Levels of CSF prostaglandin E$_2$, cognitive decline, and survival in Alzheimer’s disease

M Combrinck, J Williams, M A De Berardinis, D Warden, M Puopolo, A D Smith, L Minghetti

**Background:** Although epidemiological, clinical, and experimental evidence indicates that the inducible isozyme of cyclo-oxygenase (COX-2) may be involved in the pathogenesis of several neurodegenerative disorders, the mechanisms whereby COX-2 contributes to Alzheimer’s disease are largely unknown.

**Objective:** To undertake a longitudinal study of CSF levels of a major product of COX activity, prostaglandin E$_2$ (PGE$_2$), in relation to cognitive decline and survival in patients with Alzheimer’s disease.

**Methods:** CSF PGE$_2$ was measured on at least three annual visits in 35 controls and 33 Alzheimer patients (26 necropsy confirmed) who completed the Cambridge cognitive assessment (CAMCOG).

**Results:** Compared with controls, CSF PGE$_2$ was higher in patients with mild memory impairment, but lower in those with more advanced Alzheimer’s disease. The median survival time of patients with higher initial PGE$_2$ levels was five years longer than those with lower levels.

**Conclusions:** COX activity in Alzheimer’s disease varies with stage of the disease. PGE$_2$ levels correlate positively with patient survival. These findings suggest that inhibition of COX activity does not represent a major target for the pharmacological treatment of Alzheimer’s disease.

**METHODS**

Participants were volunteers in the Oxford project to investigate memory and aging (OPTIMA), a longitudinal observational study established in 1988 and approved by the Central Oxford Research Ethics Committee. The present study concerned 35 cognitively normal controls and 33 patients who satisfied NINCDS–ADRSA criteria for the diagnosis of probable Alzheimer’s disease (table 1). All participants underwent annual medical and neuroimaging assessments for at least three years, and six monthly cognitive assessments using the Cambridge Examination for Mental Disorders in the Elderly (CAMDEX). This included the Cambridge cognitive examination (CAMCOG) and the mini-mental state examination (MMSE). The CAMCOG learning subscale (out of 17) reflects the severity of episodic memory impairment, the cognitive domain that declines first in most patients. We used the learning subscale scores as proxy of status (control v Alzheimer’s disease) and disease progression. We excluded subjects with overt infections, systemic inflammatory conditions, and erythrocyte sedimentation rates (ESRs) over 40 mm/hour. Of the 26 patients who came to necropsy, 25 had CERAD (Consortium to Establish a Registry for Alzheimer’s Disease) “definite” and one had CERAD “probable” Alzheimer’s disease; six had Braak limbic stage and 20 had neocortical disease. Of the six controls who came to necropsy, four were confirmed as CERAD negative, while two had sparse cortical neuritic plaques. Surviving controls showed no cognitive declines over at least six subsequent years.

**Abbreviations:** ADRDA, Alzheimer’s Disease and Related Disorders Association; CAMCOG, Cambridge cognitive assessment; CERAD, Consortium to Establish a Registry for Alzheimer’s Disease; COX, cyclo-oxygenase; LMEM, linear mixed effects modelling; MMSE, mini-mental state examination; NINCDS, National Institute of Neurological and Communicative Disorders and Stroke; NSAID, non-steroidal anti-inflammatory drug; OPTIMA, Oxford project to investigate memory and aging; PGE$_2$, prostaglandin E$_2$
Table 1  Characteristics of patients with Alzheimer’s disease and controls

<table>
<thead>
<tr>
<th></th>
<th>Controls</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of subjects</td>
<td>35</td>
<td>33</td>
</tr>
<tr>
<td>Women</td>
<td>17</td>
<td>22</td>
</tr>
<tr>
<td>Clinical diagnosis (NINCDS/ADRDA)</td>
<td>35 negative</td>
<td>33 probable</td>
</tr>
<tr>
<td>Age at first visit: median (interquartile range, IQR)</td>
<td>70.4 (65.7 to 76.8)</td>
<td>71.0 (64.9 to 77.3)</td>
</tr>
<tr>
<td>Pathological diagnosis (CERAD)</td>
<td>4 negative</td>
<td>25 definite</td>
</tr>
<tr>
<td>Learning memory subscale of CAMCOG (median, IQR)</td>
<td>14.0 (13 to 16)*</td>
<td>4.0 (2.8 to 7.3)*</td>
</tr>
<tr>
<td>MMSE (median, IQR) first visit</td>
<td>28 (27 to 30)*</td>
<td>19.0 (15.5 to 22.0)*</td>
</tr>
<tr>
<td>Sporadic users of low dose aspirin</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>At one or more visits during study period</td>
<td>17</td>
<td>11</td>
</tr>
<tr>
<td>Sporadic users of NSAIDs (ibuprofen, diclofenac)</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>APOE4 allelic frequency</td>
<td>0.10</td>
<td>0.46</td>
</tr>
<tr>
<td>CSF PGE2 (pg/ml), first visit</td>
<td>11.0 (6.4 to 14.6)</td>
<td>7.5 (3.3 to 13.0)</td>
</tr>
</tbody>
</table>

*p=0.001, Wilcoxon-Mann-Whitney U test

ADRD, Alzheimer’s Disease and Related Disorders Association; CAMCOG, Cambridge cognitive assessment; CERAD, Consortium to Establish a Registry for Alzheimer’s Disease; CSF, cerebrospinal fluid; IQR, interquartile range; MMSE, mini-mental state examination; NINCDS, National Institute of Neurological and Communicative Disorders and Stroke; NSAID, non-steroidal anti-inflammatory drug.

Arbor, Michigan, USA). Interference of the CSF matrix with the enzymatic assay was excluded as previously described. Storage time did not relate to CSF PGE2 levels ($r = -0.01$, p>0.5).

For cross sectional analyses we used a non-parametric test (Wilcoxon-Mann-Whitney U). For longitudinal analyses we used linear mixed effects modelling (LMEM), which included age, sex, and learning subscale scores as fixed factors; the random factors were each individual participant. The LMEMs took into account the longitudinal nature of the data by including an autoregressive correlation function to adjust for serial correlation of errors within participants. Survival analyses used a Cox proportional hazards regression model to test whether age at death related to PGE2 levels. The Cox proportional hazards regression model co-varied learning subscale or MMSE scores, age at first PGE2 evaluation, and sex.

RESULTS

PGE2 levels and cognitive scores at the initial visit are given in table 1. At the second and third study episodes, patients’ MMSE scores declined (median (interquartile range), 13.0 (8.0 to 18.5) and 9 (4 to 16) for the second and third episodes, respectively; paired Wilcoxon-Mann-Whitney test for first and third study episodes: $V = 421.5$, p<0.0001) but control MMSE scores remained stable (Wilcoxon-Mann-Whitney $V = 100.5$, p = 0.09).

The longitudinal analysis by LMEM of the relation between CSF PGE2 levels and cognitive scores revealed a curvilinear pattern (fig 1A): PGE2 levels were highest when learning scores were just below the normal range (very early Alzheimer’s disease), but declined with progressive learning impairment (polynomial trends of levels over learning subscale scores: $F = 2.97$, 3/155 df, p = 0.034). Patients with learning scores within the top tertile ($>11/17$, n = 11), had higher CSF PGE2 than controls ($t = 2.07$, 38 df, p = 0.045). Conversely, patients with learning scores in the lowest tertile ($<6/17$) had significantly lower CSF PGE2 than controls ($t = -2.19$, 59 df, p = 0.032). When patients’ learning scores were in the middle third of the range, their CSF PGE2 levels were similar to controls ($t<1$, p>0.5). Co-varying CSF storage times did not affect these results. LMEM modelled the longitudinal nature of the PGE2 data through a first order autocorrelation structure with a continuous time covariate. This significantly improved the model’s fit ($\phi = 0.35$; Likelihood ratio = 13.05, 1 df, p = 0.0003), indicating that relations between PGE2 levels from individual participants depended on the time interval between observations.

Figure 1  (A) Dependence of the CSF PGE2 on CAMCOG learning subscale score in all participants (controls, empty circles; patients, filled triangles). A Loess line for the relation is shown. The Loess line fits the data locally using robust non-parametric models. Cerebrospinal fluid PGE2 levels are given as the natural logarithm of pg/ml values. Non-transformed PGE2 values varied from 1.6 to 75 pg/ml. (B) Cumulative survival of patients with Alzheimer’s disease with high (dashed line) and low (continuous line) initial CSF PGE2 levels. Cox proportional hazards regression. Curves are adjusted for sex, age at PGE2 measurements, and learning subscale scores. CAMCOG, Cambridge cognitive assessment; PGE2, prostaglandin E2.
Few subjects used non-aspirin NSAIDs or prophylactic low dose aspirin (150 mg daily) at one or more study episodes (table 1). There was no significant interaction between NSAID use and the polynomial trend of CSF PGE2 levels over learning subscale scores (F = 0.88, 3/151 df, p = 0.45) and the curvilinear relation between CSF PGE2 levels and learning subscale scores was even more significant when these participants were excluded (polynomial trends of PGE2 levels over learning subscale scores for participants not taking NSAIDs: F = 3.72, 3/98 df, p = 0.014).

Higher CSF PGE2 levels at the first visit predicted greater age of death (Cox proportional hazards regression model covarying learning subscale scores, age at first visit, and sex: z = 3.29, p = 0.001). To illustrate this, we split the Alzheimer patients into two groups, with CSF PGE2 levels below or above the median value (9.5 pg/ml). The median learning subscale scores of the two groups were similar (4 and 5 for low and high PGE2 group, respectively; Wilcoxon-Mann-Whitney V = 96.5, p = 0.30). The median age of death of the patient group with high PGE2 levels was approximately five years greater than that of the low PGE2 group (fig 1B). Patients with higher initial PGE2 levels had higher MMSE scores (median MMSE for high and low PGE2 22 and 16, respectively; Wilcoxon-Mann-Whitney V = 50.5, p = 0.005), but patients with higher PGE2 still survived longer even when we co-varied MMSE (z = 2.33, p = 0.023). When survival analysis was carried out in patients whose initial learning scores were in the lowest tertile, higher PGE2 levels still predicted longer survival (z = 2.46, p = 0.014).

DISCUSSION
CSF PGE2 levels in patients with Alzheimer’s disease were high when their short term memory scores were just below those of controls, but were low in later stages of the disease. These findings support the hypothesis that inflammatory processes predominate early in Alzheimer’s disease and are consistent with increased intrathecal levels of the pro-inflammatory cytokine TNFα, reported in patients with mild cognitive impairment.17

Our findings are also consistent with increased CSF PGE2 levels in probable Alzheimer’s disease reported by Montine et al;8 although the PGE2 levels reported in that study are higher than those we detected in early disease. This apparent discrepancy might reflect differences in patient characteristics or in assay methods, although the concentration range of our control group was similar to those reported in other studies.11–19

A small number of our patients presented with early symptoms and initial learning scores still in the normal range (12–17) before they subsequently progressed to dementia. Their PGE2 levels were significantly higher than those of the true controls with similar learning scores, thus further supporting the idea of an early inflammatory response in Alzheimer’s disease.

CSF PGE2 levels reflect basal COX activity in hippocampal and cortical neurons3 as well as inflammation related COX activity occurring in compromised neurons and reactive glia.4 The curvilinear relation between CSF PGE2 and dementia severity could reflect an initial increase in inflammatory COX activity, accounting for the rise in PGE2 observed in early Alzheimer’s disease, followed by a progressive neuronal loss resulting in lower basal PGE2 production. Our study cannot separate the relative contributions of each process at the different stages, but it is consistent with previous necropsy studies reporting a reduction of COX-2 positive neurons in end stage Alzheimer’s disease.8 In a more recent study, the number of neurons expressing COX-2 correlated negatively with the Braak score for Aβ deposits, with a moderate increase in COX-2 expression was detected in Alzheimer’s disease patients with the mildest amyloid stage.9

Patients with higher initial CSF PGE2 levels survived longer. High PGE2 may reflect a greater survival of COX positive neurones. Alternatively, early inflammatory processes may impede the later progression of Alzheimer’s disease. The finding that patients with higher PGE2 levels survived longer weighs against the idea that PGE2 or COX activity is neurotoxic. This finding also contrasts with that in sporadic Creutzfeldt-Jakob disease (CJD) where high levels of PGE2 were associated with a shorter survival time.10 In sporadic CJD, median PGE2 levels were about fivefold higher than in Alzheimer’s disease,11 suggesting that inflammatory processes in CJD are more florid and detrimental than they are in Alzheimer’s disease.

Retrospective epidemiological studies suggest that prolonged treatment with NSAIDs protects against Alzheimer’s disease.21 However, if NSAIDs protect against Alzheimer’s disease by inhibiting COX activity, it is paradoxical that patients with higher initial PGE2 levels should survive longer. A likely explanation is that the primary protective effects of NSAIDs are related to mechanisms not involving COX inhibition.22

In conclusion, our study shows that COX activity in Alzheimer’s disease varies during the course of the disease. It does not support the view that increased COX activity is detrimental. Our findings suggest that inhibition of COX activity does not represent a major target for the pharmacological treatment of Alzheimer’s disease.

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REFERENCES
A 37-year-old woman complained of chronic perineal pain and numbness for three years. Physical examination was unremarkable, but perineal neurophysiological testing revealed isolated abnormalities of the left pudendal nerve. The distal motor latency and the left bulbocavernous reflex latency were both lengthened (5.3 ms; normal reflex latency were 3.5 ms and 4.8 ms; normal <4.2 ms, respectively). Previous laparoscopy for tubal ligation also described bilateral ovarian varices more prominent on the left side, which were confirmed at pelvic CT (Fig 1A).

Diagnosis of Alcock syndrome was rejected because pain was not exacerbated while seated, but rather in the upright position. Although perineal pain has not been reported in pelvic congestion syndrome, the possibility of venous compression resulting in nerve damage was raised. The patient was then referred to undergo an ovarian phlebography with possible subsequent embolisation. The phlebogram disclosed an enlarged left ovarian vein with congestion of the ovarian plexus (Fig 1B) and selective left ovarian vein embolisation was performed with coils and glue (Fig 1C). Three months later, our patient began to notice marked reduction in perineal pain and numbness. Neurophysiological examination performed eight months after embolisation demonstrated normalisation of the left pudendal nerve distal motor latency. This report suggests for the first time the possible compression of the pudendal nerve by pelvic varices, and should be analysed in line with other recently reported nervous compression cases of venous origin. It also demonstrates the dramatic relief obtained after ovarian vein embolisation.

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Figure 1 A 37-year-old woman with left pudendal nerve compression by pelvic varices successfully treated with transcatheter ovarian vein embolisation. (A) Contrast enhanced CT scan through the ischial spine shows left ovarian varices (arrow). (B) Left ovarian vein phlebography shows dilated ovarian vein with congestion of the ovarian and uterine plexus (arrow) and filling of the pelvic veins across the midline. (C) Following embolisation, control phlebography demonstrates occlusion of left ovarian vein and reduction of pelvic varices (arrow).

References
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