical Pathway Maps histograms after enrichment analysis with SNPs that passed the threshold and p-value filter in GWAS stage I analyses.



The top 10 canonical maps for enriched SNPs are shown as histogram plots. Results are tabulated/sorted in the histogram based on calculated $-\log(p\text{-values})$ of hypergeometric distribution statistics.

Supplemental Figure S6. The top scoring pathway map based on the enrichment distribution in GWAS stage I analysis – *Cell adhesion: extracellular matrix remodeling.*



Top-scoring SNPs based on GWAS stage I results are linked to genes and visualized on the maps as thermometer-like symbols. Up-ward thermometers are red and indicate an odds ratio >1 for association with perioperative MI, and down-ward (blue) ones indicate an odds ratio for association <1 . Letters “B”, and “C” indicate physical interactions, B, binding; and C, cleavage. Arrows with hexagons indicate positive (green), negative (red), and unspecified (gray) effects. Arrows without hexagons indicate technical link (gray). For further information on pathway elements please see: http://pathwaymaps.com/pdf/MC_legend.pdf

Top-scoring pathways in stage I analyses were compared with enriched pathways in the stage II cohort. The probability of a random intersection between a set of genes common to both cohorts with functional ontology entities was estimated as p-value of hypergeometric distribution using the Compare Experiments Workflow in MetaCore. The top 4 scored canonical pathway maps (lowest p-values), based on the enrichment distribution, are presented below.

1. Immune response NFAT signaling and leukocyte interaction ($p = 7.2 \cdot 10^{-4}$). Nuclear factors of activated T-cells (NFATs) is a family of calcium-dependent transcription factors with pivotal roles in regulating immune responses, which include interactions between antigen-presenting cells and other leukocytes, and expression of a variety of cytokines by coupling changes in intracellular calcium concentration to gene expression. Variants in CD247, calcium channels, MHC class II, and NFAT that map to this pathway, and their association with perioperative MI is presented below in **Supplemental Table S4**.

SNPId	Gene Symbol	Gene Name	OR	p-value
rs2982480;rs2984800;rs2995054	CD247	CD247 molecule	2.16	0.00311
rs42051;rs7804449;rs1544462;rs1156325;rs2237526;rs2018982	CACNA2D1	calcium channel, voltage-dependent, alpha 2/delta subunit 1	0.71	0.00368
rs1779244;rs2068357	CACNB2	calcium channel, voltage-dependent, beta 2 subunit	0.50	0.00162
rs3117016;rs9380342	HLA-DPB2	major histocompatibility complex, class II, DP beta 2 (pseudogene)	2.45	0.00795
rs3129882	HLA-DRA	major histocompatibility complex, class II, DR alpha	1.49	0.00580
rs1562724;rs1017860;rs8090864	NFATC1	nuclear factor of activated T-cells, cytoplasmic, calcineurin-dependent 1	1.45	0.00362

2. Cell adhesion and extracellular matrix (ECM) remodeling ($p = 1.1 \cdot 10^{-3}$). An important pathway involved in responses to myocardial injury, is comprised of matrix metalloproteinases (MMPs), their endogenous tissue inhibitors (TIMPs), and various collagens. Furthermore, the plasminogen-plasmin system and its regulators (PAI-1) are implicated in proteolytic degradation of ECM. Finally, 2 categories of growth factors are part of this canonical pathway – insulin-like growth factors 1 and 2 (IGF-1 and IGF-2), and heparin-binding EGF-like growth factor (HB-EGF) – and all are involved in regulating cell growth, proliferation, and survival. IGF-1 and IGF-2 function by activating the IGF-1 receptor, but their

bioavailability is regulated by a family of insulin-like growth factor binding proteins (IGFBP4)., HB-EGF activates the epidermal growth factor receptor (EGFR) and v-erb-a erythroblastic leukemia viral oncogene homolog 4 (ErbB4), leading to cell proliferation, cell survival, and tissue remodeling (**Supplemental Table S5**).

SNPId	Gene Symbol	Gene Name	OR	P-value
rs953386;rs2391823	COL4A1	collagen, type IV, alpha 1	1.76	0.00162
rs884904;rs845552	EGFR	epidermal growth factor receptor	1.67	0.00238
rs9288433;rs3817429;rs2371276;rs1473636;rs7425448;rs10932384;rs6740117;rs12053361;rs17803152;rs7594456;rs4672615;rs1851169;rs6747637	ERBB4	v-erb-a erythroblastic leukemia viral oncogene homolog 4 (avian)	0.53	0.00613
rs2033178	IGF1	insulin-like growth factor 1 (somatomedin C)	0.50	0.00901
rs8038056;rs8028620;rs2139924;rs3784604	IGF1R	insulin-like growth factor 1 receptor	1.90	0.00383
rs734351	IGF2	insulin-like growth factor 2 (somatomedin A)	1.57	0.00159
rs12454479;rs8086477;rs12454564	LAMA3	laminin, alpha 3	2.01	0.00165
rs762052	MMP14	matrix metalloproteinase 14 (membrane-inserted)	1.60	0.00863
rs1050813	SERPINE1	serpin peptidase inhibitor, clade E (nexin, plasminogen activator inhibitor type 1), member 1	1.38	0.00874
rs783147	PLG	plasminogen	0.68	0.00979

3. *Regulation of lipid metabolism RXR-dependent regulation of lipid metabolism via PPAR, RAR, and VDR* ($p = 5.1 \times 10^{-3}$; **Supplemental Table S6**).

SNPId	Gene Symbol	Gene Name	OR	P-value
rs12364396	CPT1A	carnitine palmitoyltransferase 1A	1.779	0.006433
rs1286767;rs2164360;rs2033447	RARB	retinoic acid receptor, beta	1.647	0.005116

4. *BMP (bone morphogenic protein) signaling pathway* ($p = 5.2 \times 10^{-3}$). BMPs are members of the TGF- β superfamily, with important roles in embryonic development including cardiomyogenesis and apoptosis. BMPs transduce their signals via 2 pathways: SMAD-dependent (including SMAD9[8]), and SMAD-

independent cascade. BMP activity can be regulated by intracellular inhibitory SMADs (like SMAD6) or extracellularly by secreted antagonists (like gremlin). Variants in SMAD9 and SMAD6 were associated with an increased incidence of perioperative MI (**Supplemental Table S7**).


SNPId	Gene Symbol	Gene Name	OR	p-value
rs11858577	SMAD6	SMAD, mothers against DPP homolog 6	2.30	0.0002506
rs7998663	SMAD9	Mothers against decapentaplegic, drosophila, homolog of, 9	2.47	0.000167
rs884940	SKI	ski oncoprotein	0.61	0.0006749

In summary, functional analysis of genome-wide association data using biological ontologies allowed us to supplement our single marker analysis results by identifying a number of additional candidates for further investigation as biomarkers for perioperative MI. It also highlighted the potential mechanistic importance of several signaling pathways that have not previously been implicated in the complex and multifactorial pathogenesis of perioperative ischemia-reperfusion injury.

Supplemental Figure S7 summarizes RegulomeDB (regulome.stanford.edu) and HaploReg v2 (<http://www.broadinstitute.org/mammals/haploreg/haploreg.php>) database results for rs609408 (intergenic variant, located 1.5kb 3' of SMAD9).

A. RegulomeDB supporting data for rs609418

Protein Binding						Filter: <input type="text"/>
Method	Location	Bound Protein	? Cell Type	Additional Info	Reference	
ChIP-seq	chr13:37417308..37417652	GATA2	SH-SY5Y		ENCODE	

Motifs						Filter: <input type="text"/>
Method	Location	Motif	? Cell Type	PWM	Reference	
PWM	chr13:37417418..37417435	Elf3			19443739	

B. HaploReg v2 summary for rs609418 and variants with $r^2 \geq 0.8$

Query SNP: **rs609418** and variants with $r^2 \geq 0.8$

chr	pos (hg19)	LD (r)	LD (D)	variant	Ref	Alt	AFR freq	AMR freq	ASN freq	EUR freq	SiPhy cons	Promoter histone marks	Enhancer histone marks	DNase	Proteins bound	eQTL tissues	Motifs changed	GENCODE genes	dbSNP func annot	
13	37396093	0.98	-0.99	rs1980881	G	A	0.34	0.74	0.55	0.74			Huvec				5 altered motifs	RFXAP	intronic	
13	37396218	0.98	-0.99	rs1980880	A	G	0.34	0.74	0.55	0.74			Huvec, GM12878				6 altered motifs	RFXAP	intronic	
13	37400621	0.9	-0.99	rs7983276	T	A	0.33	0.76	0.55	0.76							Mef2,TATA	RFXAP	intronic	
13	37401286	0.9	-0.99	rs7984398	T	C	0.33	0.76	0.55	0.76							Foxp1,Pou2f2,TATA	RFXAP	intronic	
13	37407492	0.89	1	rs1571320	C	G	0.45	0.23	0.33	0.24			Ishikawa,HRCEpC,RPTEC				AP-1	4.3kb 3' of RFXAP		
13	37407870	0.9	1	rs4943419	C	T	0.45	0.23	0.33	0.24							TEF	4.6kb 3' of RFXAP		
13	37408545	0.9	1	rs8563501	A	G	0.45	0.23	0.33	0.24			FibroP,HMVEC-LBI,NH-A				HDAC2,Tgfr1	5.3kb 3' of RFXAP		
13	37408734	1	-1	rs9315450	T	C	0.35	0.74	0.55	0.74			4 cell types				Smad	5.5kb 3' of RFXAP		
13	37409508	0.9	1	rs9566166	G	A	0.45	0.23	0.33	0.24			Th2				Mef2,SIX5	6.3kb 3' of RFXAP		
13	37410696	1	-1	rs9315451	A	C	0.35	0.74	0.55	0.74							HDAC2	7.5kb 3' of RFXAP		
13	37410794	0.9	1	rs4943421	C	G	0.46	0.23	0.34	0.24							Zic	7.6kb 3' of RFXAP		
13	37411589	0.9	1	rs11838533	A	G	0.40	0.23	0.33	0.24			Th1				Pax-4	7.4kb 3' of SMAD9		
13	37412644	0.9	1	rs4943423	C	T	0.51	0.24	0.33	0.24							GATA	6.3kb 3' of SMAD9		
13	37413544	0.9	1	rs7982338	A	C	0.47	0.23	0.33	0.24			BE2_C,HIPEpC	SRF			CTCF,NF-1,p53	5.4kb 3' of SMAD9		
13	37413557	0.9	1	rs7981675	C	T	0.47	0.23	0.33	0.24			BE2_C,HIPEpC	SRF			4 altered motifs			
13	37414795	0.9	1	rs4943426	T	C	0.46	0.23	0.34	0.24			H1					4.2kb 3' of SMAD9		
13	37416234	0.88	1	rs9635072	G	A	0.39	0.23	0.34	0.23							7 altered motifs			
13	37417048	1	-1	rs7325187	G	T	0.34	0.74	0.54	0.74								1.9kb 3' of SMAD9		
13	37417206	0.9	1	rs9576121	T	C	0.46	0.23	0.34	0.24							6 altered motifs			
13	37417427	1	1	rs609418	A	C	0.67	0.26	0.46	0.26						GATA2		Gfi1,Mef2	1.5kb 3' of SMAD9	
13	37417894	0.89	1	rs9634749	C	A	0.46	0.23	0.34	0.24							ATF3,ATF6	1.1kb 3' of SMAD9		
13	37418491	0.99	1	rs35652793	TA	T	0.67	0.26	0.46	0.26							8 altered motifs			
13	37419042	0.83	0.98	rs60270973	AGTT	A	0.46	0.22	0.34	0.23							HEY1,Sox	SMAD9		
13	37420348	0.98	1	rs642866	A	G	0.66	0.26	0.46	0.25							12 altered motifs	SMAD9	3'-UTR	
13	37423032	0.87	1	rs4943431	G	A	0.42	0.23	0.34	0.23			Huvec				4 altered motifs	SMAD9	intronic	
13	37431353	0.97	1	rs10629368	A	ACT	0.80	0.28	0.51	0.25							14 altered motifs	SMAD9	intronic	
13	37434744	0.95	0.99	rs636514	G	A	0.78	0.28	0.51	0.25							CACD,NRSF	SMAD9	intronic	

and detailed view for rs609418

Sequence facts

chr	pos (hg19)	Reference	Alternate	1000 Genomes Phase 1 Frequencies				Sequence constraint		dbSNP functional annotation
				AFR	AMR	ASN	EUR	by GERP	by SiPhy	
chr13	37417427	A	C	0.67	0.26	0.46	0.26	No	No	none

Closest annotated gene

Source	Distance	Direction	ID/Link	Common name	Description
GENCODE	3'	1540	ENSG00000120693.9	SMAD9	SMAD family member 9 [Source:HGNC Symbol;Acc:6774]
RefSeq	3'	1539	NM_001127217	SMAD9	SMAD family member 9 [Source:HGNC Symbol;Acc:6774]

Proteins bound by ChIP (ENCODE)

Cell ID	Protein
SH-SY5Y	GATA2

Regulatory motifs altered

PWM	Strand	Ref	Alt	Match on:
Gfi1_2	+	10.5	11.2	Ref: TGCTATGCAGCTGGATAACTATTTCCAAAATAAATCACAAGCAGCTTTTCTGATCCCT Alt: TGCTATGCAGCTGGATAACTATTTCCAAAATAAATCACAAGCAGCTTTTCTGATCCCT HNWAATCHBDKSH
Mef2_disc1	+	12.1	7.3	DDKYTATTTTRDMH

B.6. Power calculation

We used Genetic Power Calculator (<http://pngu.mgh.harvard.edu/~purcell/gpc/>) to estimate the effect size that our study sample size can detect with 80% power. As an example, we used rs4834703 in the *SEC24D* gene, which has 0.1 MAF and odds ratio (OR) of 1.98 from the stage II analysis. In this power calculation, we assumed 11% disease prevalence, 0.1 MAF for the marker, and the same study sample sizes (225 cases and 1830 controls). We varied the minor allele frequency of the disease locus (0.05, 0.1, 0.15) to assess the genotypic relative risk (GRR) that our study sample size can detect with 80% power. We used the same significant threshold described in the paper, 9×10^{-5} , for the stage II analysis. We assumed an additive model to define GRR of Aa and AA genotypes, that is, $GRR_{Aa} = x$ and $GRR_{AA} = 2x$, where x is equivalent to the OR for the minor allele. If the marker tested was in complete linkage disequilibrium ($D' = 1$) with the disease locus, we found that our sample size has approximately 80% power to detect a GRR = 2.6 for a rare disease locus (MAF = 0.05) and GRR = 1.8 for a more common disease locus (MAF = 0.1 and 0.15). The effect sizes become slightly higher when D' is assumed at 0.8 between disease locus and marker (**Supplemental Table S8**). The OR for rs4834703 in the *SEC24D* gene in our study was 1.97, which is consistent with the estimate here. Although somewhat controversial, current evidence supports joint 2-stage analysis designs over replication analyses in GWAS, based on increased statistical power of joint analyses,^{5,6} which formed the rationale for our study design.

Supplemental Table S8. GRR estimates that our dataset can detect a given disease locus MAF at approximately 80% power when marker MAF = 0.1, sample size = 225 cases and 1830 controls, and disease prevalence = 11%.

D'	Disease locus MAF	Odds Ratio	Power
1	0.05	2.6	0.8
	0.1	1.8	0.84
	0.15	1.75	0.81
0.8	0.05	3.1	0.8
	0.1	2.15	0.84
	0.15	2	0.82

C. SUPPLEMENTAL REFERENCES

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