Circulating Nonphosphorylated Carboxylated Matrix Gla Protein Predicts Survival in ESRD

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ABSTRACT
The mechanisms for vascular calcification and its associated cardiovascular mortality in patients with ESRD are not completely understood. Dialysis patients exhibit profound vitamin K deficiency, which may impair carboxylation of the calcification inhibitor matrix gla protein (MGP). Here, we tested whether distinct circulating inactive vitamin K–dependent proteins associate with all-cause or cardiovascular mortality. We observed higher levels of both desphospho-uncarboxylated MGP (dp-ucMGP) and desphospho-carboxylated MGP (dp-cMGP) among 188 hemodialysis patients compared with 98 age-matched subjects with normal renal function. Levels of dp-ucMGP correlated with those of protein induced by vitamin K absence II (PIVKA-II; r = 0.62, P < 0.0001). We found increased PIVKA-II levels in 121 (64%) dialysis patients, indicating pronounced vitamin K deficiency. Kaplan-Meier analysis showed that patients with low levels of dp-cMGP had an increased risk for all-cause and cardiovascular mortality. Multivariable Cox regression confirmed that low levels of dp-cMGP increase mortality risk (all-cause: HR, 2.2; 95% CI, 1.1 to 4.3; cardiovascular: HR, 2.7; 95% CI, 1.2 to 6.2). Furthermore, patients with higher vascular calcification scores showed lower levels of dp-cMGP. In conclusion, the majority of dialysis patients exhibit pronounced vitamin K deficiency. Lower levels of circulating dp-cMGP may serve as a predictor of mortality in dialysis patients. Whether vitamin K supplementation improves outcomes requires further study.
The role of carboxylation, which depends on vitamin K, is better understood and determines MGP’s bioactivity as a calcification inhibitor. Impaired carboxylation of MGP is associated with both intimal and medial vascular calcification in human arteries. Recently, it was shown that arteries of dialysis patients exhibit a poor MGP carboxylation status, as shown by a high amount of uncarboxylated MGP compared with carboxylated MGP. Thus far, only total uncarboxylated MGP (dp-ucMGP) and desphospho-uncarboxylated MGP (dp-ucMGP) could be measured in plasma. Here we describe the comparison of conformation-specific ELISAs differentiating between desphospho-carboxylated MGP (dp-cMGP) and desphospho-uncarboxylated MGP (dp-ucMGP) and tested whether dp-cMGP and/or dp-ucMGP predict survival in a cohort of hemodialysis patients. In addition, we tested whether vitamin K2 supplementation can improve the deficient vitamin K status in dialysis patients.

### RESULTS

#### Circulating MGP Levels in Hemodialysis Patients

The characteristics of the dialysis population are given in Table 1. Using MGP species-specific antibodies to distinguish between dp-cMGP and dp-ucMGP, 188 hemodialysis patients exhibited 3.3-fold elevated plasma levels of dp-cMGP (6247 ± 1778 pmol/L) and 6.5-fold elevated plasma levels of dp-ucMGP (2850 ± 1768 pmol/L) compared with 98 age-matched healthy subjects with normal renal function (dp-cMGP 1921 ± 605 pmol/L and dp-ucMGP 442 ± 242 pmol/L; \( P < 0.0001 \)). dp-cMGP exhibited an inverse correlation with dialysis vintage (\( r = -0.28, P = 0.0001 \)) and a positive correlation with body mass index (\( r = 0.24, P = 0.0009 \)), whereas dp-ucMGP did not show such a relationship (data not shown). Age, diabetes, and dialysis efficacy (i.e., Kt/V) were not related to plasma levels of dp-cMGP (Table 1). Patients with lower plasma levels of dp-cMGP exhibited 3.3-fold elevated plasma levels of dp-cMGP (6247 ± 1778 pmol/L) and 6.5-fold elevated plasma levels of dp-ucMGP (2850 ± 1768 pmol/L) compared with 98 age-matched healthy subjects with normal renal function (dp-cMGP 1921 ± 605 pmol/L and dp-ucMGP 442 ± 242 pmol/L; \( P < 0.0001 \)). dp-cMGP exhibited an inverse correlation with dialysis vintage (\( r = -0.28, P = 0.0001 \)) and a positive correlation with body mass index (\( r = 0.24, P = 0.0009 \)), whereas dp-ucMGP did not show such a relationship (data not shown). Age, diabetes, and dialysis efficacy (i.e., Kt/V) were not related to plasma levels of dp-cMGP (Table 1). Patients with lower plasma levels of dp-cMGP exhibited 3.3-fold elevated plasma levels of dp-cMGP (6247 ± 1778 pmol/L) and 6.5-fold elevated plasma levels of dp-ucMGP (2850 ± 1768 pmol/L) compared with 98 age-matched healthy subjects with normal renal function (dp-cMGP 1921 ± 605 pmol/L and dp-ucMGP 442 ± 242 pmol/L; \( P < 0.0001 \)).

#### Table 1. Characteristics of patients with high and low levels of desphospho-carboxylated MGP (mean ± SD, range; or number, percent), relative risk (odds ratio), and 95% confidence intervals for low and high levels of dp-cMGP (univariate logistic regression)

<table>
<thead>
<tr>
<th>Clinical parameters</th>
<th>All Patients (n = 188)</th>
<th>dp-cMGP &lt; 6139 pmol/L (n = 94)</th>
<th>dp-cMGP &gt; 6139 pmol/L (n = 94)</th>
<th>Odds Ratio</th>
<th>95% Confidence Interval</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>age, years</td>
<td>59 ± 11</td>
<td>59 ± 11</td>
<td>59 ± 11</td>
<td>0.99</td>
<td>0.97 to 1.02</td>
<td>0.76</td>
</tr>
<tr>
<td>male/female</td>
<td>99/89</td>
<td>55 (59%)/39 (41%)</td>
<td>44 (47%)/50 (53%)</td>
<td>0.62</td>
<td>0.35 to 1.11</td>
<td>0.11</td>
</tr>
<tr>
<td>diabetes mellitus</td>
<td>21 (11%)</td>
<td>11 (12%)</td>
<td>10 (11%)</td>
<td>0.90</td>
<td>0.36 to 2.23</td>
<td>0.82</td>
</tr>
<tr>
<td>hypertension</td>
<td>164 (87%)</td>
<td>81 (86%)</td>
<td>83 (88%)</td>
<td>1.21</td>
<td>0.51 to 2.86</td>
<td>0.66</td>
</tr>
<tr>
<td>smoking</td>
<td>61 (32%)</td>
<td>32 (34%)</td>
<td>29 (31%)</td>
<td>0.86</td>
<td>0.47 to 1.59</td>
<td>0.64</td>
</tr>
<tr>
<td>body mass index, kg/m²</td>
<td>23.5 ± 3.8</td>
<td>22.7 ± 3.8</td>
<td>24.3 ± 3.6</td>
<td>1.12</td>
<td>1.03 to 1.22</td>
<td>0.007</td>
</tr>
<tr>
<td>Dialysis parameters</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>dialysis vintage, years</td>
<td>6.8 ± 4.8</td>
<td>7.5 ± 5.1</td>
<td>6.0 ± 4.3</td>
<td>0.93</td>
<td>0.88 to 0.99</td>
<td>0.03</td>
</tr>
<tr>
<td>Kt/V</td>
<td>1.28 ± 0.20</td>
<td>1.28 ± 0.21</td>
<td>1.29 ± 0.19</td>
<td>0.97</td>
<td>0.23 to 4.12</td>
<td>0.97</td>
</tr>
<tr>
<td>Biochemical serum parameters</td>
<td></td>
<td></td>
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<tr>
<td>protein, g/L</td>
<td>67.1 ± 4.9</td>
<td>67.1 ± 4.5</td>
<td>67.0 ± 5.2</td>
<td>1.00</td>
<td>0.94 to 1.06</td>
<td>0.91</td>
</tr>
<tr>
<td>calcium, mmol/L</td>
<td>2.31 ± 0.18</td>
<td>2.30 ± 0.17</td>
<td>2.31 ± 0.19</td>
<td>1.52</td>
<td>0.30 to 7.56</td>
<td>0.61</td>
</tr>
<tr>
<td>phosphate, mmol/L</td>
<td>1.62 ± 0.42</td>
<td>1.61 ± 0.40</td>
<td>1.62 ± 0.44</td>
<td>1.03</td>
<td>0.52 to 2.06</td>
<td>0.93</td>
</tr>
<tr>
<td>intact PTH, pg/ml</td>
<td>392 ± 493 (median 192)</td>
<td>454 ± 513 (median 252)</td>
<td>331 ± 468 (median 162)</td>
<td>1.00</td>
<td>1.00 to 1.00</td>
<td>0.10</td>
</tr>
<tr>
<td>cholesterol, mmol/L</td>
<td>5.13 ± 1.22</td>
<td>5.05 ± 1.26</td>
<td>5.21 ± 1.18</td>
<td>1.12</td>
<td>0.88 to 1.42</td>
<td>0.36</td>
</tr>
<tr>
<td>triglycerides, mmol/L</td>
<td>2.33 ± 1.34</td>
<td>2.16 ± 1.34</td>
<td>2.51 ± 1.34</td>
<td>1.23</td>
<td>0.98 to 1.55</td>
<td>0.08</td>
</tr>
<tr>
<td>high-sensitivity C-reactive protein, mg/L</td>
<td>7.90 ± 11.81 (median 3.25)</td>
<td>9.93 ± 14.78 (median 3.32)</td>
<td>5.92 ± 7.46 (median 2.93)</td>
<td>0.97</td>
<td>0.94 to 1.00</td>
<td>0.03</td>
</tr>
</tbody>
</table>

Bold type indicates \( P < 0.05 \).
Vitamin K Status in Dialysis Patients
Plasma levels of the liver protein induced by vitamin K absence-II (PIVKA-II) were elevated in 121 (64%) of the patients (median, 2.98; range, 0.45 to 318 ng/ml), indicating hepatic vitamin K deficiency (Figure 1). PIVKA-II levels correlated well with those of dp-ucMGP \((r = 0.62; P < 0.0001)\) and the ratio of dp-ucMGP over dp-cMGP \((r = 0.55; P < 0.0001)\) and slightly with dp-cMGP \((r = 0.19; P = 0.01)\).

MGP and Calcification
dp-cMGP did not show an association with vascular or valvular calcifications at single sites as determined by ultrasound or x-ray (Table 1). Next we compared MGP levels with two semi-quantitative calcification scores, namely the Adragao score\(^{11}\) and the extended composite score (Adragao score plus calcifications of arteriovenous [AV] fistula and neighboring arteries, carotid arteries, and mitral and aortic heart valves).\(^{12}\) These analyses showed 9 and 12% lower levels, respectively, of dp-cMGP in patients with more extensive calcifications compared with patients with fewer calcifications \((P = 0.042\) and \(P = 0.011\), respectively; Figure 2). dp-ucMGP and PIVKA-II levels did not correlate with the extent of vascular calcifications (data not shown).

dp-ucMGP and Survival in Hemodialysis Patients
We next categorized the hemodialysis patients as being above or below the median of MGP plasma levels to perform a Kaplan-Meier survival analysis over 3 years. Plasma concentrations of dp-ucMGP were not significantly associated with all-cause and cardiovascular mortality (log-rank test: \(P = 0.08\) and \(P = 0.09\), respectively). Using univariate Cox regression analysis, low levels of dp-ucMGP had a hazard ratio (HR) of 1.71 (95% confidence interval [CI], 0.92 to 3.17; \(P = 0.09\)) for all-cause mortality and an HR of 1.83 (95% CI, 0.90 to 3.70; \(P = 0.09\)) for cardiovascular mortality. High PIVKA-II levels (>2 ng/ml) were not associated with an increased mortality risk (log-rank test: \(P = 0.67\); Cox regression: HR, 1.00; 95% CI, 0.53 to 1.89; \(P = 1.00\)).

dp-cMGP and Survival in Hemodialysis Patients
Kaplan-Meier analysis showed that low dp-cMGP levels (<6139 pmol/L) were associated with an increased all-cause and cardiovascular mortality risk (Figure 3; log-rank test: \(P = 0.008\) and \(P = 0.003\), respectively). The univariate Cox regression analysis showed an HR of 2.32 (95% CI, 1.2 to 4.4; \(P = 0.009\)) for all-cause mortality and an HR of 2.98 (95% CI, 1.4 to 6.4; \(P = 0.005\)) for cardiovascular mortality (Figure 4; Table 2). When adjusting for age, low plasma levels of dp-cMGP remained a significant predictor for all-cause (HR, 2.31; 95% CI, 1.2 to 4.4; \(P = 0.010\)) and cardiovascular mortality (HR, 2.94; 95% CI, 1.4 to 6.3; \(P = 0.006\)). The multivariable Cox regression analysis with adjustment for age plus adjustment for the serum parameters calcium, phosphate, and high-sensitivity CRP yielded HRs of 2.16 (95% CI, 1.1 to 4.3; \(P = 0.027\)) for all-cause and 2.74 (95% CI, 1.2 to 6.2; \(P = 0.015\)) for cardiovascular mortality (Figure 4; Table 2).

Effect of Vitamin K2 Supplementation
To examine whether vitamin K can affect dp-ucMGP and dp-cMGP levels, we performed a vitamin K2 supplementation pilot study in 17 hemodialysis patients (Figure 5). Daily vitamin K2 supplementation (135 \(\mu\)g of menaquinone-7 orally) over a period of 6 weeks resulted in a significant reduction of dp-ucMGP (baseline: 2750 ± 39 pg of menaquinone-7 orally; \(P = 0.004\)) and of PIVKA-II (baseline: 5.6 ± 3.2 ng/ml, 6-week K2: 3.4 ± 2.2 ng/ml, \(P = 0.0004\)), whereas vitamin K2 did not change dp-cMGP levels in a significant way.
In this study, we provided the first data on plasma levels of dp-cMGP in hemodialysis patients as a marker for mortality risk. Moreover, we report that vitamin K2 supplementation can improve the vitamin K status of dialysis patients.

First, we found that dialysis patients exhibited markedly elevated plasma levels of both MGP species (dp-ucMGP and dp-cMGP) compared with subjects with normal renal function. Because both species are based on a capture antibody directed against the nonphosphorylated MGP peptide, impaired MGP phosphorylation in the dialysis population might explain the increased levels of desphospho-MGP. Increased production or release of MGP may also relate to the generally increased vascular damage observed in dialysis patients, and indeed, an accumulation of MGP in and around vascular calcifications has been documented. Moreover, decreased MGP renal clearance could be attributed to reduced kidney function. In healthy subjects, MGP, with an apparent molecular mass of 12 kD, is not found in urine, but MGP levels in renal veins are reported to be 13% lower than in renal arteries. Thus, as expected with a low-molecular mass protein, the kidneys excrete and metabolize MGP, and some degree of renal retention will occur in dialysis patients.

We previously reported low circulating t-ucMGP levels in hemodialysis patients. Although seemingly contradictory to this finding of high dp-ucMGP levels, this may be explained by the fact that low t-ucMGP levels were measured with a mono-antibody assay, irrespective of its phosphorylation status. The concentration of t-ucMGP is in the nanomole range, whereas both dp-cMGP and dp-ucMGP are in the picomole range, with an approximately 2000-fold difference. The t-ucMGP fraction is likely to consist largely of phosphorylated MGP, fragmented MGP, and only a small fraction of dp-ucMGP. The increased dp-ucMGP levels in uremia found in our study are consistent with a recent study showing increasing dp-ucMGP levels with higher chronic kidney disease (CKD) stages. In this study, the levels seemed to be even higher than those of our previous study, which may be because of the fact that we studied ESRD patients with long dialysis vintage and little to no residual renal function. Additionally, it could also point to a more pronounced vitamin K deficiency in our cohort of patients with long dialysis vintage. Our ESRD patients with long dialysis vintage are likely to represent the patient cohort with the worst vascular dysfunction. The fact that in this population all dp-cMGP levels were extremely high could explain why no other significant correlations of MGP with vascular measures were observed in our study.

The major finding of our study was that dp-cMGP levels below the median predicted all-cause and cardiovascular mortality in dialysis patients. MGP acts locally in the vessel wall,
caused by apoptosis. Thus, suboptimal production of active MGP may be attributed to the fact that MGP is no longer being phosphorylated, increased synthesis, or slow elimination. In our study, dp-cMGP levels were related to a higher mortality risk. This seemingly paradoxical result cannot easily be explained but is likely that the elevated dp-ucMGP levels observed in dialysis patients largely reflect vascular vitamin K deficiency. This observation suggests that dialysis patients are not only vitamin K deficient in the liver but in the vessel wall as well. Dialysis patients are known to exhibit subclinical vitamin K deficiency. However, direct assessment of vitamin K levels is difficult to interpret because these levels depend on recent nutritional intake. In two studies, 6 to 29% of the CKD patients had low phylloquinone levels, indicating a systemic vitamin K deficiency. However, osteocalcin, as a biomarker of vitamin K deficiency in CKD, can be compromised by the retention of fragments and secondary hyperparathyroidism. In the context of vitamin K deficiency, concerns have been raised about therapeutic vitamin K antagonism (coumarin derivatives) in dialysis patients with atrial fibrillation. In a retrospective study, it was shown that dialysis patients have an increased risk for both hemorrhagic and ischemic stroke when treated with coumarins compared with no treatment at all. In addition, in a randomized trial to prolong graft patency with warfarin, the study had to be stopped because of significantly increased major bleeding events in the treatment group. In animal models and humans, warfarin has been shown to induce significantly more cardiovascular calcifications. Given these data, vitamin K supplementation seems to be an attractive therapeutic option in patients at cardiovascular risk. Indeed, vitamin K2 (menaquinone-7) supplementation in hemodialysis patients significantly reduced the levels of dp-ucMGP in our study. In line with this, supplementing elderly subjects for 3 years with vitamin K1 significantly halted the progression of coronary artery calcification in the group of participants adherent to treatment, supporting our view that improving the vascular vitamin K status positively affects vascular health. Moreover, in subjects with normal renal function, the intake of dietary vitamin K2 was inversely correlated with the mortality rate.
In conclusion, we report for the first time that dp-cMGP may serve as a potent survival predictor in hemodialysis patients and possibly reflects their vascular health. Given the fact that vitamin K2 supplementation reduces dp-ucMGP levels, our study provides the basis for interventional studies with vitamin K supplementation.

**CONCISE METHODS**

**Patients**

We prospectively analyzed 188 prevalent hemodialysis patients with a low prevalence of diabetes (11%) from the Center for Renal Diseases of the Zvezdara University Medical Center, Belgrade (Table 1). All chronic hemodialysis patients were eligible to enter the study if they agreed to participate. Patients on warfarin treatment were excluded. The control group consisted of 98 healthy volunteers with normal renal function (58 ± 15 years). The study protocol was approved by the Ethics Committee of the Zvezdara University Medical Center, Belgrade, and each patient gave informed consent. Patients were enrolled between December 2003 and October 2005 and observed for 221 to 1662 days until the end of June 2008 (mean follow-up, 1104 days). During the observation period, 43 deaths occurred (cardiovascular, 32; malignancy, 7; other, 4). Gender was equally distributed (99 male, 89 female). Etiologies for ESRD were as follows: hypertensive nephrosclerosis, 99 (53%); glomerulonephritis, 24 (13%); autosomal dominant polycystic kidney disease, 19 (10%); pyelonephritis, tubulointerstitial disease, and obstructive nephropathy, 24 (13%); diabetic nephropathy, 10 (5%); systemic lupus erythematosus, 4 (2%); Balkan endemic nephropathy, 8 (4%). The presence of vascular disease at the start of the study was defined as a pre-existing diagnosis of coronary artery disease, cerebrovascular disease, or peripheral artery disease.

**Vascular Calcification**

Calcifications were assessed by x-ray and ultrasound. X-rays of the pelvis, hands, and AV-fistula arm were performed, and obvious vas-
cular calcifications were counted by two independent observers. In addition, echocardiography of the mitral and aortic heart valve and ultrasound of both carotid arteries were used for the detection of calcifications. Valvular calcifications were determined by one single observer using echocardiography with an Aspen-ACUSON device (Mountain View, CA) equipped with a 2.5-MHz probe and calcified carotid plaques were defined as echogenic structures showing protrusion into the lumen with focal widening that was 50% greater than the intima media thickness (IMT) of adjacent sites. In addition to single calcification sites, we calculated two semiquantitative calcification scores. First, we determined the Adragao score by analyzing conventional x-rays of the pelvis and hands. In brief, x-rays of the pelvis and both hands were divided into four sections by a median vertical line and a horizontal line just above the upper rim of the femoral heads and the metacarpal bones, respectively. The presence of linear vascular calcification in each quadrant was counted as 1 point; thus, a maximum of 8 points could be achieved. Second, we created an extended composite calcification score where not only calcifications of pelvis and hands but also calcifications of the fistula arm plus neighboring arteries, mitral, and aortic heart valves and both carotid arteries were accounted for. Each site of calcification assessment was counted as 1 point. Thus, a maximum score of 15 points could be obtained: Adragao (pelvis 4, hands 4), fistula arm, i.e., fistula itself with one (upper arm) or two (lower arm) neighboring arteries (2 or 3 points), mitral plus aortic valves (2), and carotid arteries (2). X-ray images were assessed by two experienced physicians blinded to the patient’s condition. To compare patients with a low versus a high Adragao calcification score, patients with a score of 0 to 2 were included in the low calcification group, and patients with a score of 3 to 8 were in the high calcification group. For the composite score, patients with a lower score of 0 to 6 were compared with patients with a higher score of 7 to 15. It has been shown for the Adragao score that patients with a score of 0 to 2 have a better prognosis than those with a score of 3 to 8. Moreover, the presence of calcifications of the heart valves and the AV fistula have been shown to be a mortality risk factor. Bellasi et al. reported that simple measures of cardiovascular calcification had a very good correlation with more sophisticated measurements obtained with CT.

**Assessment of Cardiovascular Parameters**

To determine cardiovascular parameters we measured systolic and diastolic BP, carotid-femoral pulse wave velocity, and IMT, as described previously. Briefly, pulse wave velocity was assessed using one carotid and one femoral sensor simultaneously to determine the velocity of the pulse in relation to the distance between the femoral artery and the suprasternal notch (Complior SP system; Artech Medical, Pantin, France). Two measurements were performed by two trained observers. To determine IMT, B-mode ultrasonography of the carotid arteries was performed using ALOCA SSD 2000 system (Tokyo, Japan) equipment with 7.5-MHz linear transducers. One trained investigator scanned both common carotid arteries, 4 cm from the bulbs, the carotid bulbs, and the first 2 cm of the internal and external carotid arteries. IMT and lumen diameter measurements were performed in a plaque-free area. IMT was measured as the distance between adventitia and the lining of the arterial lumen/intima (mm).

This was measured four times on both sides, and the mean of these measurements was recorded.

**Biochemistry**

Blood was drawn from the arterial site after a long dialysis interval just before dialysis started (nonfasting) and was collected in citrate and in serum tubes. Levels of circulating dp-ucMGP and dp-cMGP were determined in plasma using sandwich ELISA techniques. Both assays use a monoclonal antibody against the nonphosphorylated sequence 3 to 15 as capture antibody. The dp-ucMGP assay is based on the use of the detection monoclonal antibody directed against the noncarboxylated sequence 35 to 49 in human MGP (Vita K BV, Maastricht, The Netherlands). dp-cMGP levels were measured by a similar sandwich ELISA in which the detection antibody was directed against the carboxylated sequence 35 to 53 in human MGP (Vita K BV). Plasma PIVKA-II levels were assessed by ELISA (Asserachrom PIVKA-II; Stago, Asnières-sur-Seine, France); normal PIVKA-II levels were considered <2 ng/ml. Biochemical analysis of serum factors (calcium, phosphate, lipids, protein, cholesterol, triglycerides) was performed by standard laboratory procedures using an automated analyzer. In- tact PTH was assessed by a chemiluminescence assay (Diagnostic Product Corporation, Los Angeles, CA). Serum analysis for high-sensitivity CRP was performed by particle-enhanced immunonephelometry using a standard “CardioPhase hsCRP” for “BNII” (Dade Behring Holding GmbH, Liederbach, Germany). Calcium and phosphate measurements were calculated as mean values from four measurements within 4 months before the start of the study. All other parameters were single measurements at the beginning of the study.

**Vitamin K2 Supplementation**

Seventeen hemodialysis patients (mean age, 62 ± 17 years; 13 male/4 female) were recruited for a 6-week pilot study of daily supplementation with vitamin K2. Inclusion criteria were age >18 years and stable hemodialysis for >3 months. Exclusion criteria were soy allergy, warfarin treatment, history of thrombosis, inflammatory bowel disease, steroid medication, and pregnancy. After obtaining plasma samples for the determination of basal levels of dp-ucMGP and dp-cMGP, patients were orally administered 135 mg of the vitamin K2 form menaquinone-7 (MK-7; NattoPharma, Lysaker, Norway) daily over a period of 6 weeks. The protocol of the pilot study adhered to the Declaration of Helsinki and was approved by the ethics committee of the Rheinisch-Westfälische Technische Hochschule Aachen, and each patient gave written informed consent.

**Statistical Analysis**

Continuous variables were summarized by means and corresponding SD. Comparisons of the values of continuous variables between two groups were made using an unpaired t test. Paired t test was used for the analysis of dp-ucMGP and dp-cMGP levels before and after 6 weeks of vitamin K2 supplementation. Categorical variables were summarized by relative frequencies. The χ² test was used for studying associations between various categorical variables. Relative risk (odds ratio) and 95% CIs for numerous variables were calculated by univariate logistic regression. The Kaplan-Meier method was used to estimate the cumulative survival. To identify the prognostic factors of
all-cause and cardiovascular death, comparisons between survival curves were made by log-rank test. Cox regression was used (enter method) to determine the effect of MGP levels and PIVKA-II on all-cause and cardiovascular mortality. The multivariable adjusted Cox regression analysis accounted for age, gender, diabetes, dialysis vintage, body mass index, presence of vascular disease at the start of the study, and serum calcium, phosphate, and high-sensitivity CRP as possible confounders. Confounders were selected either on the basis of whether they showed a significant association with dp-cMGP (Table 1) or whether they were known to influence mortality per se. Statistical analysis was performed with SPSS 16.0. P < 0.05 was considered statistically significant.

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DISCLOSURES

C.V. is CEO of VitaK, Maastricht University, The Netherlands. L.S. is VitaK’s vice president and consultant to NattoPharma (Lysaker, Norway), the supplier of the vitamin K2 form menaquinone-7.

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