

## TRANSCRIPTIONAL ACTIVITY OF GENE ENCODING SUBUNITS R1 AND R2 OF INTERFERON GAMMA RECEPTOR IN PERIPHERAL BLOOD MONONUCLEAR CELLS IN PATIENTS WITH SLOW CORONARY FLOW

TRANSKRIPCIONA AKTIVNOST PODJEDINICA R1 I R2 KOJE KODIRAJU GENE ZA RECEPTOR ZA INTERFERON GAMA U MUNONUKLEARNIM ČELIJAMA PERIFERNE KRVI PACIJENATA SA SPORIM KORONARNIM PROTOKOM

Sanaz Faramarz-Gaznagh<sup>1</sup>, Yousef Rasmi<sup>1,2</sup>, Mohammad-Hasan Khadem-Ansari<sup>1</sup>, Mir-Hossein Seyed-Mohammadzad<sup>3</sup>, Morteza Bagheri<sup>2</sup>, Mohadeseh Nemati<sup>1</sup>, Alireza Shirpoor<sup>4</sup>, Ehsan Saboori<sup>5</sup>

<sup>1</sup>Department of Biochemistry, Faculty of Medicine, Urmia University of Medical Sciences, Urmia, Iran

<sup>2</sup>Cellular and Molecular Research Center, Urmia University of Medical Sciences, Urmia, Iran

<sup>3</sup>Department of Cardiology, Faculty of Medicine, Urmia University of Medical Sciences, Urmia, Iran

<sup>4</sup>Department of Physiology, Faculty of Medicine, Urmia University of Medical Sciences, Urmia, Iran

<sup>5</sup>Neurophysiology Research Center, Urmia University of Medical Sciences, Urmia, Iran

### Summary

**Background:** Slow coronary flow (SCF) is a coronary artery disorder characterized with delayed opacification of epicardial coronary arteries without obstructive coronary disease. The pathophysiological mechanisms of SCF remain unclear. One of the possible mechanisms that may participate in the pathology of SCF is endothelial dysfunction related to the inflammatory process. Interferon gamma (IFN- $\gamma$ ) is an inflammatory cytokine that acts through its specific receptor composed of two subunits, IFN- $\gamma$ R1 and IFN- $\gamma$ R2. Transcriptional activity of the gene encoding these subunits influences IFN- $\gamma$  activity. This study aimed to investigate the gene expression of IFN- $\gamma$  receptor subunits in peripheral blood mononuclear cells (PBMC) from patients with SCF.

**Methods:** The study was performed with 30 patients (22 male/8 female) aged 35–76 ( $52.8 \pm 11.7$  years) with SCF and 15 sex- (11 male/4 female), Body Mass Index (BMI)- and age-matched ( $54.73 \pm 9.42$  years) healthy subjects. Total mRNA was extracted from PBMC and was determined by quantitative reverse transcriptase polymerase chain reaction (qRT-PCR). The relative expression values ( $2^{-\Delta\Delta Ct}$ ) between control and case groups were determined and the Mann-Whitney *U* test was used for statistical analysis.

**Results:** There was a significant increase in the gene expression of IFN- $\gamma$ R1 in PBMC from SCF patients vs. con-

### Kratak sadržaj

**Uvod:** Spor koronarni protok (SKP) kao poremećaj koronarnih arterija odlikuje odložena opacifikacija epikardijalnih koronarnih arterija bez opstruktivne koronarne bolesti. Patofiziološki mehanizmi SKP još su nerazjašnjeni. Jedan od mehanizama koji potencijalno učestvuju u patologiji SKP je endotelna disfunkcija povezana sa inflamatornim procesom. Interferon gama (IFN- $\gamma$ ) je inflamatorni citokin koji deluje preko svog specifičnog receptora sastavljenog od dve podjedinice, IFN- $\gamma$ R1 i IFN- $\gamma$ R2. Transkripciona aktivnost gena koji kodira ove dve podjedinice utiče na aktivnost IFN- $\gamma$ . Cilj ove studije bio je da se istraži genska ekspresija podjedinica receptora IFN- $\gamma$  u mononuklearnim ćelijama periferne krvi (MČPK) pacijenata sa SKP.

**Metode:** Studijom je obuhvaćeno 30 pacijenata (23 muškarca / 7 žena) starosti 35–76 ( $52,8 \pm 11,7$ ) godina sa SKP i 15 (11 muškaraca / 4 žene) zdravih subjekata odgovarajućeg pola, indeksa telesne mase (ITM) i starosti ( $54,73 \pm 9,42$  godina). Ukupna mRNK je ekstrahovana iz MČPK i određena pomoću qRT-PCR. Određene su relativne vrednosti ekspresije između kontrolne i grupe pacijenata a Man-Vitnjev *U* test je upotrebljen za statističku analizu.

**Rezultati:** Postojao je značajan porast genske ekspresije IFN- $\gamma$ R1 u MČPK pacijenata sa SKP u poređenju s kontrolama ( $P < 0,0001$ ), ali razlike između genske ekspresije

Address for correspondence:

Yousef Rasmi

Department of Biochemistry, Faculty of Medicine,  
Urmia University of Medical Sciences, Urmia, Iran  
tel: +9844327706998, fax: +984432780801  
e-mail: rasmiy@umsu.ac.ir

trols ( $P < 0.0001$ ); but the differences in IFN- $\gamma$ R2 gene expression were statistically insignificant between patient and control groups ( $P = 0.853$ ).

**Conclusions:** It can be concluded that IFN- $\gamma$ R1 gene expression may influence the function of microvasculature and thereby contribute to the pathophysiology of SCF.

**Keywords:** slow coronary flow, interferon gamma receptor, gene expression, inflammation, coronary artery disease

## Introduction

Slow coronary flow (SCF) has been defined as an angiographic finding characterized by delayed opacification of the epicardial coronary arteries in the absence of obstructive coronary disease which was first described by Tambe et al. in 1972 (1). Incidence of this common angiographic finding has been reported to be 1–7% in patients undergoing coronary angiography (2, 3), 40% in patients with normal arteries (4), 16% in cardiac syndrome X (CSX) patients (5) and 4% in patients undergoing angiography for rapid assessment of unstable angina (6). It has been reported more frequently in young men, most commonly smokers or with the history of smoking (2).

Only a limited number of studies have focused on SCF since the first description; therefore, the precise pathophysiological mechanisms and the clinical importance of SCF have not yet been extensively understood (7). Several proposed mechanisms for this phenomenon include: small-vessel disease, microvascular vasomotor dysfunction, diffuse atherosclerosis, endothelial dysfunction (3, 8, 9), platelet dysfunction (10), and imbalance of vasoconstrictor factors (11, 12). Occlusive disease of the small coronary arteries, a form of early-phase atherosclerosis, has also been proposed as a cause (13). According to recent studies, inflammation is another important etiologic factor (14, 15). Increased levels of inflammatory cytokines in SCF patients may be an indicator of endothelial activation and inflammation, which may lead to the SCF phenomenon (14).

Interferon gamma (IFN- $\gamma$ ), a type II IFN family cytokine, is an anti-viral agent produced by many immune cell types (16). It is an important cytokine with a multitude of functions. Besides its immunomodulatory and inflammatory activities (17), this cytokine is involved in atherogenesis, apoptosis (17, 18), nociceptive pathways (19), endothelial dysfunction (20) and progression of atherosclerosis (21).

IFN- $\gamma$  acts through its specific receptor composed of two subunits, IFN- $\gamma$ R1 and IFN- $\gamma$ R2. Transcriptional activity of the gene encoding of these subunits influences IFN- $\gamma$  activity. Since one of the possible mechanisms that may participate in the pathology of SCF is endothelial dysfunction related to inflammatory process and there is no evidence regarding the possible role of IFN- $\gamma$  in SCF, the present study aimed to investigate the gene expression of IFN- $\gamma$  receptor subunits in peripheral blood mononuclear cells (PBMC) from patients with SCF.

IFN- $\gamma$ R2 pacijenata i kontrolnih subjekata nisu bile statistički značajne ( $P = 0,853$ ).

**Zaključak:** Može se zaključiti da genska ekspresija IFN- $\gamma$ R1 može uticati na funkciju mikrovaskulature i time doprineti patofiziologiji SKP.

**Ključne reči:** spor koronarni protok, receptor za interferon gama, genska ekspresija, inflamacija, koronarna arterijska bolest

## Materials and Methods

### Study population

The study includes 30 SCF patients aged 35–76 ( $52.8 \pm 11.70$  years) and 15 sex-, body mass index (BMI)- and age-matched ( $54.73 \pm 9.42$  years) healthy subjects as controls. Entry criteria were typical anginal chest pain, positive treadmill test, normal angiogram and thrombolysis in myocardial infarction (TIMI) frame count (quantitative way of assessing coronary artery flow) greater than 23 frames (22). Patients with known coronary or peripheral vascular disease, ectatic coronary arteries, non-ischemic dilated cardiomyopathy, renal and hepatic dysfunction, evidence of ongoing infection or inflammation, hematological disorders, known malignancy and diabetes mellitus were excluded from the study. A questionnaire was administered to obtain general information from each patients including age, sex, BMI, systolic and diastolic blood pressures. The study was approved by the Medical Ethics Committee (ethical approval code: IRumsu.rec.1393.26) at Urmia University of Medical Sciences, Urmia, Iran, and all subjects gave written informed consent.

### Study protocol

Ten milliliter whole blood samples were collected from the basilic vein into tubes containing EDTA and the separation of PBMC from whole blood was accomplished through density gradient centrifugation using Ficoll. Five ml of Ficoll-Hypaque (Baharafshan, Iran) was stratified under 20 mL of peripheral blood and phosphate-buffered saline (PBS) mixture, and then the sample was centrifuged at 800 g for 20 min at room temperature. PBMC were collected from buffy coat layer and were washed twice with PBS. Total RNA was extracted from PBMC, using RNX-Plus Solution (CinaGen Co., Tehran, Iran) and the purity of RNA extracts was qualitatively evaluated by electrophoresis in 1% agarose gel stained with ethidium bromide and quantified by measuring absorption at 260 nm and 280 nm, then calculating the 260A/280A ratio (260A/280A must be greater than 1.8) in a biophotometer (Ependorf AG, Germany). Primers for amplification of IFN- $\gamma$  receptor's subunits and  $\beta$ -actin as an endogenous control were as following, depicted in Table 1 (GenFanavaran Co., Tehran, Iran) (23).

**Table I** Primer sequences used for qRT-PCR.

Primers	Sequence	Ta
IFN- $\gamma$ R1	5'-ATACCGAAGACAATCCAGGAAAAGTGGAAACA-3' (forward) 5'-GCGATGCTGCCAGTTTCAGACTGGTTACTA-3' (reverse)	68 °C
IFN- $\gamma$ R2	5'-CAAGGACAGCTCACCAAAGGATGACG-3' (forward) 5'-CAGCTCCGATGGCTTGATCTCTTCCA-3' (reverse)	68 °C
$\beta$ -actin	5'-TCACCCACATGTGCCCATCTACGA-3' (forward) 5'-CAGCGGACCCGCTCATTGCCAATGG-3' (reverse)	68 °C

Ta: annealing temperature

**Table II** Demographic and clinical characteristics of SCF patients and control group†

Parameter	Control	SCF	P value
Age (years)	54.73±9.42	52.8±11.70	0.583
Sex (female/male)	4/11	8/22	0.060
BMI (kg/m <sup>2</sup> )	27.74±3.47	26.93±4.46	0.543
Systolic BP (mmHg)	139.27±11.46	128.07±15.87	0.019*
Diastolic BP (mmHg)	89.60±9.70	78.53±13.11	0.006*
Heart rate (number)	76±9	74±7	0.321
WBC (×1000 mm <sup>3</sup> )	6.44±1.17	7.52±2.68	0.289
Smoking (%)	0	60.71	0.0002*
Family history of CHD (%)	0	26.66	0.027*
Aspirin (%)	–	70	–
Statins (%)	–	63.33	–
Beta-blockers (%)	–	66.66	–

† Results expressed as mean ± standard deviation. BP: Blood pressure, BMI: Body Mass Index, WBC: White Blood Cell, SCF: Slow Coronary Flow, CHD: Coronary Heart Disease

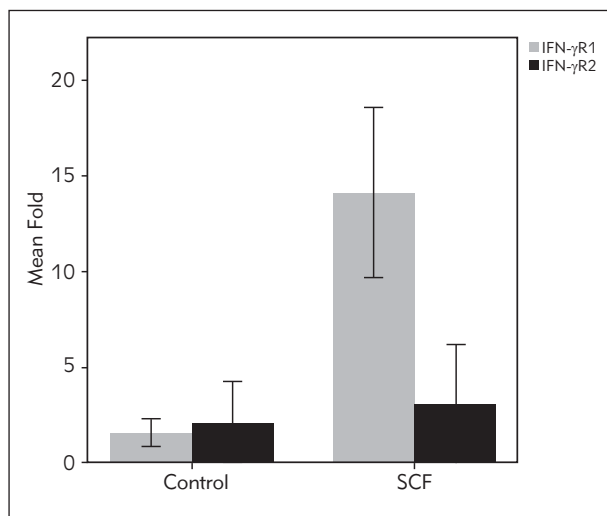
Complementary DNA (cDNA) were synthesized by using the BioRT cDNA first strand synthesis kit (Bioflux-Bioer, Hangzhou, China) according to manufacturer's instructions. In order to determine the gene expression of IFN- $\gamma$ R1 and IFN- $\gamma$ R2, quantitative reverse transcriptase polymerase chain reaction (qRT-PCR) was performed using the SYBR Green RT-PCR kit (Bioneer, Accu Power 2X Green Star™ qPCR Master mix, Deajeon, Korea). PCR conditions were as follows: 94 °C for 15 min; 45 cycles: 94 °C for 15 s, 68 °C for 30 s and 72 °C for 30 s. All reactions were carried out in duplicate. Relative gene expression was determined by  $\Delta\Delta$ Ct method between patients and controls (24). Data are presented as the fold change in gene expression normalized to  $\beta$ -actin as an endogenous reference.

#### Statistical analysis

The data were analyzed by Statistical Package for Social Sciences (SPSS) 22 software. In order to check the normality of the distribution, Kolmogorov-Smirnov test was performed. In case of a normal distribution, the *t*-student test was used; otherwise, the Mann-Whitney *U* test was performed. All values were expressed as means ± standard deviation (mean ± SD). Differences were considered to be significant at P value less than 0.05.

#### Results

Demographic and clinical characteristics of both groups are depicted in *Table II*.



**Figure 1** IFN- $\gamma$ R1 and IFN- $\gamma$ R2 mean fold changes in control and SCF groups.

In SCF and control groups, the mean differences in systolic blood pressure and diastolic blood pressure were statistically significant. There was an increase in mean WBC count in SCFs vs. controls, but it was not significant. This means leukocyte count had no effect on differences in expression of the studied gene.

Expression of gene encoding IFN- $\gamma$  receptor subunits was higher in SCF patients vs. controls (*Figure 1*). There was a significant increase in gene expression of IFN- $\gamma$ R1 in PBMC from SCF patients vs. control individuals ( $14.09 \pm 11.43$  vs.  $1.6 \pm 1.31$ ;  $P < 0.0001$ ), but the differences in IFN- $\gamma$ R2 gene expression were statistically insignificant between patients and controls groups ( $3.08 \pm 8.09$  vs.  $2.08 \pm 3.93$ ;  $P = 0.853$ ).

In this study, Spearman analysis between IFN- $\gamma$ R1 and IFN- $\gamma$ R2 expression revealed that there was a positive correlation at the 0.001 level ( $r = 0.306$ ,  $P = 0.046$ ).

In multiple logistic regression analysis, gene expression of IFN- $\gamma$ R1 strongly (OR: 1.761,  $P = 0.018$ , CI=1.104–2.809) predicted SCF.

## Discussion

Although several possible mechanisms have been proposed for the SCF phenomenon, its exact etiology remains unclear (7). Histopathological (3) and intravascular ultrasound studies (25) suggest a pathophysiologically relevant interaction between endothelial dysfunction (26), diffuse atherosclerosis and the SCF phenomenon despite angiographically normal coronary arteries (25). In recent years, mechanism-oriented studies have shown inflammation plays an important role in the initiation, development as well as evolution of atherosclerosis (27, 28). Inflammation is a major

contributing factor in many cardiovascular events and its association with the clinical setting of coronary artery disease has been demonstrated (29). Recent studies have reported a possible role of inflammatory mechanisms in the pathology of SCF (14, 15). Turhan et al. showed increased plasma levels of soluble adhesion molecules in patients with SCF (15) indicating increased levels of inflammatory cytokines in these patients may be possible markers for endothelial activation and inflammation that may lead to SCF (14). Thereby, it can be expected that differences in the expression of inflammatory cytokines and their receptors exist in these patients. Among different inflammatory cytokines, IFN- $\gamma$  is considered to have a significant role in the progression of atherosclerosis (18, 21). By stimulating cytokine production, recruiting inflammatory cells to the site of injury through increased expression of chemokines and adhesion molecules and regulating the rate of proliferation, differentiation and apoptosis, IFN- $\gamma$  has a potential impact on the process of atherosclerosis development (21). It has been shown to increase CD40 expression on macrophages, endothelial cells and smooth muscle cells (30) and therefore can potentially promote further CD40/CD40 Ligand mediated inflammation in atherosclerosis (18). Increased serum level of CD40, an indirect marker of CD40/CD40L, was demonstrated in SCF (7). IFN- $\gamma$  triggers the formation and release of reactive oxygen species which leads to oxidative stress and endothelial dysfunction (31). Oxidation of oxidation-sensitive substance like B-vitamins (eg. folic acid and B12), essential cofactors in homocysteine (Hcys)-methionine metabolism, cause hyperhomocysteinemia (32) and cellular immune activation found in coronary heart disease (31) as well as SCF (8). All the mentioned actions support IFN- $\gamma$  role in inflammation, endothelial dysfunction and eventually atherosclerosis. The half-life of circulating IFN- $\gamma$  is short, and systemic measurements cannot reliably assess its activity (33). IFN- $\gamma$  stimulates the production of neopterin, a by-product of the guanosine triphosphate-biopterin pathway, by activated macrophages and monocytes (33). It is known that neopterin level predicts adverse prognosis in coronary artery disease (34). Elevated serum level of neopterin as a systemic marker of IFN- $\gamma$  was shown in SCF patients by Varol et al. (35).

Preinflammatory condition in the vessels is associated with activation of circulating mononuclear cells in coronary artery disease (CAD) patients which is reflected by IFN- $\gamma$  (23). According to Fernandes et al. marked activation of T lymphocytes and increased expression of IFN- $\gamma$  exist in CAD patients (36). Oleviera et al. reported that PBMC are capable of producing a high rate of chemokines and cytokines such as IFN- $\gamma$  involved in the regulation of lymphocytes and monocytes migration and remaining in atherosclerotic lesions in CAD patients (37).

Recent studies have reported increased mononuclears activation leads to elevated generation of superoxide and production of proinflammatory cytokines (23). Dabek et al. showed that several fold increase in the expression of IFN- $\gamma$  receptor subunits may be responsible for the prooxidative state in CSX via higher responsiveness to this cytokine and by affecting the function of microvasculature may participate in the pathology of CSX (23).

In our study, both subunits were over-expressed, but the gene expression of IFN- $\gamma$ R1 was significant. To our knowledge, this is the first report demonstrating the relationship of SCF with gene expression of IFN- $\gamma$  receptor subunits.

Since the pathological mechanisms of slow flow phenomenon remain controversial, the information

on the role of IFN- $\gamma$  in order to prove the hypothesis of the role of inflammation in this disease can be helpful. According to our results, it can be concluded that IFN- $\gamma$ R1 gene expression may influence the function of microvasculature and thereby contribute to the pathophysiology of SCF. Further studies on a larger scale are needed to elucidate the etiology of SCF.

*Acknowledgments.* This work is derived from a Master of Science thesis in Biochemistry and supported by a research grant from the Urmia University of Medical Sciences, Urmia, Iran.

### Conflict of interest statement

The authors stated that they have no conflicts of interest regarding the publication of this article.

## References

- Tambe A, Demany M, Zimmerman HA, Mascarenhas E. Angina pectoris and slow flow velocity of dye in coronary arteries—a new angiographic finding. *Am Heart J* 1972; 84(1): 66–71.
- Beltrame JF, Limaye SB, Horowitz JD. The coronary slow flow phenomenon—a new coronary microvascular disorder. *Cardiology* 2001; 97(4): 197–202.
- Mangieri E, Macchiarelli G, Ciavolella M, Barillò F, Avella A, Martinotti A, et al. Slow coronary flow: clinical and histopathological features in patients with otherwise normal epicardial coronary arteries. *Cathet Cardiovasc Diagn* 1996; 37(4): 375–81.
- Voelker W, Euchner U, Dittmann H, Karsch KR. Long term clinical course of patients with angina and angiographically normal coronary arteries. *Clin Cardiol* 1991; 14(4): 307–13.
- Ciavolella M, Avella A, Bellagamba S, Mangieri E, Nigri A, Reale A. Angina and normal epicardial coronary arteries: radionuclide features and pathophysiological implications at long-term follow-up. *Coron Artery Dis* 1994; 5(6): 493–9.
- Diver DJ, Bier JD, Ferreira PE, Sharaf BL, McCabe C, Thompson B, et al. Clinical and arteriographic characterization of patients with unstable angina without critical coronary arterial narrowing (from the TIMI-III Trial). *The American Journal of Cardiology* 1994; 74(6): 531–7.
- Durakoğlugil ME, Kocaman SA, Çetin M, Kirbaş A, Çanğa A, Erdoğan T, et al. Increased circulating soluble CD40 levels in patients with slow coronary flow phenomenon: an observational study. *Anadolu Kardiyol Derg* 2013; 13: 39–44.
- Erbay AR, Turhan H, Yasar AS, Ayaz S, Sahin O, Senen K, et al. Elevated level of plasma homocysteine in patients with slow coronary flow. *Int J Cardiol* 2005; 102(3): 419–23.
- Cin VG, Pekdemir H, Çamsar A, Çiçek D, Akkus MN, Parmakız T, et al. Diffuse intimal thickening of coronary arteries in slow coronary flow. *Jpn Heart J* 2003; 44(6): 907–19.
- Gökçe M, Kaplan S, Tekelioğlu Y, Erdoğan T, Küçükosmanoğlu M. Platelet function disorder in patients with coronary slow flow. *Clin Cardiol* 2005; 28(3): 145–8.
- Pekdemir H, Polat G, Cin VG, Çamsari A, Cicek D, Akkus MN, et al. Elevated plasma endothelin-1 levels in coronary sinus during rapid right atrial pacing in patients with slow coronary flow. *Int J Cardiol* 2004; 97(1): 35–41.
- Camsarl A, Pekdemir H, Cicek D, Polat G, Akkus MN, Döven O, et al. Endothelin-1 and nitric oxide concentrations and their response to exercise in patients with slow coronary flow. *Circ J* 2003; 67(12): 1022–8.
- Mosseri M, Yarom R, Gotsman M, Hasin Y. Histologic evidence for small-vessel coronary artery disease in patients with angina pectoris and patent large coronary arteries. *Circulation* 1986; 74(5): 964–72.
- Li J-J, Xu B, Li Z-C, Qian J, Wei B-Q. Is slow coronary flow associated with inflammation? *Med Hypotheses* 2006; 66(3): 504–8.
- Turhan H, Saydam GS, Erbay AR, Ayaz S, Yasar AS, Aksoy Y, et al. Increased plasma soluble adhesion molecules; ICAM-1, VCAM-1, and E-selectin levels in patients with slow coronary flow. *Int J Cardiol* 2006; 108(2): 224–30.
- van Boxel-Dezaire A, Stark G. Cell type-specific signaling in response to interferon- $\gamma$ . *Interferon: The 50<sup>th</sup> Anniversary*: Springer; 2007. p. 119–54.
- Schroder K, Hertzog PJ, Ravasi T, Hume DA. Interferon- $\gamma$ : an overview of signals, mechanisms and functions. *J Leukoc Biol* 2004; 75(2): 163–89.
- McLaren JE, Ramji DP. Interferon gamma: a master regulator of atherosclerosis. *Cytokine Growth Factor Rev* 2009; 20(2): 125–35.

19. Sezgin AT, Sgrc A, Barutcu I, Topal E, Sezgin N, Ozdemir R, et al. Vascular endothelial function in patients with slow coronary flow. *Coron Artery Dis* 2003; 14(2): 155–61.
20. Koh KP, Wang Y, Yi T, Shiao SL, Lorber MI, Sessa WC, et al. T cell-mediated vascular dysfunction of human allografts results from IFN- $\gamma$  dysregulation of NO synthase. *J Clin Invest* 2004; 114(6): 846.
21. Young JL, Libby P, Schönbeck U. Cytokines in the pathogenesis of atherosclerosis. *Thromb Haemost* 2002; 88(4): 554–67.
22. Gori T, Fineschi M. Two coronary »orphan« diseases in search of clinical consideration: coronary syndromes X and Y. *Cardiovasc Ther* 2012; 30(2): e58–e65.
23. Dabek J, Kulach A, Wilczok T, Mazurek U, Jakubowski D, Gasior Z. Transcriptional Activity of Genes Encoding Interferon  $\gamma$  (IFN $\gamma$ ) and its Receptor Assessed in Peripheral Blood Mononuclear Cells in Patients with Cardiac Syndrome X. *Inflammation* 2007; 30(3–4): 125–9.
24. Livak KJ, Schmittgen TD. Analysis of relative gene expression data using real-time quantitative PCR and the 2<sup>-</sup> $\Delta\Delta$ CT method. *Methods* 2001; 25(4): 402–8.
25. Pekdemir H, Cin VG, Çiçek D, Camsari A, Akkus N, Doven O, et al. Slow coronary flow may be a sign of diffuse atherosclerosis. Contribution of FFR and IVUS. *Acta Cardiol* 2004; 59(2): 127–34.
26. Canga A, Cetin M, Kocaman S, Durakoğlugil M, Kirbaş A, Erdoğan T, et al. Increased serum resistin levels in patients with coronary slow-flow phenomenon. *Herz* 2013; 38(7): 773–8.
27. Packard RR, Libby P. Inflammation in atherosclerosis: from vascular biology to biomarker discovery and risk prediction. *Clin Chem* 2008; 54(1): 24–38.
28. Đorđević D, Pejović J, Surbatović M, Jevđić J, Radaković S, Veljović M, Perić A, Anđelić T, Popović N. Prognostic value and daily trend of interleukin-6, neutrophil CD64 expression, C-reactive protein and lipopolysaccharide-binding protein in critically ill patients: reliable predictors of outcome or not? *J Med Biochem* 2015; 34(4): 431–9.
29. Mallika V, Goswami B, Rajappa M. Atherosclerosis pathophysiology and the role of novel risk factors: a clinicobiochemical perspective. *Angiology* 2007; 58(5): 513–22.
30. Alderson MR, Armitage RJ, Tough TW, Strockbine L, Fanslow WC, Spriggs MK. CD40 expression by human monocytes: regulation by cytokines and activation of monocytes by the ligand for CD40. *The Journal of Experimental Medicine* 1993; 178(2): 669–74.
31. Schroecksadel K, Frick B, Winkler C, Fuchs D. Crucial role of interferon- $\gamma$  and stimulated macrophages in cardiovascular disease. *Curr Vasc Pharmacol* 2006; 4(3): 205–13.
32. Rasmi Y, Mehraban K, Sadreddini M, Zeynalzadeh J, Majidinia M, Seyyed-Mohammadzad M, et al. Lack of significant association between *Helicobacter pylori* infection and homocysteine levels in patients with cardiac syndrome X. *Cardiol J* 2012; 19(5): 466–9.
33. Fuchs D, Avanzas P, Arroyo-Espliguero R, Jenny M, Con-suegra-Sanchez L, Kaski J. The role of neopterin in atherogenesis and cardiovascular risk assessment. *Curr Med Chem* 2009; 16(35): 4644–53.
34. Grammer TB, Fuchs D, Boehm BO, Winkelmann BR, Maerz W. Neopterin as a predictor of total and cardiovascular mortality in individuals undergoing angiography in the Ludwigshafen Risk and Cardiovascular Health study. *Clin Chem* 2009; 55(6): 1135–46.
35. Varol E, Gulcan M, Aylak F, Ozaydin M, Sütçü R, Erdogan D, et al. Increased neopterin levels and its association with angiographic variables in patients with slow coronary flow: an observational study. *Anadolu Kardiyol Derg* 2011; 11(8): 692–7.
36. Fernandes JL, Mamoni RL, Orford JL, Garcia C, Selwyn AP, Coelho OR, et al. Increased Th1 activity in patients with coronary artery disease. *Cytokine* 2004; 26(3): 131–7.
37. de Oliveira RTD, Mamoni RL, Souza JRM, Fernandes JL, Rios FJO, Gidlund M, et al. Differential expression of cytokines, chemokines and chemokine receptors in patients with coronary artery disease. *Int J Cardiol* 2009; 136(1): 17–26.

Received: September 3, 2015

Accepted: October 31, 2015