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Genome-wide association studies identify genetic loci for low Von Willebrand factor levels

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Abstract

Low VWF levels are associated with bleeding symptoms and are a diagnostic criterion for von Willebrand disease; the most common inherited bleeding disorder. To date, it is unclear which genetic loci are associated with reduced VWF levels. Therefore, we conducted a meta-analysis of genome-wide association studies to identify genetic loci associated with low VWF levels. For this meta-analysis we included 31,149 participants of European ancestry from eleven community-based studies. From all participants VWF antigen (VWF:Ag) measurements and genome-wide single nucleotide polymorphisms (SNPs) scans were available. Each study conducted analyses using logistic regression of SNPs on dichotomized VWF:Ag measures (lowest 5% for blood group O and non-O) with an additive genetic model adjusted for age and sex. An inverse-variance weighted meta-analysis was performed for VWF:Ag levels. A total of 97 SNPs exceeded the genome-wide significance threshold of $5 \times 10^{-8}$ and comprised five loci on four different chromosomes: 6q24 (smallest p-value $5.8 \times 10^{-10}$), 9q34 (2.4$\times 10^{-64}$), 12p13 (5.3$\times 10^{-22}$), 12q23 (1.2$\times 10^{-8}$), 13q13 (2.6$\times 10^{-8}$). All loci were within or close to genes, including STXBP5 (6q24), STAB5 (12q23), ABO (9q34), VWF (12p13), and UFM1 (13q13). Of these, UFM1 has not been previously associated with VWF:Ag levels. Four genes that were previously associated with VWF levels (VWF, ABO, STXBP5 and STAB2) were also associated with low VWF levels, and in addition we identified a new gene, UFM1, that is associated with low VWF levels. These findings point to novel mechanisms for the occurrence of low VWF levels.
Introduction

Von Willebrand factor (VWF) is a multifunctional glycoprotein, which is secreted by endothelial cells and released upon endothelial cell activation. VWF initiates the adherence of platelets to the injured vessel wall, and the subsequent platelet aggregation facilitates adequate haemostasis.1,2

Plasma levels of VWF antigen (VWF:Ag) are characterized by a large inter-individual variation and range from 0.60 to 1.40 IU/mL in healthy individuals. Various environmental and lifestyle factors affect VWF:Ag levels, but approximately 60% of the variability in VWF:Ag levels can be explained by genetic factors.4

The necessity of maintaining normal VWF levels in the circulation is illustrated by two clinical manifestations that may occur when VWF exceeds its normal range. High VWF:Ag levels are associated with an increased risk of venous thrombosis and arterial thrombosis.5-8 Conversely, low VWF:Ag levels are associated with an increased bleeding tendency and are a characteristic of von Willebrand disease (VWD). VWD is the most common inherited bleeding disorder in humans and is caused by a quantitative deficiency of VWF (type 1 and 3 VWD) and/or a qualitative defect of VWF molecules (type 2 VWD).9

Most severe forms of type 1 VWD are caused by dominant-negative family-based variations in the VWF gene (VWF).10,11 However, in individuals with moderately decreased VWF:Ag levels VWF variations are often not found and linkage with the VWF locus is rarely seen.10,11 Hence, it is difficult to differentiate between subjects with physiologically low VWF:Ag levels and subjects with low VWF:Ag levels because of VWD.12,13 However, since VWF:Ag levels are strongly genetically determined, it is expected that more common genetic variations in other genes than VWF are likely to be involved in the occurrence of low VWF:Ag levels and therefore in the etiology of type 1
VWD. We have previously shown that several loci outside the VWF gene are indeed associated with VWF:Ag levels and that the VWF decreasing alleles are more frequently observed in individuals diagnosed with VWD\textsuperscript{13}. To identify common genetic loci that are associated with low VWF:Ag levels, related to an increased bleeding tendency, we performed a meta-analysis of genome-wide association studies (GWAS) in eleven large population-based cohort studies.

**Methods**

**Study populations**

This meta-analysis was conducted in the CHARGE Consortium\textsuperscript{14}, which includes data from several population-based cohort studies. VWF:Ag measurements were available in four of these; the Rotterdam Study (RS) I and II, the Framingham Heart Study (FHS), and the Atherosclerotic Risk in Communities (ARIC) study. In addition, we included data from seven other studies that had VWF:Ag measurements and genome-wide data available: the British 1958 Birth cohort (B58C) study, the PROspective Study of Pravastatin in the Elderly at Risk (PROSPER), the Prevention of Renal and Vascular Endstage Disease (PREVEND) study, Lothian Birth Cohort 1921 and 1936 (LBC1921, LBC1936), Vis Croatia Study (CROATIA-Vis) and ORKNEY complex Disease Study (ORCADES). The designs of the studies have been described previously\textsuperscript{15-25}.

Genome-wide scans and VWF:Ag measurements were available for analysis in 31,149 individuals. Eligible participants were not using a coumarin-based anticoagulant at the time of VWF:Ag measurement and were of European ancestry by self-report. All studies were approved by their respective institutional review committee. In addition, written informed consent was obtained from all participants, as well as permission to use their DNA for research purposes.
Baseline measurements and von Willebrand factor measures

Baseline measures of clinical and demographic characteristics were obtained at the time of cohort entry for ARIC, CROATIA-Vis, ORCADES, PROSPER, PREVEND and RS, and at the time of phenotype measurements for B58C, LBC1921, LBC1936, and FHS. Measures were obtained using standardized methods as specified by each study and included measures of height and weight, as well as self-reported treatment of diabetes and hypertension, current alcohol consumption, and prevalent cardiovascular disease (history of myocardial infarction, angina, coronary revascularisation, stroke, or transient ischemic attack). Blood group antigen phenotypes (O and non-O) were reconstructed using genotype data of rs687289:C>T, which is a marker for the O allele. VWF:Ag was measured in all cohorts using enzyme-linked immunosorbent assays (ELISA) (supplementary table 3).

Genotyping

For the genotyping, DNA was collected from phlebotomy from all studies except B58C, which used cell lines. Genome-wide assays of SNPs were conducted independently in each cohort using various Affymetrix and Illumina panels (Supplementary table 3). Each study conducted genotype quality control and data cleaning, including assessment of Hardy-Weinberg equilibrium and variant call rates. Details on genotyping assays have been described in detail previously and are provided in supplementary table 3. For this analysis we investigated genetic variation in the 22 autosomal chromosomes. Genotypes were coded as 0, 1, and 2 to represent the number of copies of the coded alleles for all chromosomes. Each study independently imputed its genotype data to the ≈ 2.6 million SNPs identified in the HapMap Caucasian (CEU) sample from the
Centre d’Etude du Polymorphisme Humain\textsuperscript{28-30}. Imputation software, including MACH, BIMBAM, or IMPUTE, were used to impute unmeasured genotypes with SNPs that passed quality-control criteria based on phased haplotypes observed in HapMap. Imputation results were summarized as an “allele dosage”, which was defined as the expected number of copies of the minor allele of that SNP (a continuous value between 0 and 2) for each genotype. Each cohort calculated the ratio of observed to expected variance of the dosage statistics for each SNP. This value, which generally ranges from 0 to 1 (i.e. poor to excellent), reflects imputation quality.

Public Repository: Our data are available on the European Genome-phenome Archive (https://ega.crg.eu, accession number EGAS00001001341).

Statistical analysis
Genotype-phenotype data were analysed independently by each study. VWF:Ag measurements were used as dichotomous variable (low versus normal) with low VWF defined as the lowest 5% within blood groups, i.e. blood group O and non-O. All studies used logistic regression with an additive genetic model adjusted for age and sex to conduct analyses of all directly genotyped and imputed SNPs and their association with dichotomous VWF:Ag measures. FHS used generalized estimation equations to account for familial correlation. ARIC and PROSPER adjusted for field site, additionally. B58C adjusted for sex, date and time of sample collection, postal delay, and the nurse who performed the inclusion, which also adjusts for the region of residence. Age adjustment was not necessary in B58C, since all cohort members were born in one week. An inverse-variance weighted meta-analysis was performed using METAL software (http://www.sph.umich.edu/csg/abecasis/Metal/index.html) with genomic control.
correction being applied at the cohort level\textsuperscript{31}.

The a priori threshold of genome-wide significance was set at a p-value of $5.0 \times 10^{-8}$. When more than one SNP clustered at a locus, the SNP with the smallest p-value was selected to represent the locus.

**Results**

For this meta-analysis 31,149 participants of European ancestry were included. The sample size and participant characteristics from each cohort are displayed in supplementary table 1. The mean age ranged from 45 years in B58C to 87 years in LBC1921 and on average 48% of the participants was female.

A quantile-quantile plot of the observed p-value from meta-analysis against expected p-value distribution is shown in figure 1. Figure 2 illustrates the primary findings from the meta-analysis and presents p-values for each of the interrogated SNPs across the 22 autosomal chromosomes. A total of 97 SNPs exceeded the genome-wide significance threshold of $5 \times 10^{-8}$ and clustered around five genetic loci on four different chromosomes (figure 3). The SNP with the strongest signal was rs8176704:A>G, which is located at 9q34 (intron) in the ABO blood group gene ($P = 2.4 \times 10^{-64}$). The odds ratio (OR) for having VWF levels in the lowest 5% was 2.83 [95% CI 2.52;3.18]. In addition, we performed a conditional analysis. Based on this analysis we found three independent signals at 9q34. The analysis shows that rs579459 and rs8176747 are independently significant after taking into account the LD structure and their correlation with rs817704. The second most significant locus was marked by rs216303:T>C, which is located at 12p13 (intron) in the VWF gene (OR 0.57 [95% CI 0.51;0.64], $P = 5.3 \times 10^{-22}$). The third genome-wide significant signal at chromosomal position 6q24 (intron) was within \textit{STXBP5} (Syntaxin Binding Protein 5). Rs1221638:A>G was associated with
the smallest p-value ($5.8 \times 10^{-10}$) in this region (OR 1.28 [95% CI 1.19;1.39]). The fourth statistical significant signal was marked by rs4981022A>G, which is located at 12q23 (intron) in STAB2 (stabilin-2) (OR 0.79 [95% CI 0.73;0.85], $P = 1.2 \times 10^{-8}$). The final genome-wide significant locus was marked by rs17057285:A>C (OR 0.41 [95% CI 0.30;0.56], $P = 2.6 \times 10^{-8}$), which is 200kb upstream from UFM1 (ubiquitin-fold modifier 1). There are two SNPs close to rs17057285. The first one is rs17057209 which is 52 kb far from rs17057285 and is in complete LD with rs17057285 ($R^2 = 1$). Both of these SNPs are missing in five studies (VIS, ORKNEY, Prevend, LBC1921, LBC1936) out of 11 studies who contributed to the study. The third SNP is rs7323793 which is 67 kb far and is partly in LD with rs17057285 ($R^2 = 0.496$). Rs7323793 is missing only in Prevend Study.

In addition to our five genome-wide significant loci, five other loci demonstrated multiple-SNP hits with p-values below $1.0 \times 10^{-6}$: rs10848820:A>G ($P = 1.2 \times 10^{-7}$) within TSPAN9 (tetraspanin 9), rs4276643:T>C ($P = 3.4 \times 10^{-7}$) within SCARA5 (scavenger receptor class A, member 5), rs17398299:A>C ($P = 4.1 \times 10^{-7}$) close to 1 gene, LPHN2 (latrophilin 2), rs5995441:T>C ($P = 8.3 \times 10^{-7}$) within CARD10 (caspase recruitment domain family, member 10), and rs3750450:T>G ($P = 9.6 \times 10^{-7}$) within EPB41L4B (erythrocyte membrane protein band 4.1 like 4B).

Discussion

In this meta-analysis of GWA data from eleven population-based cohorts comprising 31,149 individuals of European ancestry, we identified five genetic loci that are associated with low VWF levels: ABO, VWF, STXBP5, STAB2, and UFM1.

The most significant signal in our study came from a well-known determinant of VWF:Ag levels, the ABO locus. The presence of blood group A and B antigens on
VWF molecules leads to a decreased clearance of VWF molecules. Consequently, individuals with blood group O have 25% lower VWF plasma concentrations than individuals with blood group non-O. Although we used a different cut-off point for low VWF levels for blood group O and non-O separately to minimize the effect of blood group, the ABO locus still reached a very high level of statistical significance. This implies that blood group O versus non-O explains not the total ABO locus effect, and that A or B antigens also determine VWF levels. Indeed, carriers of the B antigen have higher VWF levels than carriers of the A antigen and carriers of both antigens have the highest VWF levels.

The second locus is within the VWF gene. It has been well established that common genetic polymorphisms in the VWF gene contribute to the variability in VWF:Ag levels. The most significant SNP that marked the VWF locus was rs216303:T>C, which is located within an intronic region. Until recently, intronic polymorphisms were often considered less relevant for disease development and regulating protein levels in plasma. However, there is now an increasing recognition that intronic variants can contribute by for example influencing the form and efficacy of gene splicing and mRNA stability. Another possibility is that SNPs in the intronic regions are in high LD with functional SNPs in adjacent regions.

The third locus is within the STXBP5 gene, which encodes the syntaxin binding protein 5. STXBP5 can bind to Soluble N-ethylmaleimide-sensitive factor (NSF) Attachment protein Receptor (SNARE) proteins, among which syntaxin-2 and syntaxin-4. Syntaxin-4 has been shown to be involved in Weibel Palade Body exocytosis, the well known mechanism for the secretion of VWF molecules from endothelial cells. We have previously shown in a well defined cohort of young patients with a first event of arterial thrombosis that genetic variation in STXBP5 is associated with VWF:Ag levels.
LD between rs1221638:A>G and the SNP that had the highest significance in the previous meta-analysis is $D' = 0.90$ and $R^2 = 0.67$.

The fourth locus was marked by rs4981022:A>G, which is located in $STAB2$. Stabilin–2 is a transmembrane receptor protein and is primarily expressed in liver and spleen sinusoidal endothelial cells. Stabilin-2 can bind various ligands, such as heparin, LDL, bacteria, and advanced glycosylation products, and subjects them to endocytosis\textsuperscript{40}. $STAB2$ variation might be important in the regulation of VWF levels via the clearance of VWF molecules.

The final genome-wide significant locus was marked by rs17057285:A>C, which is upstream from $UFM1$. $UFM1$ encodes the ubiquitin-fold modifier 1, which has been recently identified as a novel protein conjugating system\textsuperscript{41}. Although the precise function has not been elucidated yet, the UFM1 cascade seems to be involved in cellular homeostasis, influencing cell division, growth and endoplasmatic reticulum function\textsuperscript{42}. $UFM1$ is highly expressed in the pancreatic islets of Langerhans and has a role in the development of type-2 diabetes. Another study showed possible involvement in the development of ischemic heart disease. In this study chronic inflammation in mice led to a strong up regulation of UFM1 in cardiomyocytes\textsuperscript{43}. Since VWF:Ag levels also have been associated with an increased risk of ischemic heart disease, this is an interesting finding. However, UFM1 has not yet been linked to VWF directly yet and is a novel association needing replication.

Four of the identified loci for low VWF:Ag levels (i.e. $ABO$, $VWF$, $STXBP5$, and $STAB2$) have previously shown to be involved in the regulation of VWF:Ag levels in general\textsuperscript{44}. The other identified new genetic loci for continuous VWF:Ag levels (i.e. $SCARA5$, $STX2$, $TC2N$, and $CLEC4M$) were not associated with low VWF levels. $UFM1$ is a novel genetic locus associated with low VWF levels that was not associated
with the continuous VWF:Ag levels. Rs17057285:A>C, the SNP with the highest P-value that marks this locus, has a very small minor allele frequency of about 0.5%. Therefore this finding should be interpreted with care.

In today’s clinical practice it is hard to distinguish between physiologically low VWF levels and VWF:Ag levels due to VWD, because both VWF levels and bleeding symptoms are highly variable and occur frequently in the general population\textsuperscript{45}. Until recently, it was believed that low VWF:Ag levels and VWD are caused by variations in the VWF gene only. However, now it has been shown that 35% of type 1 (partial quantitative deficiency of VWF) VWD patients have no apparent \textit{VWF} variations\textsuperscript{10,11}. This suggests that genetic variations in genes other than \textit{VWF} may lead to low VWF:Ag levels, also in patients diagnosed as having VWD\textsuperscript{13}. Indeed, our current findings confirm this hypothesis that next to ABO blood group and \textit{VWF}, other genetic loci are involved in the occurrence of low VWF levels.

In the current study we have not included a replication cohort. Generally, it has been recommended to include all cohorts in the discovery panel to maximize statistical power, rather than use some of the cohorts for replication. In addition, the identified genetic loci comprise extremely small p-values and were previously discovered in the meta-analysis using VWF:Ag as a continuous measure. For these reasons it is very unlikely that our findings are false-positive or came out by chance.

In conclusion, we identified five genetic loci that are associated with low VWF levels: \textit{ABO}, \textit{VWF}, \textit{STXB5}, \textit{STAB2}, and \textit{UFM1}. Our findings confirm the hypothesis that genes other than \textit{VWF} lead to low VWF:Ag levels. Further research is warranted in order to elucidate whether these genetic loci also contribute to the incidence of bleeding symptoms and VWD.
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Disclosures

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Table 1. Genome-wide Significant Association of 5 Loci with low VWF levels

<table>
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<tr>
<th>SNP</th>
<th>Region</th>
<th>MAF</th>
<th>(P)</th>
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<th>Het I²</th>
<th>Het p-value</th>
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<td>9q34</td>
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<td>(2.4 \times 10^{-64})</td>
<td>2.83 [2.52;3.18]</td>
<td>46.4</td>
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<td>(5.3 \times 10^{-22})</td>
<td>0.57 [0.51;0.64]</td>
<td>-12.6</td>
<td>0.39</td>
<td>VWF (intronic)</td>
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<td>6q24</td>
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<td>(5.8 \times 10^{-10})</td>
<td>1.28 [1.19;1.39]</td>
<td>0</td>
<td>0.85</td>
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<td>(1.2 \times 10^{-08})</td>
<td>0.79 [0.73;0.85]</td>
<td>-0.5</td>
<td>0.29</td>
<td>STAB2 (intronic)</td>
</tr>
<tr>
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<td>0.005</td>
<td>(2.6 \times 10^{-08})</td>
<td>0.42 [0.30;0.56]</td>
<td>23.2</td>
<td>0.10</td>
<td>200 kb from UFM1</td>
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</table>

Abbreviations used in this table are: SNP for single nucleotide polymorphism, MAF for minor allele frequency, \(P\) for statistical significance level, OR for odds ratio, and Het for heterogeneity. Reference sequence Hg 18 (NCBI build 36)

†Odds Ratio (OR) represents the risk of having VWF:Ag levels in the lowest 5% relative to the upper 95%.
Figure 1.
Figure 2.
Figure 3.

A.

B.
Figure legends

**Figure 1.** Quantile-quantile plot of the observed and expected distribution of \( P \) values for all \(~2.6\) million SNPs and their association with low VWF levels based on meta-analyzed data.

**Figure 2.** −Log\(_{10}\) \( P \) values for each of the \(~2.6\) million tests performed as part of the GWA analysis of low VWF levels. The grey dashed horizontal line marks the \( 5 \times 10^{-8} \) \( P \) value threshold of genome-wide significance.

**Figure 3.** Regional plots of top marker loci associated with low VWF levels. A through E: The association \( P \) values (−log\(^{10}\) transformed, indicated by the left \( y \) axis) for SNPs in a 60-kb region of each of the five loci (\( ABO, VWF, STXBP5, STX2, UFMI \)) are plotted against their chromosome positions (NCBI build 3) on \( x \) axis. The top SNPs are presented as a large diamond in red font and neighbouring variants are presented in different colors based on linkage disequilibrium based on HapMap Caucasian data: red: \( 1 \leq r^2 > 0.8 \); orange: \( 0.8 \geq r^2 > 0.6 \); yellow: \( 0.6 \geq r^2 > 0.3 \); green: \( 0.3 \geq r^2 > 0.1 \); blue: \( 0.1 \geq r^2 > 0.05 \); light blue: \( 0.05 \geq r^2 > 0.0 \). The left \( y \)-axis is the \( p \)-value on the −log\(^{10}\) \( p \)-value scale and the gray line marks the threshold of genome-wide significance (\( P = 5 \times 10^{-8} \)). Shown in light blue are the estimated recombination rates in HapMap with values indicated by the right \( y \) axis. Regional genes and their direction of transcription are depicted with green arrows.