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1 **Genetic invalidation of Lp-PLA₂ as a therapeutic target:**

2 **large-scale study of five functional Lp-PLA₂ lowering alleles**

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31 **ABSTRACT (248 words)**

32 **Aims:** Darapladib, a potent inhibitor of lipoprotein-associated phospholipase A₂ (Lp-PLA₂), has not reduced
33 risk of cardiovascular disease outcomes in recent randomized trials. We aimed to test whether Lp-PLA₂ enzyme
34 activity is causally relevant to coronary heart disease (CHD).

35 **Methods:** In 72,657 patients with CHD and 110,218 controls in 23 epidemiological studies, we genotyped five
36 functional variants, four rare loss-of-function mutations (c.109+2T>C[rs142974898], Arg82His[rs144983904],
37 Val279Phe[rs76863441], Gln287Ter[rs140020965]) and one common modest-impact variant
38 (Val379Ala[rs1051931]) in *PLA2G7*, the gene encoding Lp-PLA₂. We supplemented de-novo genotyping with
39 information on a further 45,823 CHD patients and 88,680 controls in publicly available databases and other
40 previous studies. We conducted a systematic review of randomized trials to compare effects of darapladib
41 treatment on soluble Lp-PLA₂ activity, conventional cardiovascular risk factors, and CHD risk with
42 corresponding effects of Lp-PLA₂-lowering alleles.

43 **Results:** Lp-PLA₂ activity was decreased by 64% ($p=2.4\times 10^{-25}$) with carriage of any of the four loss-of-function
44 variants, by 45% ($p<10^{-300}$) for every allele inherited at Val279Phe, and by 2.7% ($p=1.9\times 10^{-12}$) for every allele
45 inherited at Val379Ala. Darapladib 160mg once-daily reduced Lp-PLA₂ activity by 65% ($p<10^{-300}$). Causal risk
46 ratios for CHD per 65% lower Lp-PLA₂ activity were: 0.95 (0.88-1.03) with Val279Phe; 0.92 (0.74-1.16) with
47 carriage of any loss-of-function variant; 1.01 (0.68-1.51) with Val379Ala; and 0.95 (0.89-1.02) with darapladib
48 treatment.

49 **Conclusions:** None of a series of Lp-PLA₂-lowering alleles was related to CHD risk, suggesting that Lp-PLA₂
50 is not a valid therapeutic target.

51

52 **KEY WORDS:** Human genetics, target validation, coronary heart disease, Lipoprotein-associated
53 phospholipase A₂, darapladib

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59 **ABBREVIATIONS**

60 CHD = Coronary Heart Disease

61 CI = Confidence Interval

62 HDL = High-density lipoprotein

63 LDL = Low-density lipoprotein

64 Lp-PLA₂ = Lipoprotein-associated phospholipase A₂

65 MI = Myocardial infarction

66 SD = Standard deviation

67

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69 3 main figures, 2 tables, 1 Appendix

70 Supplement (comprising a supplementary note and 6 tables, 4 figures)

71 INTRODUCTION

72 Lipoprotein-associated phospholipase A₂ (Lp-PLA₂), an enzyme expressed by inflammatory cells in
73 atherosclerotic plaques, is carried in the circulation bound predominantly to low-density-lipoprotein (LDL)¹. Lp-
74 PLA₂ (also called platelet-activating factor acetyl hydrolase) hydrolyzes oxidized phospholipids to yield pro-
75 inflammatory products implicated in endothelial dysfunction, plaque inflammation, and formation of necrotic
76 core in plaque¹. Observational² and experimental studies in humans and animals have suggested that Lp-PLA₂
77 could be a valid therapeutic target, postulating this enzyme to link oxidative modification of LDL and
78 development of inflammatory responses to arterial intima¹. Previous studies have investigated genetic variants
79 altering Lp-PLA₂ function in relation to coronary heart disease (CHD) risk^{3,4}. However, these studies have
80 generally yielded inconclusive, or conflicting results^{3,4}, perhaps due to limited statistical power and to limited
81 knowledge about variants altering Lp-PLA₂ function (i.e., previous studies have been able to consider only one
82 loss-of-function variant in *PLA2G7*, the gene encoding Lp-PLA₂).

83 However, two phase 3 randomized trials of darapladib, a potent inhibitor of Lp-PLA₂ activity, have not shown
84 reductions in cardiovascular risk^{5,6}. These results could, at least in part, have been due to features of the trials.
85 One of the phase 3 trials was restricted to patients recently hospitalized with acute coronary syndromes⁵, yet
86 many cardiovascular events occurring early after acute coronary syndromes may relate to thrombotic
87 mechanisms and not be modifiable through Lp-PLA₂ inhibition. Trials used statins as background therapy, so
88 any Lp-PLA₂ inhibition achieved with statins could have reduced any incremental benefits of darapladib. Trials
89 could not assess the effects of prolonged Lp-PLA₂ inhibition because they recorded only about 3-4 years of
90 median follow-up^{5,6}.

91 An alternative explanation is that darapladib did not reduce cardiovascular risk because Lp-PLA₂ is not a causal
92 risk factor in cardiovascular disease. We tested this possibility by investigating natural loss of Lp-PLA₂ activity.
93 Studies of Lp-PLA₂-lowering alleles should complement randomized trials of darapladib because genotypes are
94 fixed at conception, avoiding potential distorting effects of pre-existing disease and medication usage.

95 Furthermore, Lp-PLA₂-lowering alleles should produce lifelong, rather than shorter-term, Lp-PLA₂ inhibition.

96 In over 260,000 participants of European, South Asian, or East Asian ancestries, we studied five functional
97 variants in *PLA2G7*. We compared effects of Lp-PLA₂-lowering alleles on soluble Lp-PLA₂ activity,
98 conventional cardiovascular risk factors, and CHD risk with corresponding effects of darapladib, using results
99 from randomized trials.

100 METHODS

101 *Study design*

102 **Figure 1** summarises the study approach. **Table 1** provides definitions and sources of data used. First, we
103 identified four loss-of-function mutations and one missense variant in *PLA2G7* suggested by previous
104 experimental and bioinformatics studies, thereby developing an allelic series for Lp-PLA₂ activity. Second, we
105 assessed associations of these variants — both singly and in combination — with soluble Lp-PLA₂ activity,
106 conventional cardiovascular risk factors, and CHD risk in people of European, South Asian, or East Asian
107 continental ancestries. Third, we compared associations of Lp-PLA₂-lowering alleles with the aforementioned
108 traits and CHD risk with the effects of darapladib treatment through a systematic review of randomized trials.

109 *Genetic variants*

110 We defined loss-of-function variants as non-synonymous variants with *in vitro* or *in vivo* evidence
111 demonstrating complete lack of Lp-PLA₂ activity or sequence changes expected to abolish Lp-PLA₂ function
112 (e.g., nonsense variants or mutations in essential splice sites). We selected variants through a systematic search
113 for loss-of-function variants using the UniProt database⁷, the Exome Aggregation Consortium database
114 (Cambridge, MA, USA; URL: <http://exac.broadinstitute.org>; [accessed November 2014])⁸, studies of site-
115 directed mutagenesis⁹⁻¹¹ and results from targeted gene sequencing¹². Among the full set of variants identified
116 (**eTable1**), we selected the following variants that could be detected in the 1000 Genomes¹³ or the Exome
117 sequencing¹⁴ projects (and, hence, potentially studied at the population level): the splice site mutation
118 109+2T>C (rs142974898); two non-synonymous variants — Arg82His (rs144983904) and Val279Phe
119 (rs76863441); and the nonsense variant Gln287Ter (rs140020965). These loss-of-function variants are rare in
120 European and South Asian ancestry populations, whereas carriage of 279Phe is common in East Asian ancestry
121 populations and abolition of Lp-PLA₂ activity is well documented¹⁵. Additionally, we studied Val379Ala
122 (rs1051931), a functional variant common in European ancestry populations, which lowers Lp-PLA₂ activity
123 only modestly^{9, 16}, in contrast with the substantial Lp-PLA₂-lowering achieved by the loss-of-function variants
124 described above.

125 *Samples and data for genetic studies*

126 We aimed to maximise study power and comprehensiveness by using the following complementary approaches
127 to generate new data on, as well as to collate systematically existing relevant information about, the *PLA2G7*

128 variants mentioned above: (1) we conducted de-novo genotyping for 72,657 CHD patients and 110,218 controls
129 (the majority of whom also had information available on some cardiovascular risk factors); (2) we accessed non-
130 overlapping summary-level data from the only known global genetics consortium of CHD¹⁷, yielding
131 information on a further 35,735 CHD patients and 73,481 controls; (3) we conducted a systematic review
132 (supplemented by provision of tabular data from each study investigator) of published East Asian CHD studies
133 of Val279Phe because these studies were not represented in the global CHD consortium, yielding information
134 on a further 10,088 CHD cases and 15,199 controls; (4) we accessed summary-level data from the largest
135 available global genetics consortium on each of several relevant cardiovascular risk factors (eg, Lp-PLA₂
136 activity, conventional lipids, blood pressure), yielding information on 489,045 participants. Each of these
137 sources of information is summarised below and in **Table 1**.

138 Coronary heart disease outcomes For CHD outcomes, we had access to data for a total of 92,995 patients and
139 162,228 controls. For 182,875 of these participants (72,657 CHD patients, 110,218 controls), we did de-novo
140 genotyping of the four loss-of-function variants (c.109+2T>C, Arg82His, Val279Phe, Gln287Ter) and
141 Val379Ala using customized Exome arrays (Illumina, California, USA) by technicians masked to the
142 phenotypic status of the participants' samples. For 35,829 CHD cases, 44,948 controls in eight studies, we had
143 access to individual-participant data. The eight studies were: the Bangladesh Risk of Acute Vascular Events
144 Study (BRAVE)¹⁸, Copenhagen City Heart Study (CCHS)¹⁹, Copenhagen Ischemic Heart Disease/Copenhagen
145 General Population Study (CIHDS/CGPS)¹⁹, European Prospective Investigation into Cancer and Nutrition-
146 Cardiovascular Disease Study (EPIC-CVD)²⁰, MONICA Risk, Genetics, Archiving, and Monograph
147 (MORGAM) study^{21, 22}, Pakistan Risk of Myocardial Infarction Study (PROMIS)²³, Pravastatin in elderly
148 individuals at risk of vascular disease (PROSPER) trial²⁴ and the West of Scotland Coronary Prevention Study
149 (WOSCOPS)²⁵ (these eight studies are collectively called the "CHD Exome+ consortium"). For 15 additional
150 studies (collectively called the "MICAD consortium"), we used similar genotyping methods to those described
151 above but did not genotype c.109+2T>C and had access only to study-level data. We supplemented de-novo
152 data on Val379Ala with non-overlapping consortium-level results from a further 35,735 CHD patients and
153 73,481 controls in the transatlantic Coronary Artery Disease Genome-wide Replication and Meta-analysis
154 (CARDIoGRAM)²⁶ and Coronary Artery Disease Genetics (C4D)²⁷ consortia (**Table 1**). We obtained tabular
155 data on Val279Phe from seven East Asian studies involving a total of 10,088 CHD cases and 15,199 controls,
156 identified through systematic review (**eTable 5** and **Supplement**). About 90% of CHD patients in our genetic

157 analysis had myocardial infarction or other major acute coronary events; the remainder had angiographic
158 evidence alone (eg, >50% coronary stenosis; **eTables 2 & 5**).

159 Lp-PLA₂ activity For 13,835 participants, we had information on functional variants in *PLA2G7* and Lp-PLA₂
160 activity, using data from de-novo genotyping in MORGAM^{21,22} and PROSPER²⁴, supplemented by published
161 data from the CHARGE Consortium (ie, from the Atherosclerosis Risk in Communities [ARIC] Study²⁸,
162 Cardiovascular Health Study¹⁶, Framingham Heart Study¹⁶, and Rotterdam study¹⁶), and from 12 East Asian
163 studies identified through the systematic review described above (**Table 1, Supplement & eFigure1, eTables**
164 **2-3**).

165 Conventional cardiovascular risk factors For 177,343 participants, we had information on functional variants in
166 *PLA2G7* and conventional cardiovascular risk factors and several other traits, including circulating
167 concentrations of LDL-cholesterol, HDL-cholesterol, triglycerides, glucose, insulin, and C-reactive protein, and
168 values of systolic and diastolic blood pressure, body-mass index, and estimated glomerular filtration rate. Again,
169 we supplemented data from our de-novo genotyping, with information from existing global genetics consortia
170 (**Table 1, eTables 2-4**).

171 *Randomized trials of darapladib*

172 To compare genetic associations with effects of pharmacological Lp-PLA₂ inhibition, we conducted a
173 systematic review to identify randomized placebo-controlled trials of darapladib that had reported on Lp-PLA₂
174 activity, conventional risk factors, and/or CHD events (**Supplement**). CHD events in the trials were defined as
175 fatal CHD, MI or urgent revascularisation, as recorded in STABILITY (Stabilization of Atherosclerotic Plaque
176 by Initiation of Darapladib Therapy) and in SOLID-TIMI 52 (Stabilization of Plaque Using Darapladib-
177 Thrombolysis in Myocardial Infarction 52)^{5,6}. We pooled results across trials by fixed-effect inverse-variance
178 weighted meta-analysis (**eFigures 2&3**; see Supplement for details of the methods used).

179 *Statistical methods*

180 We defined effect alleles as those associated with lower Lp-PLA₂ activity and assumed an additive model. For
181 participant-level data, we assessed associations of Lp-PLA₂-lowering alleles with CHD using the genome-wide
182 efficient mixed model analysis, an approach that models each genetic variant as a fixed-effect, but includes both
183 fixed-effect and random-effects of genetic inheritance²⁹ to account for population stratification and relatedness
184 among participants (**Supplement**). The four rare loss-of-function variants were tested jointly within each study

185 by counting the number of loss-of-function alleles carried by each participant. Log odds ratios and standard
186 errors were meta-analysed across studies using fixed-effect meta-analysis. For studies contributing only study-
187 level data, we performed a similar test by conducting a combined burden test across studies using the R package
188 seqMeta v1.2 (<http://cran.r-project.org/web/packages/seqMeta/>).

189 We calculated associations of Lp-PLA₂-lowering alleles with soluble Lp-PLA₂ activity and conventional risk
190 factors using linear regression within each study, and then combined the regression coefficients using fixed-
191 effect meta-analysis. When data were missing, we used information on rs1805018 as a proxy for Val279Phe and
192 information on rs7756935 or rs3799277 as proxies for Val379Ala (**Supplement**). To account for population
193 stratification, we adjusted for the first principal component of ancestry (**Supplement**). We calculated risk ratios
194 for CHD with decrements in Lp-PLA₂ activity, dividing the log transformed risk ratio and confidence interval
195 (CI) by the effect on Lp-PLA₂ activity of the instrument (ie, the genetic variant)³⁰. We investigated
196 heterogeneity using the I² statistic. We used Stata 13.1.

197

198 **RESULTS**

199 Of the 261,950 total participants in this analysis, we studied 195,715 individuals of European ancestry, 34,221
200 individuals of South Asian ancestry, and 32,014 individuals of East Asian ancestry. In people of European or
201 South Asian ancestry without CHD, the frequency of alleles in *PLA2G7* that lower Lp-PLA₂ activity was
202 0.005% at c.109+2T>C, 0.04% at Arg82His, 0.04% at Val279Phe, and 0.025% at Gln287Ter (i.e., in aggregate,
203 0.2% of the European or South Asian participants in the current study carried one of these loss-of-function
204 alleles, although no one carried more than one of these variants), and about 80% at Val379Ala. In people of East
205 Asian ancestry without CHD, the frequency of Val279Phe was about 15% and about 2% of the individuals were
206 homozygous carriers of the 279Phe allele.

207 ***Soluble Lp-PLA₂ activity***

208 Compared with non-carriers, homozygote carriers of the 279Phe allele had 94% lower Lp-PLA₂ activity ($p < 10^{-300}$).
209 For each 279Phe allele inherited, Lp-PLA₂ activity decreased by 45% (1.59 SD, 95% CI: 1.61-1.57; $p < 10^{-300}$).
210 In Europeans who inherited any one of the four rare Lp-PLA₂ loss-of-function alleles, Lp-PLA₂ activity
211 decreased by 64% (2.25 SD, 2.68-1.83; $p = 1.6 \times 10^{-25}$). For each 379Ala allele inherited, Lp-PLA₂ activity
212 decreased by 2.7% (0.096 SD, 0.122-0.069; $p = 1.9 \times 10^{-12}$). By comparison, 160mg once-daily darapladib reduced
213 Lp-PLA₂ activity by 65% (2.26 SD, 2.31-2.21; $p < 10^{-300}$). Study-level estimates are provided in **eFigure 2**.

214 ***Cardiovascular risk factors***

215 None of the Lp-PLA₂-related variants we studied was significantly associated with values of LDL-cholesterol,
216 HDL-cholesterol, triglycerides, systolic or diastolic blood pressure, body-mass index, estimated glomerular
217 filtration rate, glucose, insulin, and C-reactive protein (**Figure 2**). By comparison, in previous randomized
218 placebo-controlled trials, darapladib did not significantly affect concentrations of LDL-cholesterol or log
219 triglycerides, but could have slightly increased systolic blood pressure and HDL-cholesterol values and slightly
220 decreased C-reactive protein concentration (**Figure 2**).

221

222 *Clinical CHD outcomes*

223 Compared to non-carriers, the odds ratio for CHD was 0.99 (0.95-1.03) in 279Phe heterozygotes, and 0.93
224 (0.82–1.05) in 279Phe homozygotes (i.e. nearly complete loss of Lp-PLA₂ function: **Figure 3**). For each loss-of-
225 function (279Phe) allele inherited, the odds ratio for CHD was 0.97 (0.91-1.02; I²=30%; P_{Heterogeneity}=0.2). In
226 Europeans and South Asians who inherited one of the four rare Lp-PLA₂-loss-of-function alleles, the odds ratio
227 for CHD was 0.92 (0.74-1.16; I²=0%; P_{Heterogeneity}=0.8; **Figure 3**). For each 379Ala allele inherited, the odds
228 ratio for CHD was 1.00 (0.98-1.02; I²=0.0%; P_{Heterogeneity}=0.5; **Figure 3**). Study-level results are provided in
229 **eFigure 3**. In sensitivity analyses, odds ratios with each loss-of-function variant were similar to the odds ratio
230 that combined information across the four loss-of-function variants we studied. There was no evidence of
231 heterogeneity in odds ratios between European and South Asian ancestry populations (**eFigure 4**).

232 Genetic risk ratios for CHD per 65% lower Lp-PLA₂ activity (i.e. the reduction achievable with darapladib
233 treatment) were: 0.95 (0.88-1.03) with Val279Phe in East Asians; and 0.92 (0.74-1.16) with carriage of any one
234 of the four rare variants studied in Europeans and South Asians; and 1.01 (0.68-1.51) with Val379Ala (**Table 2**).
235 By comparison, the risk ratio for CHD with darapladib treatment (i.e. also per 65% lower Lp-PLA₂ activity) was
236 0.95 (0.89-1.02; **Table 2**).

237

238 **DISCUSSION**

239 In 2008, GlaxoSmithKline launched a ~\$1 billion program of phase 3 trials of darapladib, a compound which
240 did not reduce cardiovascular event rates in two secondary prevention trials. We tested whether Lp-PLA₂
241 enzyme activity is causally relevant to CHD by studying five functional alleles that produce widely differing
242 degrees of reduction in Lp-PLA₂ activity. We found that none was related to CHD risk. Hence, our large-scale
243 human genetic data, which are concordant with results from phase 3 trials, suggest that Lp-PLA₂ enzyme
244 activity is not causally relevant to CHD. The implication is that darapladib did not reduce CHD risk in recent
245 trials principally because Lp-PLA₂ is not a valid therapeutic target.

246 Three features of our study merit comment. First, we studied almost 20 times more CHD patients than the
247 previous largest study of loss-of-function *PLA2G7* alleles, thereby providing the first robust genetic evaluation
248 of effect sizes of Lp-PLA₂ inhibition relevant to phase 3 trials such as relative risk reductions for CHD of 20%.
249 For example, for the Val279Phe variant we had >99% power to detect a 20% risk reduction in CHD for a 65%
250 genetic reduction in Lp-PLA₂ activity (ie, an effect on Lp-PLA₂ activity similar to that achieved by darapladib).

251 Second, our study has provided the first investigation in CHD of a series of functional alleles that each reduce
252 Lp-PLA₂ function via different molecular mechanisms. Specifically, we studied five different Lp-PLA₂-
253 lowering alleles: three of the alleles were coding variants that produced different amino acid substitutions; two
254 of the alleles produced protein truncations (one due to a nonsense mutation; the other due to a splice-site
255 mutation). Because we observed null and broadly concordant findings for CHD risk across these alleles that
256 each changed the enzyme in a different way, we can more confidently conclude there is no material cause-and-
257 effect relationship. By contrast, when the initial phase 3 trial of darapladib was launched in 2008, only two of
258 the five alleles we studied had yet been identified: data on Val379Ala, a weak effect missense variant, were
259 inconclusive because CHD studies were under-powered³¹; data on Val279Phe, a loss-of-function variant, and
260 CHD risk were sparse and restricted to East Asian populations.

261 A third feature was our study's analysis of substantial data from three different major ethnic groups: Europeans,
262 South Asians, and East Asians. This ethnic diversity enhanced the generalisability of our results.

263 Our study had potential limitations. We used the "major coronary events" endpoint from phase 3 darapladib
264 trials for comparison of pharmacological inhibition of Lp-PLA₂ with genetic inhibition, whereas definitions of
265 CHD used in human genetic studies were not strictly uniform (eg, some studies included patients with only

266 angiographic evidence of CHD). However, about 90% of CHD cases included in our genetic analyses had
267 myocardial infarction or other major acute coronary events.

268 It could be that cardioprotective benefits of Lp-PLA₂ inhibition were obscured by pleiotropic effects of *PLA2G7*
269 variants; for example, 279Phe is known to produce a misfolded version of Lp-PLA₂ not secreted by cells,
270 prompting suggestions that its carriage could produce “off-target” effects such as increased cell death^{32, 33}.
271 However, because we found null associations between four other functional alleles in *PLA2G7* and CHD, each
272 of which operates via a different molecular mechanism, it argues against this explanation.

273 Lifelong genetic reductions in Lp-PLA₂ could result in compensatory responses that increase CHD risk.
274 However, this explanation seems unlikely because it would require any such compensation to apply similarly
275 across alleles that produce widely differing degrees of reduction in Lp-PLA₂ activity. Furthermore, any such
276 compensation could not operate through known cardiovascular mechanisms because we observed no
277 associations between Lp-PLA₂-lowering alleles and several established and emerging cardiovascular risk
278 factors.

279 Soluble enzyme activity could be an imperfect indicator of the relevance of Lp-PLA₂ to atherosclerotic plaques.
280 However, for homozygote carriers of 279Phe, Lp-PLA₂ activity should be almost abolished across all tissues.
281 Finally, we studied life-long genetic reductions in Lp-PLA₂ activity in relation to first-onset CHD outcomes
282 rather than recurrent CHD, whereas darapladib trials studied recurrent coronary events in patients with stable or
283 acute coronary disease.

284 Our findings suggest that, in retrospect, the lack of efficacy of darapladib in phase 3 trials could, in principle,
285 have been anticipated. However, it is important to acknowledge that the methods and data used in the current
286 analysis were not available at the time the darapladib program was launched. Nevertheless, the current data
287 underscore the growing importance of human genetic approaches to enhance the efficiency of development of
288 medicines by validating (or invalidating) novel drug targets³⁴⁻³⁷. Our results also illustrate how human genetic
289 evidence can assist interpretation of observational epidemiological data. We found that functional alleles in
290 *PLA2G7* do not alter levels of pro-atherogenic lipids (eg, LDL-C). This result suggests that such pro-atherogenic
291 lipids do not mediate associations between Lp-PLA₂ activity and CHD, supporting the need to adjust
292 epidemiological associations of Lp-PLA₂ activity with CHD risk for pro-atherogenic lipids (an approach which
293 yields results consistent with non-causality)².

294 In summary, none of a series of Lp-PLA₂-lowering alleles was related to CHD risk, suggesting that Lp-PLA₂ is
295 not a valid therapeutic target.

296

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303 **DISCLOSURES**

304 Anders Malarstig and Maria Uria-Nickelsen are full time employees of Pfizer. Since October 2015, Daniel
305 Freitag has been a full time employee of Bayer. The funders had no role in the design and conduct of the study,
306 in the collection, analysis, and interpretation of the data, and in the preparation, review, or approval of the
307 manuscript.

308

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657 AUTHOR CONTRIBUTIONS:

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659 **FIGURE LEGENDS**

660 **Figure 1:** Summary of study design

661 **Figure 2** Mean per allele differences in Lp-PLA₂ activity and cardiovascular risk factor levels by Lp-PLA₂
662 lowering alleles or with darapladib 160mg daily

663 **Figure 3:** Association of Lp-PLA₂-lowering alleles with Lp-PLA₂ activity and CHD risk

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665 **APPENDIX**

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747 **Table 1:** Definitions and source of contributing data for the main study outcome

Lp-PLA ₂ assessment tool	Val279Phe, Loss-of-function variant common in East Asians‡	Four loss-of-function variants*, rare in Europeans & South Asians†		Val379Ala, modest impact variant				Darapladib
Data sources	Systematic review: Study-level data from up to 12 East Asian studies	De-novo genotyping and participant-level data: up to 8 European or or South Asian ancestry studies from the CHD Exome+ Consortium ¹⁸⁻²⁵ ; De-novo genotyping and study-level data: up to 15 European ancestry studies from the MICAD Exome consortium ³⁷ and 3 European ancestry studies from the CHARGE Consortium ^{16, 28} ; Plus publicly available consortium data						Systematic review: Study-level data from up to 5 randomized clinical trials ^{5, 6} ³⁸⁻⁴⁰ from a systematic review
Endpoint	Number of studies and unique individuals contributing to analyses; n total or cases / controls							
Coronary heart disease[^]	7 East Asian studies	8 European or South Asian ancestry studies from the CHD Exome+ Consortium ¹⁸⁻²⁵	15 European ancestry studies from the MICAD Exome consortium ³⁷	8 European or South Asian ancestry studies from the CHD Exome+ Consortium ¹⁸⁻²⁵	8 European ancestry studies from the MICAD Exome consortium ³⁷	14 European ancestry studies from the CARDIoGRAM consortium ²⁶	4 European or South Asian ancestry studies from the C4D consortium ²⁷	2 phase III randomized clinical trials of darapladib ^{5, 6}
	10,088 cases 15,199 controls	35,829 cases 44,948 controls	35,533 cases 64,130 controls	32,196 cases 41,464 controls	14,976 cases 32,084 controls	20,315 cases 58,419 controls	15,420 cases 15,062 controls	3364 cases 25,490 non-cases
Lp-PLA₂ activity[§]	12 East Asian studies	1 European ancestry study from the CHD Exome+ Consortium ²⁴	1 European ancestry study from the CHARGE Consortium ²⁸	2 European ancestry studies from the CHD Exome+ Consortium ^{21, 22, 24}		3 European ancestry studies from the CHARGE consortium ¹⁶		3 phase II randomized clinical trials ³⁸⁻⁴⁰
	8468	1240	8564	2173		11,662		854
Conventional risk factors[§]	12 East Asian studies	8 European or South Asian ancestry studies from the CHD Exome+ Consortium ¹⁸⁻²⁵		8 European or South Asian ancestry studies from the CHD Exome+ Consortium ¹⁸⁻²⁵		Publicly available consortium data		5 randomized clinical trials ^{5, 6, 38-40}
<i>BMI</i>	17,898	76,584		51,201		126,142 from 46 studies from the GIANT Consortium ⁴¹		NA
<i>Blood pressure</i>	6705	72,450		71,256		69,245 from 29 studies from the ICBP Consortium ⁴²		323
<i>Lipids</i>	17,643	76,826		55,431		94,311 from 46 studies from the GLGC Consortium ⁴³		803
<i>C-reactive protein</i>	2914	40,484		41,442		66,185 from 15 studies from the CHARGE Consortium ⁴⁴		848
<i>Glycaemic traits</i>	2914	9420		9408		46,186 from 21 studies from the MAGIC Consortium ⁴⁵		NA
<i>eGFR</i>	4017	32,929		32,190		74,354 from 26 studies from the CKDGen Consortium ⁴⁶		NA

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[^] In genetic analysis, CHD was defined as myocardial infarction and other major coronary events (~90% of cases) or angiographic stenosis only (~10% of cases) see eTables 2 & 3 for details. In the darapladib analysis CHD was defined as fatal coronary disease, non-fatal MI or urgent revascularization for myocardial ischaemia.

[§] See eTables 2 & 3 for details on risk factor measurements

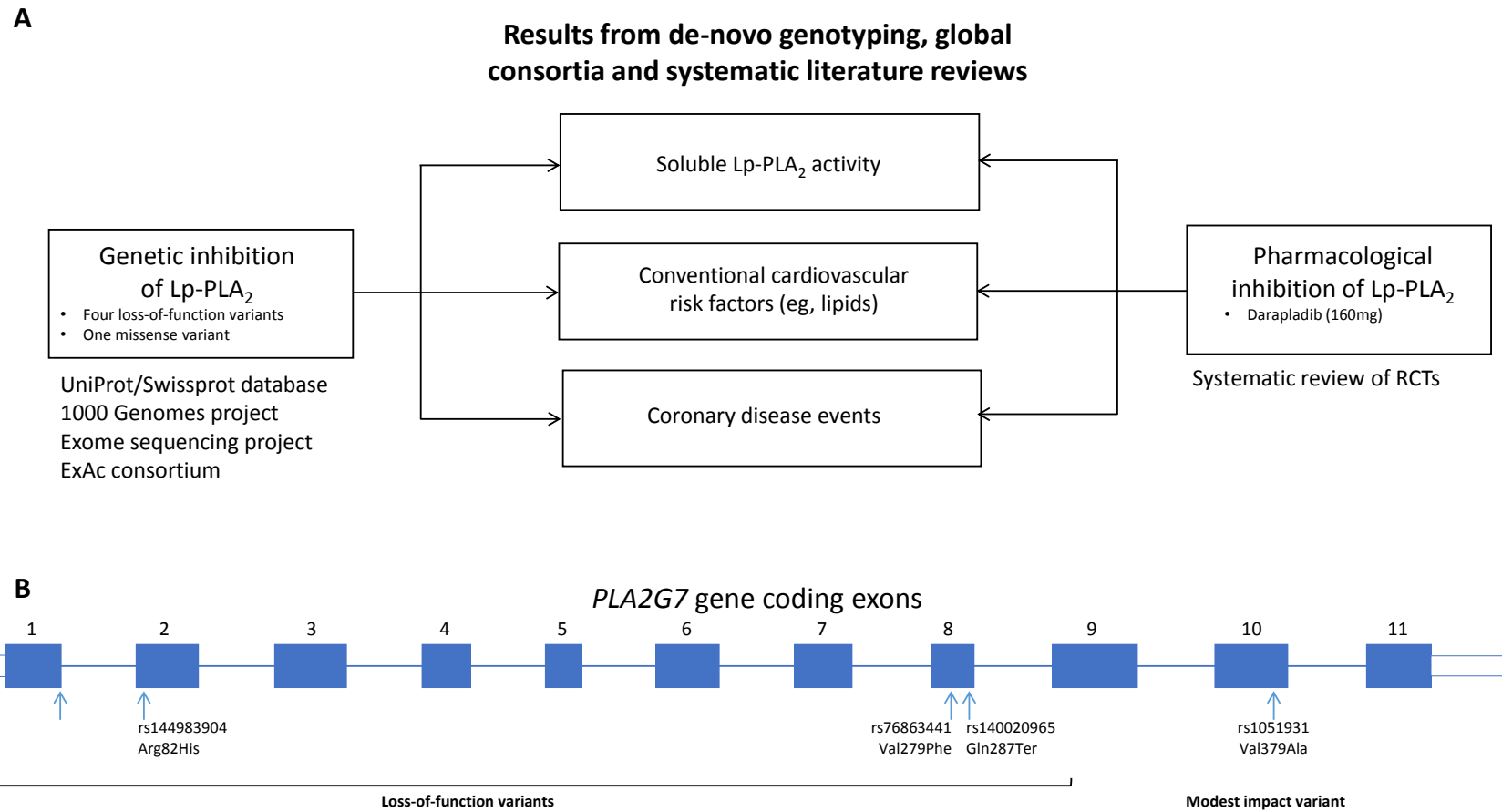
rs142974898 (c.109+2T>C), rs144983904 (Arg82His), rs76863441 (Val279Phe), rs140020965 (Gln287Ter); see also **Figure 1B** for further variant details; BMI = Body-mass index, eGFR = estimated glomerular filtration rate, NA= Data not available. Further detail on the individual studies is provided in eTables 2-3.

CARDIoGRAM=Coronary ARtery Disease Genome wide Replication and Meta-analysis; CHARGE=Cohorts for Heart and Aging Research in Genomic Epidemiology; CKDGen=Chronic Kidney Disease GENetics consortium; GIANT=Genetic Investigation of ANthropometric Traits Consortium; GLCC=Global Lipids Genetics Consortium; ICBP=International Consortium for Blood Pressure; MAGIC=Meta-Analyses of Glucose and Insulin-related traits Consortium;

	CHD patients	Controls	Risk ratio for CHD per 65% lower Lp-PLA ₂ activity (95% CI)
<i>Genetically lowered Lp-PLA₂</i>			
Val279Phe (East Asian LoF variant)	10,088	15,199	0.95 (0.88 - 1.03)
Four LoF variants*	71,362	109,078	0.92 (0.74 - 1.16)
Val379Ala	82,907	147,029	1.01 (0.68 - 1.51)
<i>Pharmacologically lowered Lp-PLA₂</i>			
Darapladib	3364	25,490	0.95 (0.89 - 1.02)

759 * Carriage of any of the four loss-of-function variants c.109+2T>C, Arg82His; Val279Phe; Gln287Ter; LoF = Loss-of-function

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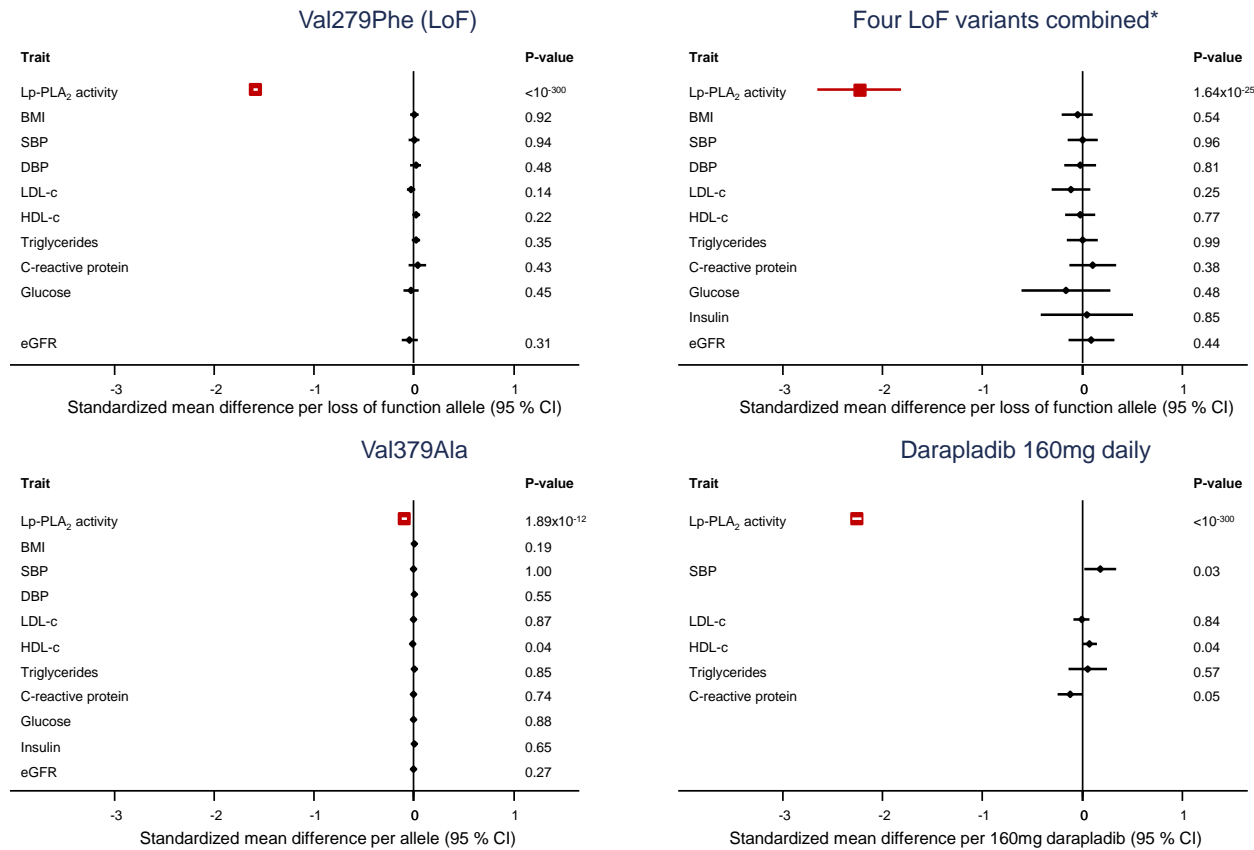


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763 A) Flow chart of study design B) Exonic structure of the *PLA2G7* gene and location of variants used in this study.; ExAc = Exome Aggregation consortium, Lp-PLA₂ = Lipoprotein-associated phospholipase A₂, RCT =

764 Randomized controlled trial, UniProt/Swissprot = Manually annotated and reviewed section of the Universal Protein resource database.

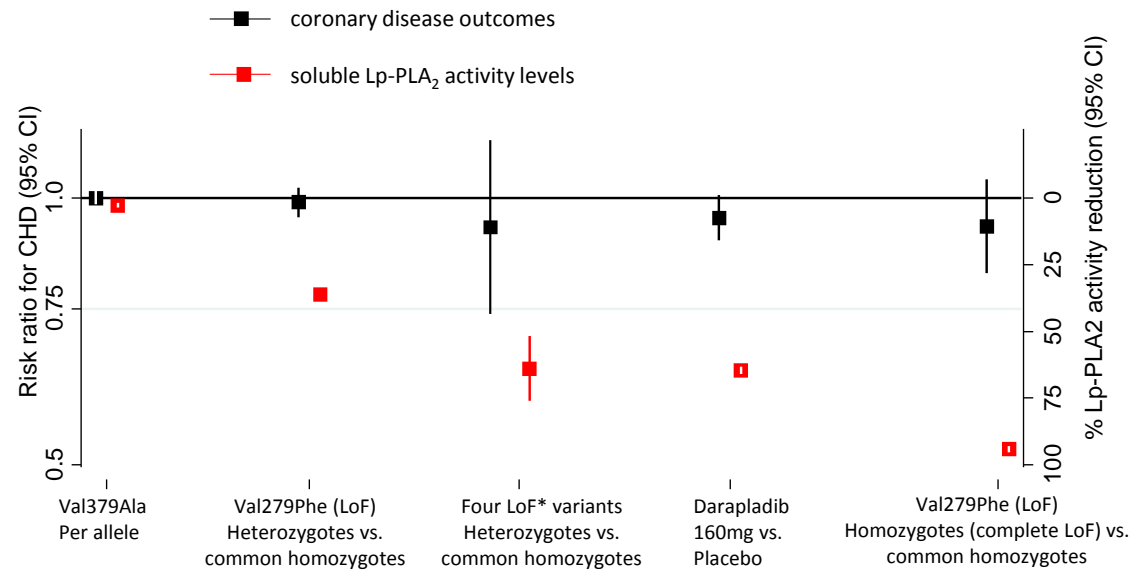
765 **Figure 2**



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767 To enable comparison of the magnitude of associations across several different markers, analyses were undertaken with standardized units of measurement for each marker. Associations are presented as per allele
 768 change in the biomarker expressed as standard deviations. * Carriage of any of the four loss-of-function variants c.109+2T>C, Arg82His; Val279Phe; Gln287Ter; BMI = Body-mass index, DBP = Diastolic blood
 769 pressure, eGFR = estimated glomerular filtration rate, HDL-c = High-density lipoprotein cholesterol, LDL = low-density lipoprotein cholesterol, LoF = Loss-of-function, Lp-PLA₂ = Lipoprotein associated
 770 phospholipase A₂, SBP = systolic blood pressure. Numbers of participants are provided in **Table 1**. Details of contributing studies are provided in **eTables 2-3**.

771 **Figure 3**



Analysis of coronary heart disease outcomes	Cases	82,907	8789†	71,362	3364	6983†
	Controls	147,029	13,190†	109,078	25,490	10,206†
Analysis of soluble Lp-PLA ₂ activity	Participants	13,835	8264	9804	854	5997

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773 Spectrum of functional alleles in *PLA2G7* and effects on Lp-PLA₂ activity (red estimates) and coronary heart disease risk (black estimates); * Carriage of any of the four loss-of-function variants c.109+2T>C,

774 Arg82His; Val279Phe; Gln287Ter; † One study did not provide tabular data to enable calculation of CHD odds ratios in heterozygotes or homozygotes. Hence, numbers are less than those presented for the per allele

775 analysis in **Table 2**; LoF = Loss-of-function

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