Abstract

Aim: In this study, we aimed to investigate the utility of hematological parameters associated with acute coronary syndrome (ACS) in the differentiation of non-ST elevation myocardial infarction (NSTEMI) from unstable angina (UA).

Material and Methods: The retrospective study included patients aged over 18 years who presented to the emergency department with a prediagnosis of ACS and were diagnosed with NSTEMI and UA between January 1, 2014 and February 28, 2018. Sociodemographic and clinical characteristics, including age, gender, and white blood cell count (WBC), platelet count (PLT), mean platelet volume (MPV), red cell distribution width (RDW), and neutrophil-to-lymphocyte ratio (NLR) were recorded for each patient.

Results: The study included a total of 1005 patients (749 NSTEMI and 256 UA). In multivariate logistic regression analysis, the mean WBC level was 1.375(1.258-1.503) times and the mean NLR was 3.631(range, 2.864-4.602) times higher in the NSTEMI group compared to the UA group(p<0.001). In the ROC analysis, the cutoff value of NLR for the differentiation of NSTEMI from UA was 2.237, with a sensitivity of 84.1% and a specificity of 81.6%.

Discussion: WBC and NLR values can be used as inflammatory markers in the differentiation of NSTEMI from UA.

Keywords
Hematological parameters; Unstable angina; NSTEMI; Neutrophil-to-lymphocyte ratio

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Introduction
The clinical spectrum of acute coronary syndrome (ACS) is classified into ST-elevation myocardial infarction (STEMI) and non-ST elevation ACS (NSTEMI-ACS) based on electrocardiography (ECG) findings. The NSTEMI-ACS group is further divided into non-ST elevation myocardial infarction (NSTEMI) and unstable angina (UA) [1]. A pathological correlate for ACS at the myocardial level is cardiomyocyte necrosis in patients with NSTEMI and myocardial ischemia without cell damage in patients with UA [2]. Due to the differences in their pathophysiological processes and treatment strategies, the differentiation of these two clinical conditions in the early period in the emergency department is of paramount importance.

Diagnosis, treatment, and risk management of patients with suspected NSTEMI-ACS often includes clinical evaluation, 12-lead ECG, and biomarkers. Moreover, measurement of cardiac troponin, the most important biomarker of cardiomyocyte damage, is mandatory, since troponin levels are often positive in NSTEMI and are often negative in UA [3-5]. Additionally, troponin is the most sensitive and tissue-specific cardiac marker and is also considered the golden-standard biochemical tool for ACS risk stratification. Nonetheless, troponin positivity may not be detected in approximately 40-60% of patients with ACS [6].

There have been recent studies investigating the inflammatory mechanism in the ACS process and these studies have shown the efficacy of numerous hematological parameters in the diagnosis of ACS, including white blood cell count (WBC), platelet count (PLT), mean platelet volume (MPV), red cell distribution width (RDW), and neutrophil-to-lymphocyte ratio (NLR) [7-9]. However, to our knowledge, there have been no large-scale studies investigating the utility of hematological parameters in the differential diagnosis of NSTEMI and UA.

The aim of this study was to investigate the utility of hematological parameters, along with cardiac troponin measured at the time of admission to the emergency department in the differential diagnosis of NSTEMI and UA.

Material and Methods

Study design and setting
Ethics committee approval was obtained before starting the study (Erciyes University Ethics Committee approval date: 20.06.2018 and the Decision Number: 2018/325). The study was conducted in an emergency department, which is visited by approximately 300,000 patients a year. The retrospective study included patients aged over 18 years who presented to the emergency department with a prediagnosis of ACS and were diagnosed with NSTEMI and UA between January 1, 2014, and February 28, 2018. The patients included in the study were selected from the hospital data registry system, taking into account the relevant ICD codes (chest pain R07.4, unstable angina pectoris I20.1, acute subendocardial myocardial infarction I21.4). The NSTEMI group was determined as the patients with non-ST elevation, with troponin positivity and having lesion, detected in coronary angiography. The unstable angina group, on the other hand, was composed of patients with clinical symptoms of unstable angina, with the negativity of troponin, and lesions detected in coronary angiography. Sociodemographic and clinical characteristics including age, gender, and WBC, NLR, RDW, MPV, and PLT levels were recorded for each patient.

Inclusion and exclusion criteria
All male and female patients over the age of 18 who met the diagnostic criteria for UA and NSTEMI were included in the study. Patients aged under the age of 18 and those with a diagnosis of STEMI, patients with missing data, patients with a normal coronary artery in coronary angiography, patients with a history of hematological disease (anemia, thrombocytopenia, bicytopenia, pancytopenia, immune thrombocytopenic purpura, thrombotic thrombocytopenic purpura, leukemia, lymphoma etc.), and patients with evidence of infection (those who were started antibiotic treatment during hospitalization due to infection, such as pneumonia, urinary tract, etc., or who were asked for an infectious diseases consultation during hospitalization) were excluded from the study (Figure 1).

Statistical analysis
Data were analyzed using SPSS for Windows version 25.0 (Armonk, NY: IBM Corp.). Normal distribution of continuous variables was assessed using the Lilliefors-corrected Kolmogorov-Smirnov test. Continuous variables (age, WBC, NLR, RDW, MPV, and PLT) were compared between the two groups (NSTEMI and UA) using the Mann-Whitney U Test with Monte Carlo Simulation. Categorical variables (treatment method and gender) were compared between the two groups using Pearson’s Chi-Squared test, followed by Fisher’s exact test for gender and Monte Carlo simulation for treatment method. Subsequently, column proportions were compared and expressed according to the Benjamini-Hochberg adjusted p-value. Multivariate Logistic Regression (method=enter) was used to determine thecause-effect relationship between the diagnosis (NSTEMI and UA) and continuous variables (age, WBC, NLR, RDW, MPV, and PLT) and categorical variables (treatment method). Continuous variables were expressed as medians (minimum/maximum), and categorical variables were expressed as frequencies (n). A p-value <0.05 was considered significant.

Results
The study included 1005 patients (749 NSTEMI and 256 UA). Table 1 presents the demographic data of the patients. The mean WBC level in all patients was 9.5 (range, 4.0-27.6) x10^3/ul, mean NLR was 2.9 (range, 0.5-42.4), mean RDW was 42.1 (range, 31.8-69.2) fl, mean MPV was 10.2 (range, 7.7-14.0) fl, and mean PLT was 240 (range, 54-736) x 10^3/ul.

A significant difference was found between the two groups with regard to WBC, PLT, RDW, and NLR values (p<0.05), whereas no significant difference was found with regard to MPV values (p=0.123) (Table 1).

The mean WBC level was 1.375 (1.258-1.503) times higher in the NSTEMI group compared to the UA group (Figure 2). The multivariate logistic regression model indicated that both NLR and WBC predicted NSTEMI and UA with a sensitivity of 92.8% and 66.8%, respectively, and also had an overall sensitivity of 86.2% (model, p=0.001), which suggests that both NLR and WBC were significant independent predictors of NSTEMI (Table 2).
Table 1. Numerical data of patients and analysis of quantitative and categorical variables with respect to NSTEMI and UA diagnosis

<table>
<thead>
<tr>
<th></th>
<th>NSTEMI (n=749)</th>
<th>UA (n=256)</th>
<th>Total (N=1005)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median (IQR)</td>
<td>Median (IQR)</td>
<td>Median (IQR)</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>66 (18)</td>
<td>62 (15)</td>
<td>64 (18)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Gender (Female)</td>
<td>244 (32.6)</td>
<td>75 (29.3)</td>
<td>319 (31.7)</td>
<td>0.351</td>
</tr>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
<td></td>
</tr>
<tr>
<td>WBC (10^3/μL)</td>
<td>10.435 (3.98)</td>
<td>7.86 (2.63)</td>
<td>9.545 (4.17)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>RDW (fL)</td>
<td>42.4 (5.2)</td>
<td>41.55 (4.66)</td>
<td>42.1 (5.2)</td>
<td>0.001</td>
</tr>
<tr>
<td>MPV (fL)</td>
<td>10.2 (1.3)</td>
<td>10.15 (1.3)</td>
<td>10.2 (1.2)</td>
<td>0.123</td>
</tr>
<tr>
<td>PLT (10^3/μL)</td>
<td>242 (92)</td>
<td>234 (70)</td>
<td>240 (87)</td>
<td>0.029</td>
</tr>
<tr>
<td>NLR</td>
<td>3.61 (3.27)</td>
<td>1.7 (0.75)</td>
<td>2.91 (2.75)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
<td></td>
</tr>
<tr>
<td>NLR &lt;2.237</td>
<td>119 (36.3)</td>
<td>209 (63.7)</td>
<td>328 (32.6)</td>
<td></td>
</tr>
<tr>
<td>NLR &gt;2.237</td>
<td>630 (93.1)</td>
<td>47 (6.9)</td>
<td>677 (67.4)</td>
<td></td>
</tr>
</tbody>
</table>

Table 2. Multiple Logistic Regression Analysis Findings for Age, Treatment Type, WBC, NLR, RDW, PLT Variables with NSTEMI and UA Dependent Variables

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>S.E.</th>
<th>P</th>
<th>Odds Ratio 95% C.I. for Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lower</td>
</tr>
<tr>
<td>Age</td>
<td>-0.0005</td>
<td>0.0085</td>
<td>0.954</td>
<td>1.000</td>
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<tr>
<td>WBC</td>
<td>-0.3174</td>
<td>0.0454</td>
<td>&lt;0.001</td>
<td>1.375</td>
</tr>
<tr>
<td>NLR</td>
<td>-1.2854</td>
<td>0.1210</td>
<td>&lt;0.001</td>
<td>3.631</td>
</tr>
<tr>
<td>RDW</td>
<td>-0.0439</td>
<td>0.0243</td>
<td>0.899</td>
<td>0.915</td>
</tr>
<tr>
<td>PLT</td>
<td>0.0003</td>
<td>0.0015</td>
<td>0.859</td>
<td>1.000</td>
</tr>
<tr>
<td>Constant</td>
<td>7.4518</td>
<td>1.1893</td>
<td>&lt;0.001</td>
<td></td>
</tr>
</tbody>
</table>

Discussion

Troponin is the most important biomarker in patients admitted to the emergency department with a prediagnosis of ACS[10]. Our findings indicated that hematological parameters could be beneficial when used together with the troponin value in the differential diagnosis of NSTE-ACS in the emergency department. To our knowledge, there have been no studies evaluating the utility of hematological parameters in the differential diagnosis of NSTE-ACS.

Studies have shown that inflammation plays a key role in the pathogenesis and progression of atherosclerosis by participating in many processes such as endothelial damage and plaque formation[11,12]. In the literature, proinflammatory functional responses of neutrophils have been shown to be associated with cardiovascular risk factors in atherosclerosis, and the role of neutrophils has been shown in both acute and chronic vascular damage [13,14]. Lymphocytes constitute a heterogeneous subgroup of WBC, along with pro-atherogenic and pro-inflammatory cells, and also may influence immune regulatory pathways [15]. NLR has recently emerged as a novel potential biomarker in the detection of individuals at risk for new cardiovascular events. A previous review indicated that NLR is the best predictor of death and major adverse cardiovascular events in patients with ACS[16]. Another study reported that the NLR value, assessed on admission, is a strong and independent predictor of cardiovascular mortality in NSTEMI and UA patients [17]. Tahito et al. evaluated the inflammatory parameters of 50 acute myocardial infarction (AMI) and 50 UA patients and reported that the mean NLR value was significantly higher in the AMI group compared to the UA group (7.22 vs. 4.62) [18]. In our study, the mean NLR was 3.6 in the NSTEMI group as opposed to 1.7 in the UA group. Moreover, the mean WBC level was 1.375 (1.258 - 1.503) times and the mean NLR was 3.631 (range, 2.864 - 4.602) times higher in the NSTEMI group compared to the UA group. Accordingly, the higher levels of WBC and NLR...
in our NSTEMI group compared to the UA group support the literature findings. In addition to these findings, multivariate logistic regression analysis revealed that WBC and NLR were strong predictors in the differentiation between NSTEMI and UA.

Limitations

The fact that our study was retrospective and conducted as a review of the data recording system caused difficulties in the classification of patients and in determining the missing parts in the history. Again, it is possible that we have no idea about the way and duration of taking the hemogram panel, determining other factors that will cause variations in the parameters. Another problem is that the approach of the cardiologist in determining the treatment method is uncertain. Another limitation is that we cannot include patients with unstable angina who were discharged despite admitting to the emergency department and could not be detected.

Conclusion

Our study is the first step towards using hematological parameters in the differential diagnosis of NSTE-ACS. WBC and NLR can be safely used as independent markers in the differential diagnosis of NSTEMI and UA. Further multi-center and comprehensive studies are needed to substantiate our findings.

Scientific Responsibility Statement

The authors declare that they are responsible for the article's scientific content including study design, data collection, analysis and interpretation, writing, some of the main line, or all of the preparation and scientific review of the contents and approval of the final version of the article.

Animal and human rights statement

All procedures performed in this study were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. No animal or human studies were carried out by the authors for this article.

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Conflict of interest

None of the authors received any type of financial support that could be considered potential conflict of interest regarding the manuscript or its submission.

References