Serum hepcidin level and rheumatoid arthritis disease activity

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Abstract

Objective: The present study aimed to determine the relationship between the serum hepcidin level and disease activity in patients with rheumatoid arthritis (RA).

Methods: This study was conducted on 80 patients with RA (36 cases with anemia of chronic disease [ACD] and 44 patients without ACD). Disease activity was measured by the 28-joint Disease Activity Score based on the erythrocyte sedimentation rate (DAS28-ESR). According to the DAS28-ESR score, 52 and 28 cases were categorized as inactive to moderately active RA (DAS28-ESR<5.1) and highly active RA (DAS28-ESR>5.1), respectively. In addition, the serum hepcidin level was evaluated in all patients to determine its correlation with the DAS28-ESR score.

Results: There was no significant difference between the RA with ACD and RA without ACD groups in terms of the median (interquartile range) hepcidin level (1207 [985.2] vs. 923.8 [677.3] ng/mL; P=0.57). Likewise, no significant difference was observed between the active RA and inactive to moderately active RA groups in this regard (1131.8 [991.3] vs. 1090.9 [631.4] ng/mL; P=0.53).

Conclusion: Hepcidin has no association with disease activity in RA. Therefore, it is not necessary to measure hepcidin to determine the RA activity.

Keywords: Rheumatoid arthritis, anemia, anemia of chronic disease, hepcidin, inflammation, DAS28-ESR

Introduction

Rheumatoid arthritis (RA) is the most common autoimmune arthritis, affecting approximately 0.5%-1% of people all over the world. In RA, proliferative synovitis leads to irreversible cartilage damage and joint destruction (1). Inflammatory synovitis in RA is partially related to the overproduction of tumor necrosis factor alpha (TNF-α), interleukin-1 (IL-1), IL-6, and IL-17 (1). In particular, IL-6 plays an important role in synovitis, and its serum level is directly associated with disease activity. The IL-6 blockers have been shown as highly effective in the treatment of RA (2). Hepcidin is an acute-phase reactant protein synthesized in the liver. This peptide fulfills two main functions through acting as a homeostatic regulator of iron metabolism (via iron release and mobilization control in hepatocytes, macrophages, etc.) and an inflammatory mediator (3, 4). The release of hepcidin is triggered by inflammatory mediators, such as IL-6 (4). Recent studies have revealed that this peptide adjusts the immune performance with neutralizing ferroportin in macrophages, hepatocytes, and enterocytes. Moreover, hepcidin increases intracellular iron resources and reduces gastrointestinal iron absorption and serum iron (3).

Several studies have addressed the role of hepcidin in RA (5-7). The majority of these studies have focused on the anemia of chronic disease (ACD), commonly observed in RA, and its association with hepcidin. The circulating serum hepcidin level is reported to increase in the RA patients with ACD (6). As inflammation is a chronic condition in RA, proinflammatory cytokines can affect the serum iron levels and the synthesis of ferritin and hepcidin (9). Considering those facts and interactions among IL-6 and other cytokines, rheumatoid anemia, and hepcidin, hepcidin has been studied with some clinical implications. One of them is differentiating ACD from iron deficiency anemia, which can occur in RA as a result of the
treatments addressing RA (4, 5). These observations resulted in the identification of hepcidin as a major inducer of ACD in patients with RA (3, 8). This mostly relates to the rise of hepcidin as a result of cytokines, including IL-6, and the effect of this increased circulating hepcidin level on the iron metabolism.

In addition, some studies have investigated the relationship between hepcidin and the RA disease activity based on the associations between hematological parameters (e.g., hemoglobin level) and RA disease activity (6, 10, 11). There is evidence regarding the relationship of prohepcidin (i.e., prohormone of hepcidin) and IL-1 receptor antagonist gene polymorphism with the RA disease activity assessed by 28-joint Disease Activity Score (DAS28) (12). Considering this, hepcidin was proposed as a promising tool for the diagnosis and management of ACD in patients with RA. Furthermore, in a study, the reduction of disease activity was accompanied by a decrease in serum hepcidin levels (13). However, some studies observed no relationship between the serum hepcidin and RA disease activity (7).

Hepcidin has recently gained attention in the management of patients with RA; however, the application of this protein in the routine clinical management of this disease still requires further investigation. With this background in mind, the current study was conducted to determine the relationship between the serum hepcidin level and RA disease activity among patients with RA considering the role of ACD.

Methods

Study design and setting
This descriptive-analytic cross-sectional study was conducted in our Rheumatic Diseases Research Center (RDRC) between 2015 and 2016.

Study population and eligibility criteria
The study population corresponded to a group of RA patients with and without ACD. The RA diagnosis was based on the American College of Rheumatology criteria for RA (14). Furthermore, considering the World Health Organization criteria, anemia was defined as the serum hemoglobin levels of less than 12 and 13 g/dL for females and males, respectively. The patients referred for routine visits and follow-ups of their condition, and those whose laboratory findings indicated anemia, were eligible to participate in the study.

The patients who developed anemia due to ACD were included in the research. Therefore, those with anemia due to other causes, including iron deficiency, minor thalassemia, megaloblastic anemia, hemolysis, and drug-induced bone marrow suppression, were excluded from the study. The diagnosis of ACD was accomplished by complete iron studies, including serum ferritin, serum iron, and total iron binding capacity (TIBC).

The ACD was defined as normal to decreased mean corpuscular volume, normal to increased red cell distribution width, decreased red blood cell count, low serum iron (normal level, 60-150 mcg/dL) and TIBC, increased serum ferritin (normal level, 40-200 mcg/L), and elevated erythrocyte sedimentation rate (ESR; normal levels, 0-20 mm/h in males and 0-30 mm/h in females) (15).

The exclusion criteria entailed the following: 1) underlying chronic/inflammatory conditions that can cause anemia (e.g., malignancy, renal disease, heart failure, diabetes, and autoimmune diseases other than RA); 2) pregnancy; 3) malnutrition; 4) bone marrow suppression; and 5) medication consumption for anemia, except for folic acid in methotrexate therapy), diabetes, and malignancy.

Research sampling
The study population was selected using the consecutive sampling technique. In this regard, the RA patients referring to the RDRC were evaluated for the inclusion criteria. Out of 268 RA patients, 36 showed pure ACD, and 44 did not have any subtype of anemia. Therefore, the study was conducted on 80 patients.

Laboratory measurements
Venous blood samples were obtained from the brachial vein. Subsequently, the samples were clotted at the room temperature and centrifuged at 3,000 rpm for 10 min. The centrifuged samples were then stored at -20ºC. The serum hepcidin level was measured by the enzyme-linked immunosorbent assay. In addition, serum iron, ferritin, transferrin, TIBC, and ESR were recorded for each patient for more statistical analyses.

Clinical variables
After interviewing, the patients were subjected to clinical examinations by the researchers who were board-certified rheumatologists. The number of the swollen and tender joints was recorded for each patient. In addition, the visual analog scale was used for global health assessment. Then, the DAS28 based on ESR (DAS28-ESR) was administered to patients (16). Both DAS28-C-reactive protein and DAS28-ESR are valid and simple tools to assess disease activity in patients with RA in daily practice (17, 18). Based on the DAS28-ESR level, the included patients were categorized into two groups, namely, inactive to moderately active RA (n=52; DAS28-ESR level ≤5.1) and highly active RA (n=28; DAS28-ESR level >5.1).

Other documented data were the RA duration and the treatment and medications the patients received. The prescribed medications mostly included oral prednisolone (5-7.5 mg per day), methotrexate (2.5 up to 15 mg per week), sulfasalazine (500-2,000 mg: in a few patients), alendronate (7 mg per week), a daily combination of calcium (1,000 mg) with vitamin D (800 IU), and folic acid (5 mg per week).

Statistical analysis
The continuous variables were presented as the mean, standard deviation, median, and interquartile range. The normality of distribution in the continuous data was assessed using the Kolmogorov-Smirnov test, Shapiro-Wilk test, and histograms. To compare the categorical variables between the RA patients with and without ACD, the Chi-square test or Fischer’s exact test was employed. Furthermore, the comparison of the continuous variables between the RA patients with and without ACD, as well as between the inactive to moderately active RA and highly active RA groups, was performed using Student’s t-test and the Mann-Whitney U test for the normally and non-normally distributed data, respectively.

In addition, binary logistic regression analysis (stepwise method) was run to predict the variables that could affect the DAS28-ESR score. In this analysis, the DAS28-ESR score was considered as the dependent variable. A p-value less than 0.05 was considered statistically significant for two-by-two analyses. For logistic analysis, a p-value equal to 0.1 was considered statistically significant. All data analyses were performed in the SPSS software version 20.0 (IBM Corp.; Armonk, NY, USA).

Ethical consideration
This study was in line with the Declaration of Helsinki. The research objectives were explained to the patients, and their consent was obtained prior to the study. The study protocol was approved by the Ethics Committee of Mashhad University of Medical Sciences.

Results

Anemia of chronic disease
According to the results, 87.5% (n=70) of the participants were female. The mean age of the patients was 50.1±13.58 years (age range, 24-80 years). The data indicated that 36 (45%)...
Hepcidin and rheumatoid arthritis

Table 1. Comparison of the demographic and clinical characteristics of rheumatoid arthritis patients with and without anemia of chronic disease

<table>
<thead>
<tr>
<th></th>
<th>All patients (n=80)</th>
<th>RA with ACD (n=36)</th>
<th>RA without ACD (n=44)</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, year</td>
<td>50.15 (±13.58)</td>
<td>51.97 (±14.18)</td>
<td>48.66 (±13.04)</td>
<td>0.28</td>
</tr>
<tr>
<td>Gender, female</td>
<td>70 (87.5%)</td>
<td>36 (100%)</td>
<td>34 (77.3%)</td>
<td>0.002b</td>
</tr>
<tr>
<td>BMI, kg/m²</td>
<td>27.08 (±5.23)</td>
<td>25.19 (±4.69)</td>
<td>28.57 (±5.19)</td>
<td>0.004b</td>
</tr>
<tr>
<td>RA duration, month</td>
<td>62.49 (±56.15)</td>
<td>48 (60)</td>
<td>54 (69)</td>
<td>0.56*</td>
</tr>
<tr>
<td>RA therapy duration, month</td>
<td>4.78 (±4.38)</td>
<td>3.5 (4.8)</td>
<td>4 (5)</td>
<td>0.34*</td>
</tr>
<tr>
<td>DAS28-ESR</td>
<td>4.51 (±1.51)</td>
<td>4.96 (±1.57)</td>
<td>4.15 (±1.37)</td>
<td>0.01b</td>
</tr>
<tr>
<td>Serum hepcidin, ng/mL</td>
<td>1200.09 (±684.97)</td>
<td>1207 (985.2)</td>
<td>923.8 (677.3)</td>
<td>0.57*</td>
</tr>
<tr>
<td>Serum iron, µg/dL</td>
<td>62.11 (±32.55)</td>
<td>53 (54)</td>
<td>57 (50)</td>
<td>0.55*</td>
</tr>
<tr>
<td>Iron binding capacity, µg/dL</td>
<td>348 (±60.1)</td>
<td>349.42 (±75.15)</td>
<td>346.84 (±45.14)</td>
<td>0.93b</td>
</tr>
<tr>
<td>Prednisolone</td>
<td>49 (61.3%)</td>
<td>21 (58.3%)</td>
<td>28 (63.6%)</td>
<td>0.62b</td>
</tr>
<tr>
<td>Methotrexate</td>
<td>39 (48.8%)</td>
<td>16 (44.4%)</td>
<td>23 (52.3%)</td>
<td>0.48b</td>
</tr>
</tbody>
</table>

RA: rheumatoid arthritis; TS: transferrin saturation; BMI: body mass index

*Student’s t-test, data are shown as the mean±standard deviation; bChi-square test; *Mann-Whitney U test, data are presented as median [interquartile range]

Table 2. Comparison of demographic and clinical characteristics of patients with rheumatoid arthritis based on disease activity measured by DAS28-ESR

<table>
<thead>
<tr>
<th></th>
<th>DAS28-ESR ≤5.1 (n=52)</th>
<th>DAS28-ESR &gt;5.1 (n=28)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>47.91 ±13.18</td>
<td>54.56 ±13.5</td>
<td>0.04b</td>
</tr>
<tr>
<td>Gender, female</td>
<td>44 (84.61%)</td>
<td>26 (92.85%)</td>
<td>0.15b</td>
</tr>
<tr>
<td>BMI, kg/m²</td>
<td>26.71 ±5.1</td>
<td>27.84 ±5.5</td>
<td>0.39b</td>
</tr>
<tr>
<td>RA duration, month</td>
<td>48 [57]</td>
<td>36 [96]</td>
<td>0.91*</td>
</tr>
<tr>
<td>RA therapy duration, month</td>
<td>4 [4]</td>
<td>3 [7.09]</td>
<td>0.83*</td>
</tr>
<tr>
<td>Anemia of chronic disease</td>
<td>18 (34.61%)</td>
<td>18 (64.28%)</td>
<td>0.005</td>
</tr>
<tr>
<td>Serum hepcidin, ng/mL</td>
<td>1090.9 [631.4]</td>
<td>1131.8 [991.3]</td>
<td>0.53*</td>
</tr>
<tr>
<td>Serum iron, µg/dL</td>
<td>57 [51]</td>
<td>46 [46]</td>
<td>0.09*</td>
</tr>
<tr>
<td>TIBC, mcg/dL</td>
<td>352.42 (60.62)</td>
<td>339.33 (59.24)</td>
<td>0.36*</td>
</tr>
<tr>
<td>Transferrin saturation, %</td>
<td>16.86 [15.67]</td>
<td>14.01 [11.55]</td>
<td>0.2*</td>
</tr>
<tr>
<td>Prednisolone</td>
<td>37 (71.15%)</td>
<td>12 (42.85%)</td>
<td>0.02 b</td>
</tr>
<tr>
<td>Methotrexate dosage</td>
<td>3.75 [2.5]</td>
<td>1.25 [1.56]</td>
<td>0.01*</td>
</tr>
</tbody>
</table>

RA: rheumatoid arthritis; BMI: body mass index

*Student’s t-test, data are shown as the mean±standard deviation; bChi-square or Fischer’s exact test; *Mann-Whitney U test, data are presented as median [interquartile range]

Table 3. Input variables in the multiple logistic regression model recognized as significant predictors of active rheumatoid arthritis (DAS28-ESR>5.1)

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>SE</th>
<th>p</th>
<th>Adjusted OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methotrexate dosage</td>
<td>-0.72</td>
<td>0.39</td>
<td>0.06</td>
<td>0.48</td>
</tr>
<tr>
<td>Constant</td>
<td>0.16</td>
<td>1.002</td>
<td>0.86</td>
<td>1.18</td>
</tr>
</tbody>
</table>

SE=standard error; OR=odds ratio

Discussion

Hepcidin is a small peptide associated with the red blood cell kinetics and inflammation in healthy individuals. This peptide acts as a major regulator of iron absorption in the intestines and iron recycling via macrophages (19). Hepcidin is considered to be an acute-phase reactant. The diagnostic significance of hepcidin has been reported in several conditions, such as inflammation, neoplastic diseases, and diabetes mellitus (20, 21).

Anemia is a major contributor to morbidity in RA (3). In the current study, we evaluated the serum hepcidin level in patients with RA and its correlation with inflammation and anemia. Based on our findings, hepcidin showed no association with the RA activity, and it could not significantly predict active RA. These results are somehow inconsistent with some of the previously reported studies, which suggested that serum hepcidin may act as a surrogate marker for inflammation.
Hepcidin has gained attention in RA studies owing to the involvement of IL-6 as a major multifunctional cytokine in this disease, which induces the hepcidin production (22, 23). Given the significant role of IL-6 in joint destruction, acute-phase reactant induction, and overall disease activity (24), blocking this interleukin reduces the RA activity (25). The IL-6 has been also introduced as the central ACD mediator (26). This interplay among IL-6, disease activity, and serum hepcidin has been the main reason to concentrate on the hepcidin level as a marker that could be used to evaluate the RA activity.

In the current study, the DAS28-ESR cut-off value of 5.1 was used to divide the patients into the low and high RA activity groups, following previous studies (1). In this report, the authors showed that, in agreement with our results, the hepcidin level was not different in RA with and without ACD cases. However, hepcidin showed a moderate correlation with disease activity (r=0.4). In the mentioned study, ESR had a higher correlation with disease activity (r=0.53) than hepcidin.

Given more evidence on the possible role of hepcidin in chronic inflammation, several studies have been conducted to elucidate other possible applications of hepcidin in clinical practice. For example, some efforts have been made to use hepcidin in discriminating ACD from iron deficiency anemia; however, hepcidin was not applicable in this regard (4). In addition, this peptide has been used to determine the clinical efficacy of some therapeutic interventions (27).

The RA duration can be also considered as a significant contributor when evaluating hepcidin and anemia in RA. In this regard, hepcidin was reported to show no correlation with changes in the hemoglobin level at the earlier RA stages (13). In the present study, the RA duration was not a significant predictor for the RA activity. Although the hepcidin level was higher in the RA with ACD group than that in the RA without ACD group, the difference was not statistically significant.

However, this result was in line with those from the previous studies demonstrating the elevation of the hepcidin level in the presence of ACD (6). The serum iron level could be normal or increased in patients with ACD. In the current study, serum iron was within the normal range in all participants, and it did not differ between the two groups based on the presence or absence of ACD.


17. Wells G, Becker JC, Teng J, Dougdos M, Schiff M, Smolen J, et al. Validation of the 28-joint Disease Activity Score (DAS28) and European League Against Rheumatism response criteria based on C-reactive protein against disease progression in patients with rheumatoid arthritis, and comparison with the DAS28 based on erythrocyte sedimentation rate. Ann Rheum Dis 2009; 68: 954-60. [CrossRef]


