

RESEARCH

Open Access

Prediction of LDL cholesterol response to statin using transcriptomic and genetic variation

Kyungpil Kim¹, Eugene Bolotin¹, Elizabeth Theusch¹, Haiyan Huang², Marisa W Medina^{1*} and Ronald M Krauss^{1*}

Abstract

Background: Statins are widely prescribed for lowering LDL-cholesterol (LDLC) levels and risk of cardiovascular disease. There is, however, substantial inter-individual variation in the magnitude of statin-induced LDLC reduction. To date, analysis of individual DNA sequence variants has explained only a small proportion of this variability. The present study was aimed at assessing whether transcriptomic analyses could be used to identify additional genetic contributions to inter-individual differences in statin efficacy.

Results: Using expression array data from immortalized lymphoblastoid cell lines derived from 372 participants of the Cholesterol and Pharmacogenetics clinical trial, we identify 100 signature genes differentiating high versus low statin responders. A radial-basis support vector machine prediction model of these signature genes explains 12.3% of the variance in statin-mediated LDLC change. Addition of SNPs either associated with expression levels of the signature genes (eQTLs) or previously reported to be associated with statin response in genome-wide association studies results in a combined model that predicts 15.0% of the variance. Notably, a model of the signature gene associated eQTLs alone explains up to 17.2% of the variance in the tails of a separate subset of the Cholesterol and Pharmacogenetics population. Furthermore, using a support vector machine classification model, we classify the most extreme 15% of high and low responders with high accuracy.

Conclusions: These results demonstrate that transcriptomic information can explain a substantial proportion of the variance in LDLC response to statin treatment, and suggest that this may provide a framework for identifying novel pathways that influence cholesterol metabolism.

Background

Statins reduce low density lipoprotein cholesterol (LDLC) levels by inhibiting 3-hydroxy-3-methylglutaryl coenzyme A reductase (*HMGCR*), the enzyme that catalyzes the rate-limiting step of cholesterol biosynthesis. Although numerous clinical trials have demonstrated statin efficacy for reducing cardiovascular disease risk, and have shown that this is proportional to LDLC lowering [1], there is substantial variation among individuals in the magnitude of this response [2,3].

Variation in the LDLC response to statin treatment has been attributed to both phenotypic and genetic factors. Phenotypic predictors include age, ancestry and smoking status [2]. Genetic association studies have also identified some single nucleotide polymorphisms (SNPs)

and haplotypes associated with statin response [4-8]. For example, candidate gene analyses have found variants in known regulators of cholesterol metabolism such as *HMGCR*, *APOE*, *PCSK9*, *ACE*, and *LDLR* to be associated with statin response [5-7]. In addition, genome-wide association studies (GWAS) have identified several SNPs in the *LPA* and *APOE/TOMM40* loci that achieved genome-wide significance for association with the magnitude of LDLC reduction [9]. However, taken together, these genotypes account for only a small proportion of the variation (approximately 4%) in statin-mediated LDLC reduction [9]. On the other hand, alternative splicing of *HMGCR* in lymphoblastoid cell lines (LCLs) was found to explain >6% of the variance in LDLC response in individuals from whom the LCLs were derived [10]. Notably, rs3846662, a SNP that directly regulates *HMGCR* alternative splicing, in itself was not a significant determinant of statin response, demonstrating that investigation of variation at the level of the transcriptome may

* Correspondence: mwmedina@chori.org; rkrauss@chori.org

¹Children's Hospital Oakland Research Institute, 5700 Martin Luther King Jr Way, Oakland, CA 94609, USA

Full list of author information is available at the end of the article

be more powerful for detecting novel markers of statin efficacy compared to traditional SNP association studies.

Gene expression profiling of patient-derived cell lines has been used to identify a panel of genes, or signature genes, associated with response to various drugs [11]. In the present study we sought to identify a transcriptomic profile associated with variation in LDLC response to statin treatment using non-negative matrix factorization (NMF) and radial-basis support vector machines (SVMs) prediction models to define a panel of signature genes whose expression levels differed between extremes of the LDLC response distribution. We then further refined our prediction model by incorporating SNPs either associated with expression levels of the signature genes (eQTLs) or previously associated with statin response by GWAS. Our present study represents the first attempt to predict inter-individual variation in LDLC response to statin treatment using both transcriptomic and genomic information.

Results

Identification of signature genes characterizing high and low statin responders

NMF is a useful feature extraction tool for multivariate data. It attempts to decompose the input data into a product of two non-negative matrices (that is, non-negative basis vectors and coefficients) to represent the data in a low dimensional feature space [12,13]. NMF has been successfully used to distinguish cancer subtypes based on large-scale and genome-wide gene expression data [14-16].

Using transcriptomic data of LCLs derived from 372 Caucasian non-smoking participants of the Cholesterol and Pharmacogenetics (CAP) simvastatin clinical trial (ClinicalTrials.gov ID: NCT00451828, Table 1) [17], we performed NMF clustering to determine the optimal number of individuals defined as either 'high' or 'low' responders in the age-adjusted LDLC response distribution curve (Additional file 1: Figure S1).

Table 1 Baseline clinical characteristics of participants in our study

	CAP372	CAP212	P value
N	372	212	-
Men	54%	52%	0.62
Smoker (%)	0%	36%	2.2×10^{-6}
Age (years)	54.9 ± 12.6	53.7 ± 12.6	0.29
BMI (kg/m ²)	27.7 ± 5.3	27.7 ± 5.3	0.89
LDLC level (mg/dl)	132 ± 28	134 ± 37	0.38
LDLC level change after statin treatment (mg/dl)	-56.7 ± 19.8	-55.7 ± 23.8	0.61

Data are presented as numbers, percentages or means \pm SDs.
 BMI: Body mass index.

We evaluated sample numbers ranging from 20 to 80 (with samples evenly divided between the extremes of the high and low response tails), by progressively including samples from less extreme ranges of the response distribution. A similar analysis of two randomly selected groups was also performed for comparison of separation to the true high *versus* low response groups. To maximize the *purity* difference between the true high *versus* low responder groups and the randomly selected group, as well as maximize the purity while maintaining a reasonable sample size for subsequent analyses, we selected 52 samples, 26 from each responder group (Figure 1a; Additional file 1: Figure S2). We found that expression data from these samples had the most robust clustering when divided into two groups (or ranks), compared to three, four, or five groups (Figure 1b and c). Stable clustering into two groups indicates that the tails of the LDLC change distribution are discrete sets, and that individuals could be categorized into high and low response groups by gene expression measures alone.

Next, we designed an algorithm to identify differentially expressed genes between the selected high and low responders. Specifically, we adapted a version of empirical Bayes moderated *t*-statistics to test differential expression. A *t*-statistic for each gene *i* is the ratio of the average gene expression difference of the high and low responders and the sample standard error. To obtain reliable estimates of sample standard errors and reliable *t*-tests, empirical Bayes methods have been popularly used to shrink the gene-wise sample variances towards a common value. Following a similar idea, Tusher et al. [18] introduced a constant s_0 (that is related to a prior expected value of standard error $s(i)$) and proposed to use $s(i) + s_0$ as an estimate of the gene-wise sample standard error, resulting in a moderated statistic $d(i)$. However, we found that this $d(i)$ was still sensitive to the expression level of each gene and presented increasing variability when $s(i)$ decreases (Figure 2a and b). To further stabilize the variance of $d(i)$, we introduced varying s_0 values to the standard error estimates, with results shown in Figure 2c and d. Genes were then ranked based on the statistical significance of the corresponding test statistics (details are in Materials and methods), and the top 100 most significant genes were selected based on their prediction performance compared to other gene sets with smaller or larger numbers of genes (Additional file 1: Figure S3). For ease of notation, these 100 genes were denoted as *SG*, and another set of genes obtained in the absence of s_0 was denoted as *SG_{NO}*. Of the 100 genes in *SG*, 67 were expressed to a greater extent in high responders than low responders while the other 33 genes were more highly expressed in low responders (Figure 3; Additional file 1: Table S1).

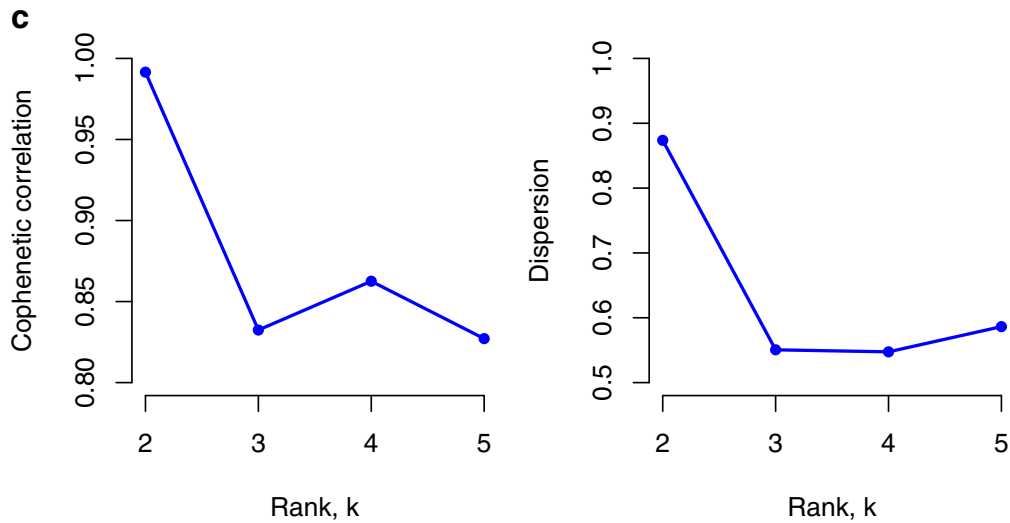
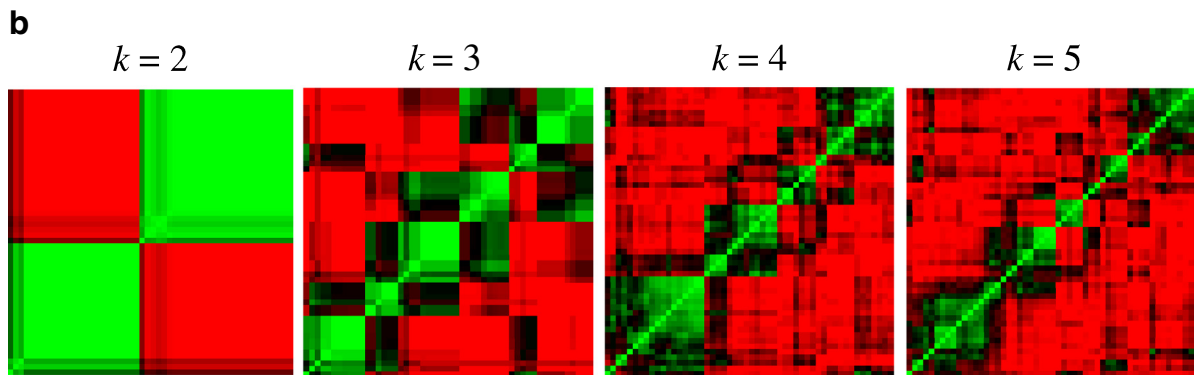
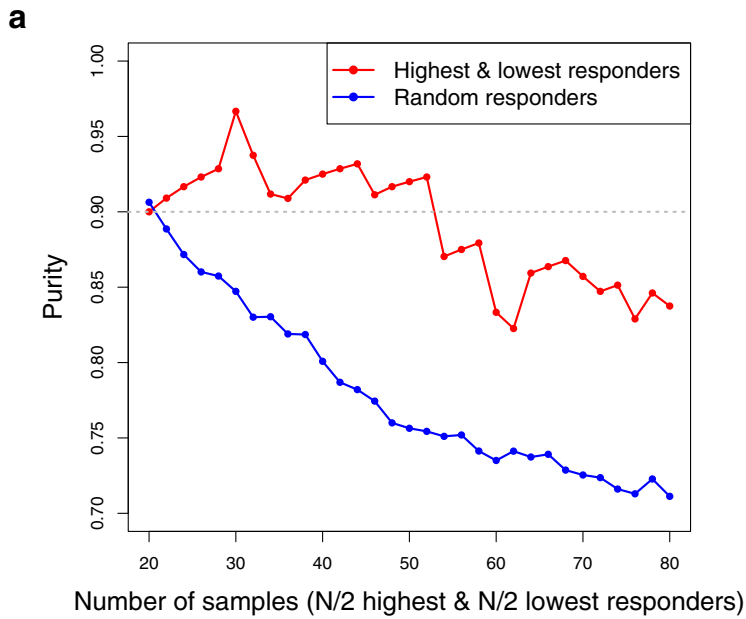


Figure 1 (See legend on next page.)

(See figure on previous page.)

Figure 1 Summary of the NMF clustering results. (a) Purity curves measuring the performance of NMF in clustering. The red line was calculated from the $N/2$ highest and $N/2$ lowest samples ($N = 20, \dots, 80$) and the blue line was obtained from the N randomly selected samples from the entire set of samples. Purity cutoff, 0.9, is denoted with a grey dotted line. (b) Consensus matrices for the 26 highest and 26 lowest responder samples, averaging 500 connectivity matrices computed at $k = 2, 3, 4, 5$. Comparison of the visualized consensus matrices across different ranks is a graphical way of deciding the best rank since clear block patterns along the diagonal of the consensus matrices indicate robustness of clustering in the corresponding ranks. (c) Cophenetic correlation and dispersion measures assessing the stability of clustering associated with each rank k .

Two of the 100 *SG* genes identified, cytochrome P450, family 51, subfamily A, polypeptide 1 (*CYP51A1*) and nuclear transcription factor Y, gamma (*NFYC*), have known roles in cholesterol metabolism [19,20]. In addition, 48 of the 100 genes were significantly enriched among 3,170 *HMGCR* correlated genes (FDR adjusted $P < 0.05$), and this degree of enrichment was substantially greater than expected by chance ($P < 1.3 \times 10^{-4}$). *HMGCR* encodes the rate-limiting step of the cholesterol biosynthesis pathway, and expression levels of this gene can be used as a quantitative marker of cellular cholesterol content [21]. Furthermore, using the enrichment analysis

tool *Enrichr* [22], we found that miR-200B and miR-429 predicted binding sites were over-represented in the *SG* list (FDR adjusted $P = 4.5 \times 10^{-3}$). These micro-RNAs have been previously described to target both *SREBP-1c* and *HMGCR* [23]. Thus these results are consistent with the possibility that other genes identified within the *SG* list may impact cholesterol metabolism.

Prediction using *SG*-based models

SVMs and related kernel methods are extremely good at solving prediction problems in computational biology such as prediction of a gene's function, its interactions,

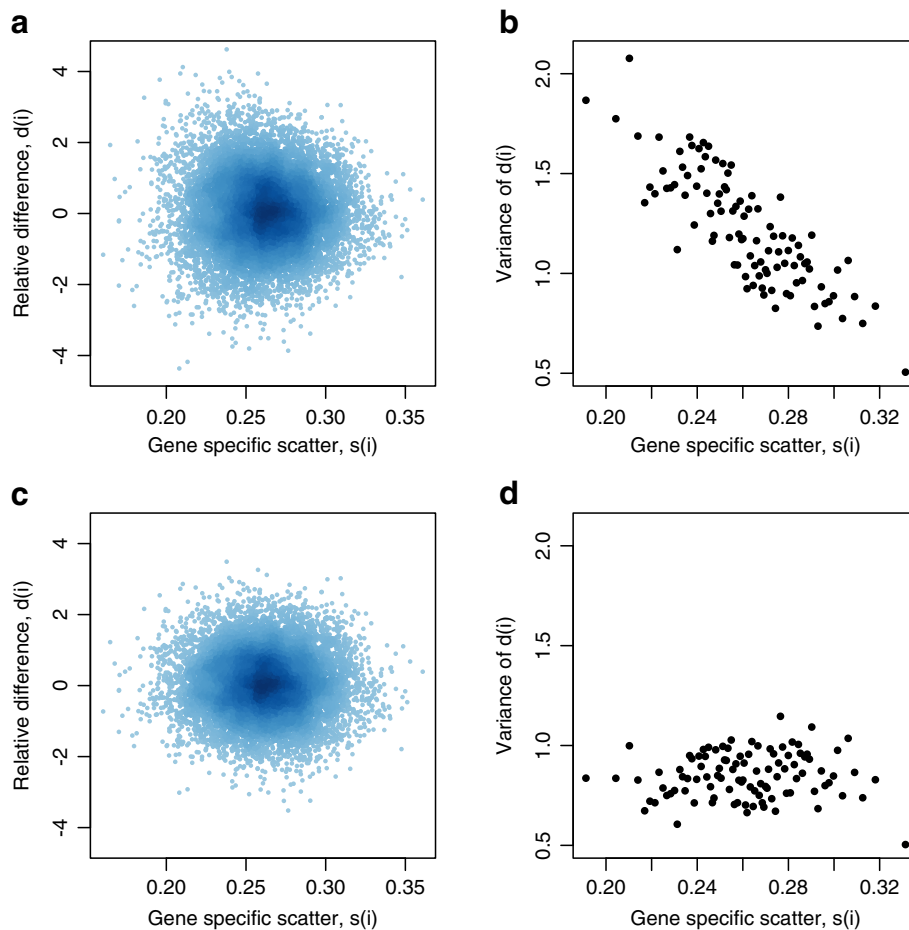


Figure 2 Gene specific scatter plots. Scatter plots of the gene specific scatter $s(i)$ vs. the relative difference $d(i)$ with (a) $s_0 = 0$ and (c) the varying s_0 values. The corresponding variance of $d(i)$ as $s(i)$ increases is shown in (b) and (d), respectively.

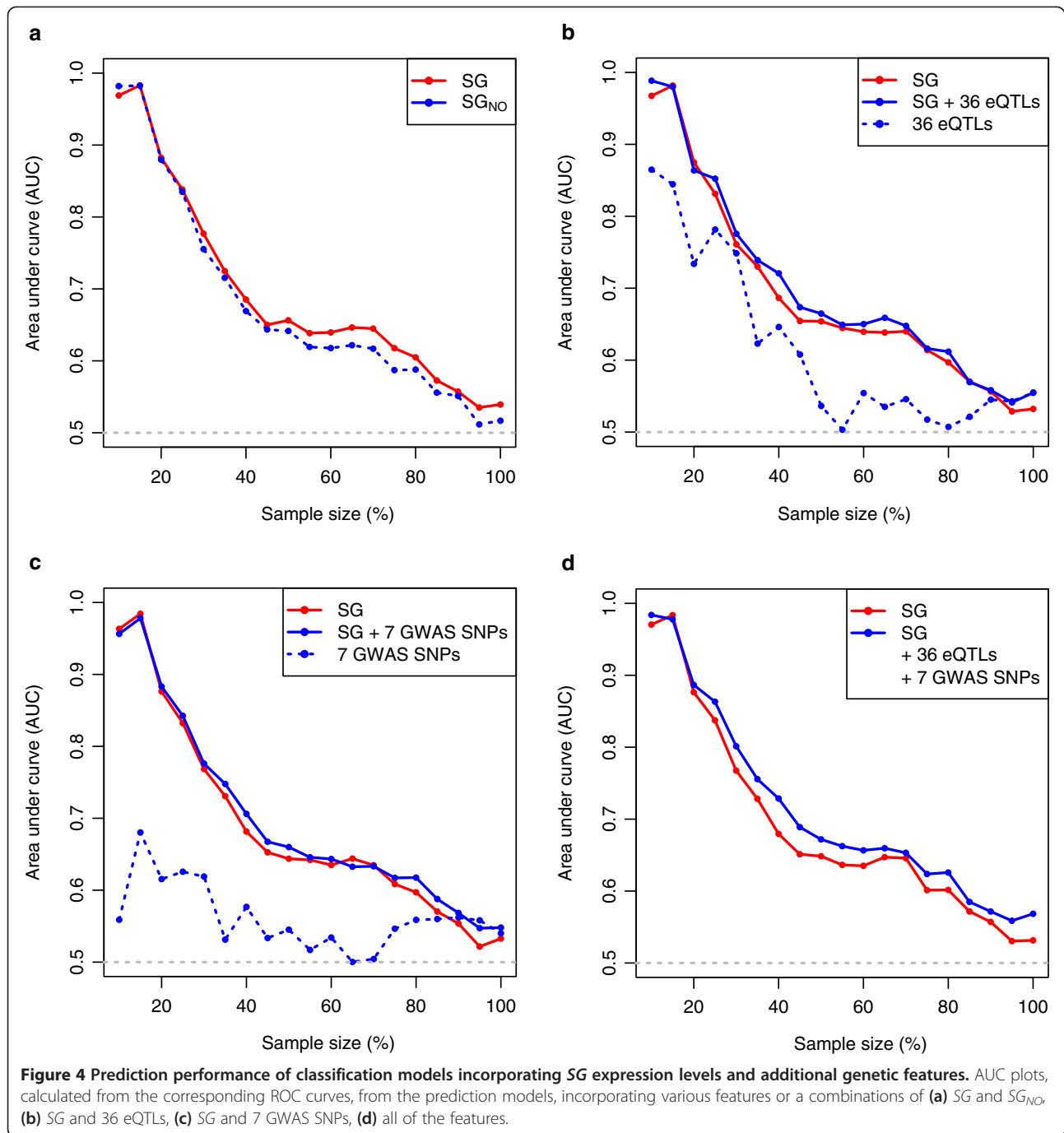


Table 2 Explained variance in plasma lipids of the entire CAP372 by signature gene expression levels of SG

	Explained variance (%)
Change in LDLC	12.3
Baseline LDLC	0.8
Change in triglyceride	1.9
Change in APOB	0.3
Change in HDLC	0.2

responders, with the AUC of 0.86 for the 10% tails and 0.75 for the 30% tails. When we included the 36 eQTLs in the SG-based model, such that 36 genes were represented by both their expression levels and their best eQTL genotypes, while the remaining 64 genes were represented by their expression level measurements alone, the overall prediction performance improved slightly and the AUC for the very extreme responders (10% tails) increased from 0.96 to 0.99. The combined model with SG and 36 eQTLs

explained 13.5% of variance in change of LDLC, which was 1.2% higher than the variance explained by the *SG* based model.

Since the improvement caused by the incorporation of eQTLs into the *SG*-based model was modest, we hypothesized that the eQTLs were highly redundant with the expression levels of the *SG*. Confirming our hypothesis, when the 36 signature genes' expression levels were replaced by the 36 eQTLs in the *SG* model (64 signature genes' expression levels + 36 eQTLs), the prediction curve did not change significantly (data not shown), with 12.2% of the variance explained vs. 12.3% for the *SG*-based model. However, the sum of the variance explained by the 64 signature genes alone (9.5%) and the 36 eQTLs alone (1.3%) was less than that for the combined model (10.8% vs. 12.2%) suggesting a synergistic interaction between these two feature sets.

Notably, we found that the ability of eQTLs to substitute for signature genes was highly dependent on the significance of eQTL *P* values. For example, when 56 eQTLs less strongly correlated with expression levels of the *SG* genes ($P < 10^{-5}$) replaced the corresponding 56 genes in the *SG*-based model, the model explained 1.5% less variance in LDLC change compared to the *SG*-based model.

Although the CAP trial included 584 self-identified Caucasians with genome-wide genotype data, only 372 subjects were used in the initial analysis due to either smoking status ($N = 64$) or lack of gene expression data ($N = 148$). The remaining subgroup of 212 individuals, designated *CAP212*, was very similar to our initial study population (*CAP372*) in demographic and clinical characteristics with the exception of smoking status (Table 1). In addition, although we previously reported that smoking status is associated with variation in statin-induced LDLC change [2], we did not observe this relationship in the self-reported Caucasian subgroup, indicating that *CAP212* may be an appropriate population to investigate the utility of the 36 *SG* eQTLs as genetic markers for discriminating high and low statin responders. As shown in Table 3, using samples comprising the 15%, 20%, and 25% tails of the LDLC response distribution, the variance explained by the 36 *SG* eQTLs-based model for *CAP212* was 17.2%, 14.6%, and 6.4% while the respective values

were 8.2%, 8.5%, and 13.4% for *CAP372* and 6.7%, 7.0%, and 6.1% for the full CAP population (*CAP584*).

Prediction using additional genetic features

We next tested the extent to which individuals in the extreme tails of the LDLC response distributions could be discriminated by a model including SNPs previously reported in GWAS studies to be associated with the magnitude of LDLC reduction at a genome-wide level of significance [9,26]. Seven SNPs were identified that were previously annotated as representing the *APOE*, *ABCG2*, and *LPA* genes (Additional file 1: Table S4). As shown in Figure 4c, the AUC plot for the model based on the seven GWAS SNPs did not exhibit substantial prediction power for the extreme responders. This suggests that genetic markers strongly related to statin response in the entire population are not necessarily informative for discriminating the very high and low responders [27]. When the GWAS SNPs were added to the *SG*-based model, prediction performance was unchanged for the extreme responders but slightly increased when the middle responders were considered as well. This combined model explained 13.8% of the variance in statin-induced change in LDLC, which was comparable to the amount of variance explained by the *SG* with the 36 eQTLs-based model (13.5%).

To determine if addition of SNPs with sub-genome-wide associations ($P < 10^{-6}$) further improved our model, we incorporated 15 such SNPs (for a total of 22 SNPs) [9,26]. Although the 22 SNPs-based model slightly improved the prediction for the extreme responders, the overall prediction performance was decreased (Additional file 1: Figure S5), suggesting that only SNPs that achieve genome-wide significance are capable of improving predictive power.

Finally we combined all the features into one model including *SG*, eQTLs, and GWAS SNPs (Figure 4d). Compared to the *SG*-based model, the prediction performance increased substantially across all sample sizes and explained 15.0% of the variance in LDLC change, 2.7% more than the *SG*-based model alone. Although no prominent synergistic interaction was observed among different features, inclusion of these additional genetic features substantially increased the explained variance in statin efficacy compared to gene expression levels alone.

Table 3 Explained variance (%) in statin-mediated LDLC reduction calculated by 36 eQTLs based prediction model

	Sample size (%)		
	15	20	25
<i>CAP212</i>	17.2	14.6	6.4
<i>CAP372</i>	8.2	8.5	13.4
<i>CAP584</i>	6.7	7.0	6.1

Discussion

Obtaining a comprehensive understanding of genetic factors contributing to variation in drug response is critical for understanding the molecular pathways underlying these differences and providing tools for optimizing treatment for individual patients. For statins, candidate gene and genome-wide SNP association studies have identified only a few loci associated with variation in statin response

as assessed by reduction in LDLC, and together, account for only a small portion of variance in LDLC response. To find additional genetic predictors of statin efficacy, we first tried to identify signature genes using an empirical Bayes moderated *t*-statistic that searches for differentially expressed genes between high and low responders by properly shrinking the gene-wise sample variances. Using prediction models based on radial-basis SVMs, we demonstrated that the variation from the signature genes was able to differentiate 'high' versus 'low' statin responders. We then refined our prediction model by including SNPs either associated with expression levels of the identified signature genes (eQTLs) or directly associated with statin response in previously published GWAS analyses. Overall our approach accounted for 15.0% of the variance of LDLC response to simvastatin. To our knowledge this is the largest proportion of variance in statin efficacy explained by molecular biomarkers to date.

Two of 100 signature genes, *CYP51A1* and *NFYC*, have been previously implicated in cholesterol metabolism. The enzyme encoded by *CYP51A1*, lanosterol 14- α -demethylase, catalyzes the conversion of lanosterol to 24,25-dihydrolanosterol in one of the later steps of the cholesterol biosynthesis pathway. Interestingly, we found that 'high' statin responders had greater levels of endogenous *CYP51A1* gene expression compared to 'low' responders, consistent with the possibility that endogenously high levels of cholesterol synthesis may result in greater LDLC lowering with statin treatment. Of our signature gene list that differentiates 'high' versus 'low' responders, *NFYC* is the most highly expressed gene in the 'low' responder group (Additional file 1: Table S1). *NFYC* encodes one subunit of the NFY trimeric complex comprised of *NFYA*, *NFYB*, and *NFYC*, which functions as a transcription factor [19,28]. NFY has been shown to interact with sterol regulatory element binding transcription factor 2 (*SREBF2*, aka *SREBP2*), the major transcription factor known to modulate both the cholesterol synthesis and uptake pathways to maintain intracellular cholesterol homeostasis [29]. Interestingly, *NFYC* was very recently identified to be a target of mir-33* [19], the passenger strand micro-RNA generated during the expression of mir-33, a well-established regulator of lipid homeostasis [28].

Since *HMGCR* encodes the rate-limiting enzyme in the cholesterol biosynthesis pathway, and its transcript levels are very precisely regulated [30], variation in *HMGCR* expression can be considered to be a marker of intracellular cholesterol homeostasis. Our findings that expression levels of almost half of the *SG* genes were correlated with expression of *HMGCR*, and that the *SG* genes have an over-representation in miR-200B and miR-429 predicted binding sites, are consistent with the likelihood that these genes are regulated by changes in

intracellular cholesterol levels and thus may impact cholesterol metabolism. Since the majority of the *SG* genes have not been previously implicated in cholesterol metabolism, functional studies will be necessary to determine if these genes are not only markers, but also determinants of cellular cholesterol metabolism.

Substituting gene expression levels with eQTLs is a new and promising approach for the development of diagnostic tools, as novel eQTLs are rapidly discovered from various tissues [31]. We found that when the eQTLs were very strongly correlated with gene expression variation ($P < 5 \times 10^{-8}$), replacement of the gene expression measurements with the SNP genotypes had little detrimental effect on the predictive ability of our model. These results suggest that genotype information of robustly associated eQTLs can largely substitute for gene expression data, and hence that analyses of transcript expression levels can serve as a proxy for underlying genetic variation. Not unexpectedly, we found that as the association between gene expression levels and SNP genotype lessened, the ability of eQTLs to substitute for gene expression was diminished.

While replication in an independent population is typically the gold standard used for validating genetic associations, our particular population is unique in that we have measures of *in vivo* statin response from participants of a clinical trial paired with measures of cellular gene expression from LCLs established from those participants. Since we had not utilized data from the entire CAP population and to our knowledge there is no other similar dataset or cell repository, given the ability of the eQTLs to replace gene expression measurements, we attempted to 'replicate' our results by testing only the effect of the eQTLs model to predict statin response in the *CAP212* population. Unexpectedly, we found that the model appeared to have even better predictive power in defining the extreme (<20%) tails than the *CAP372* subset of the population that was used to originally define the model, consistent with the likelihood that the *SG* are related to variation in statin response. Notably, the *CAP212* subset has a greater representation of extreme low responders compared to the *CAP372* subset (Additional file 1: Figure S6). Thus, the increased predictive power of the eQTL model in the *CAP212* subset is consistent with our observations that the models have greater power at the tails of the distribution. However, replication should be tested in additional relevant populations as they become available.

When we assessed the power of SNPs identified by GWAS to predict statin response, unlike the *SG* genes or eQTLs, we found that they were less informative for predicting the extreme responders. This performance discrepancy may be due to the fact that eQTLs in our study were derived from genes that reflect only variation

between the extreme responders of the population while GWAS SNPs were discovered from more general populations.

Conclusions

We propose novel integrated prediction models to investigate inter-individual variation in statin efficacy using a comprehensive method that combines transcriptomic and genetic information. With this approach, we explain a substantial percentage of variation in LDLC response to simvastatin treatment. As genotypic, eQTLs and phenotypic datasets grow, our approach can provide a promising framework for identifying novel genes, SNPs, and pathways involved in drug response.

Materials and methods

CAP study participants

The Cholesterol and Pharmacogenetics (CAP) trial involved 944 healthy volunteers (609 self-identified Caucasians) selected on the basis of plasma cholesterol levels between 160 and 400 mg/dL who were treated with 40 mg/day simvastatin for 6 weeks. The CAP clinical trial (NCT00451828) was approved by IRBs at the San Francisco General Hospital (H11082-19536), UCLA School of Medicine (01-11-089), where recruitment was performed, as well as the Children's Hospital Oakland Research Institute (2002-032), where the study was coordinated. All participants provided informed consent before enrollment, and research was carried out in accordance with the Helsinki declaration. Fasting plasma was collected at two pre-treatment time points (screening visit and enrollment visit) and at two post-treatment time points (4 and 6 weeks of treatment). Because LDLC levels were not significantly different between screening and enrollment, the average of these two measurements was used as the pre-treatment LDLC value to minimize technical variation. For the same reason, the average of 4- and 6-week measurements was used as the post-treatment LDLC value. Since the absolute change in LDLC is very highly correlated with the baseline values in the LDLC, we performed analyses on the relative change in LDLC, $\log(\text{LDLC-change})$, which was defined as $\log(\text{post-treatment LDLC value}) - \log(\text{pre-treatment LDLC value})$ (Additional file 1: Figure S7). To adjust for the clinical covariate effects, three candidate covariates (sex, age, and BMI) were tested with linear regression but only the age covariate significantly related to change in LDLC ($P < 6.6 \times 10^{-4}$) was adjusted. The distribution of the adjusted change measure, $\log(\text{LDLC-change})$, is shown in Additional file 1: Figure S1.

Gene expression measurements

Gene expression levels were measured using the Illumina Human-Ref8v3 beadarray in 480 LCLs derived from

Caucasian American participants in the CAP study, after 24 h incubation under standardized conditions as previously described [17]. We excluded smokers (64 samples) as well as 44 samples for which, after using a Bayesian method of predicting SNP genotypes from expression data of the LCLs, the predicted genotypes did not accurately match directly measured genotypes from the plasma of the LCL donor [32]. The baseline characteristics of the remaining 372 CAP participants (CAP372) are presented in Table 1. Each array was quantile transformed to the overall average empirical distribution across all arrays. Expression levels of each gene were then quantile normalized, adjusted for known covariates (date, RNA labeling batch, beadarray hybridization batch, and gender) and quantile normalized again.

Genotype data

Genotyping was performed on the HumanHap300 ($N = 304$) or HumanHap610-Quad ($N = 280$) BeadChips (Illumina, San Diego, CA, USA) as previously described [4]. These genotypes were imputed to over 2 million SNPs using BIMBAM [33,34] and HapMap CEU as a reference as previously described [4].

Selecting subsets of the high and low responders using NMF analysis

NMF aims to extract a small number of features (k), each defined as a positive linear combination of n genes, and express gene expression level as a positive linear combination of these pre-defined features. Given a non-negative data matrix $\mathbf{A}_{n \times m}$ (n : number of gene, m : number of samples), NMF factorizes \mathbf{A} into two matrices $\mathbf{W}_{n \times k}$ and $\mathbf{H}_{k \times m}$. Each of the m columns in \mathbf{H} matrix represents the predicted class expression pattern of the corresponding sample, which is used to assign m samples into k predicted classes. The stochastic nature of the seeding method used to generate the initial \mathbf{W} and \mathbf{H} matrices requires multiple NMF runs to achieve stability and the lowest approximation error. For this purpose, we used the NMF R package [35] and all the results from NMF analysis reported in this work were based on the best fit after performing 500 runs for each dataset. To meet the non-negative requirement of the data matrix, each entry in the normalized gene expression data matrix was replaced with the value of its P value subtracted from one, where the P values were calculated under the assumption of normality.

In order to select subsets that reflect the biological distinctions between high and low responder groups, NMF clustering was used with the following strategy fixing the number of features or ranks to two so as to represent the two extreme responder groups: (1) choose $N/2$ (10 to 40) each of the highest and lowest responder samples, N in total; (2) select 2,000 genes that have the

greatest mean difference between the two groups. Two thousand was the maximum number of genes that provided separation between two groups in our study; (3) Perform NMF analysis and evaluate cluster quality using the *purity* and *entropy* measures; (4) repeat (1) to (3) for another randomly selected 500 sets of N samples and calculate the average *purity* and *entropy* values for comparison. To evaluate the cluster quality of NMF analysis, *purity* and *entropy* measures were used [15]. *Purity* is a measure of cluster coherence while *entropy* measures how the various classes of samples are distributed in a cluster. Given l true class labels, suppose NMF generates k clusters. *Purity* is defined as $\frac{1}{n} \sum_{i=1}^k \max_{1 \leq j \leq l} (n_i^j)$, where n is the total number of samples and n_i^j is the number of samples in the cluster i that belong to original class j . *Entropy* is given by $-\frac{1}{n \log_2 l} \sum_{i=1}^k \sum_{j=1}^l n_i^j \log_2 \frac{n_i^j}{n_i}$, where n_i is the size of cluster i . *Purity* values close to 1, and *entropy* values close to 0 represent perfect clustering.

Identifying signature genes

To identify signature genes from the subsets selected, we first defined a score *relative difference* (in the same form as a t -statistic), $d(i)$, for each gene on the basis of change in gene expression relative to the *gene specific scatter*, $s(i)$, which is the standard deviation of repeated measurements. In particular, the *relative difference* and the *gene specific scatter* are defined as

$$d(i) = \frac{\bar{x}_H(i) - \bar{x}_L(i)}{s(i) + s_0} \quad (1)$$

$$s(i) = \sqrt{\frac{1}{N(N-1)} \left(\sum_{H=1}^N [x_H(i) - \bar{x}_H(i)]^2 + \sum_{L=1}^N [x_L(i) - \bar{x}_L(i)]^2 \right)} \quad (2)$$

where $\bar{x}_H(i)$ and $\bar{x}_L(i)$ are defined as the average levels of expression for gene i in the high (H) and low (L) responder groups, respectively, and N is the sample size of the high (or low) responder group. Based on an empirical Bayes approach, in order to stabilize the variance of $d(i)$ irrespective of the gene expression level, s_0 was introduced in the denominator of Equation (1) as described in Tusher et al. [18]. However, using a constant s_0 value as in Tusher et al, the variance of $d(i)$ was not fully stabilized in our data, causing difficulty in detecting significantly differentially expressed genes in our application. To better reflect the characteristics of our dataset, we developed the following procedure: (1) calculate the relative difference, $d(i)$, as in Equation (1) with varying s_0 values. Specifically, s_0 starts with a small constant value and decreases toward 0 as $s(i)$ increases (see Additional file 1 for details); (2) for each of 1,000 permutations of the

samples within each gene, calculate relative difference $d_p(i)$ to get the null distribution of the test statistic $d(i)$; (3) to find significant changes in gene expression, get the corresponding P value of each observed relative difference $d(i)$ based on the null distribution calculated in (2).

Prediction using SVM

Radial-basis SVMs were used for training and predicting in the SVM classification and regression models. The performance of the models was evaluated as follows: the data were randomly split into 10 sets, with nine assigned as training set and the tenth as testing set. The model was then trained using the training set and applied to the testing set for prediction. This process was repeated 1,000 times and the prediction power of the model was estimated based on the 1,000 testing sets. The SVM function in the R package (kernlab) was used to implement the models with default parameter settings [36]. For the SVM the radial basis kernel was chosen due to its superior performance in the cross-validation results to other kernel functions such as linear, polynomial, or hyperbolic tangent kernel (Additional file 1: Figure S8). The classification performance was evaluated by ROC curve analysis and quantitated by AUC using the ROCR package in R [37].

Data access

The gene expression data have been deposited in the Gene Expression Omnibus (GEO) under accession number GSE36868 and in Synapse [38] under accession number syn299510. The genotype data have been deposited in the database for genotypes and phenotypes (dbGaP, [39]) under accession number phs000481.

Additional file

Additional file 1: Supplementary Figures S1 to S8 and Table S1 to S4.

Abbreviations

APOB: Apolipoprotein B; CAP: Cholesterol and Pharmacogenetics; eQTL: Expression quantitative trait loci; GWAS: Genome-wide association studies; HDLC: High-density lipoprotein cholesterol; LCLs: Lymphoblastoid cell lines; LDLC: Low density lipoprotein cholesterol; NMF: Non-negative matrix factorization; SNPs: Single nucleotide polymorphisms; SVM: Support vector machine.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

KK conceived the study, performed data analysis, and wrote the manuscript. EB participated in eQTL studies and Enrichr analysis. ET was involved in data preparation. HH participated in NMF clustering analysis and method development. MWM and RMK supervised the project and manuscript development. All authors read and approved the final manuscript.

Acknowledgements

This work was funded by the following NIH grants: U19 HL069757 (RMK), R01 HL104133 (MWM), U01HG007031 (HH) and T32 HL098057 (KK, EB); and also by AHA post-doctoral fellowship 12POST10430005 (ET).

Author details

¹Children's Hospital Oakland Research Institute, 5700 Martin Luther King Jr Way, Oakland, CA 94609, USA. ²Department of Statistics, University of California, Berkeley, CA 94720, USA.

Received: 16 May 2014 Accepted: 3 September 2014

Published online: 30 September 2014

References

1. Cholesterol Treatment Trialists' (CTT) Collaboration: Efficacy and safety of more intensive lowering of LDL cholesterol: a meta-analysis of data from 170000 participants in 26 randomized trials. *Lancet* 2010, **376**:1670–1681.
2. Simon JA, Lin F, Hulley SB, Blanche PJ, Waters D, Shiboski S, Rotter JL, Nickerson DA, Yang H, Saad M, Krauss RM: Phenotypic predictors of response to simvastatin therapy among african-americans and caucasians: The Cholesterol and Pharmacogenetics (CAP) study. *Am J Cardiol* 2006, **97**:843–850.
3. Ridker PM, Danielson E, Fonseca FAH, Genest J, Gotto AM, Kastelein JJP, Koenig W, Libby P, Lorenzatti AJ, MacFadyen JG, Nordestgaard BG, Shepherd J, Willerson JT, Glynn RJ: Rosuvastatin to prevent vascular events in men and women with elevated C-reactive protein. *N Engl J Med* 2008, **359**:2195–2207.
4. Barber MJ, Mangravite LM, Hyde CL, Chasman DI, Smith JD, McCarty CA, Li X, Wilke RA, Rieder MJ, Williams PT, Ridker PM, Chatterjee A, Rotter JL, Nickerson DA, Stephens M, Krauss RM: Genome-wide association of lipid-lowering response to statins in combined study populations. *PLoS One* 2010, **5**:e9763.
5. Krauss RM, Mangravite LM, Smith JD, Medina MW, Wang D, Guo X, Rieder MJ, Simon JA, Hulley SB, Waters D, Saad M, Williams PT, Taylor KD, Yang H, Nickerson DA, Rotter JL: Variation in the 3-hydroxy-3-methylglutaryl coenzyme A reductase gene is associated with racial differences in low-density lipoprotein cholesterol response to simvastatin treatment. *Circulation* 2008, **117**:1537–1544.
6. Chasman DI, Posada D, Subrahmanyam L, Cook NR, Stanton VP Jr, Ridker PM: Pharmacogenetic study of statin therapy and cholesterol reduction. *JAMA* 2004, **291**:2821–2827.
7. Donnelly LA, Doney ASF, Dannfeld J, Whitley AL, Lang CC, Morris AD, Donnan PT, Palmer CNA: A paucimorphic variant in the HMG-CoA reductase gene is associated with lipid-lowering response to statin treatment in diabetes: a GoDARTS study. *Pharmacogenet Genomics* 2008, **18**:1021–1026.
8. Thompson JF, Hyde CL, Wood LS, Paciga SA, Hinds DA, Cox DR, Hovingh GK, Kastelein JJP: Comprehensive whole-genome and candidate gene analysis for response to statin therapy in the treating to new targets (TNT) cohort. *Circ Cardiovasc Genet* 2009, **2**:173–181.
9. Deshmukh HA, Colhoun HM, Johnson T, McKeigue PM, Betteridge DJ, Durrington PN, Fuller JH, Livingstone S, Charlton-Menys V, Neil A, Poulter N, Sever P, Shields DC, Stanton AV, Chatterjee A, Hyde C, Calle RA, DeMicco DA, Trompet S, Postmus I, Ford I, Jukema JW, Caulfield M, Hitman GA: Genome-wide association study of genetic determinants of LDL-c response to atorvastatin therapy: importance of Lp(a). *J Lipid Res* 2012, **53**:1000–1011.
10. Medina MW, Krauss RM: The role of HMGCR alternative splicing in statin efficacy. *Trends Cardiovasc Med* 2009, **19**:173–177.
11. Lamb J, Crawford ED, Peck D, Modell JW, Blat IC, Wrobel MJ, Lerner J, Brunet J-P, Subramanian A, Ross KN, Reich M, Hieronymus H, Wei G, Armstrong SA, Haggarty SJ, Clemons PA, Wei R, Carr SA, Lander ES, Golub TR: The connectivity map: using gene-expression signatures to connect small molecules, genes and disease. *Science* 2006, **313**:1929–1935.
12. Brunet J-P, Tamayo P, Golub TR, Mesirov JP: Metagenes and molecular pattern discovery using matrix factorization. *Proc Natl Acad Sci U S A* 2004, **101**:4164–4169.
13. Devarajan K: Nonnegative matrix factorization: An analytical and interpretive tool in computational biology. *PLoS Comput Biol* 2008, **4**:e1000029.
14. Collisson EA, Sadanandam A, Olson P, Gibb WJ, Truitt M, Gu S, Cooc J, Weinkle J, Kim GE, Jakkula L, Feiler HS, Ko AH, Olshen AB, Danenberg KL, Tempero MA, Spellman PT, Hanahan D, Gray JW: Subtypes of pancreatic ductal adenocarcinoma and their differing responses to therapy. *Nat Med* 2011, **17**:500–503.
15. Kim H, Park H: Sparse non-negative matrix factorizations via alternating non-negativity-constrained least squares for microarray data analysis. *Bioinformatics* 2007, **23**:1495–1502.
16. Tamayo P, Scanfeld D, Ebert BL, Gillette MA, Roberts CWM, Mesirov JP: Metagene projection for cross-platform, cross-species characterization of global transcriptional states. *Proc Natl Acad Sci U S A* 2007, **104**:5959–5964.
17. Mangravite LM, Engelhardt BE, Medina MW, Smith JD, Brown CD, Chasman DI, Mecham BH, Howie B, Shim H, Naidoo D, Feng Q, Rieder MJ, Chen YI, Rotter JL, Ridker PM, Hopewell JC, Parish S, Armitage J, Collins R, Wilke RA, Nickerson DA, Stephens M, Krauss RM: A statin-dependent QTL for GATM expression is associated with statin-induced myopathy. *Nature* 2013, **502**:377–380.
18. Tusher VG, Tibshirani R, Chu G: Significance analysis of microarrays applied to the ionizing radiation response. *Proc Natl Acad Sci U S A* 2001, **98**:5116–5121.
19. Goedeke L, Vales-Lara FM, Fenstermaker M, Cirera-Salinas D, Chamorro-Jorganes A, Ramires CM, Mattison JA, de Cabo R, Soares Y, Fernandez-Hernando C: A regulatory role for microRNA 33* in controlling lipid metabolism gene expression. *Mol Cell Biol* 2013, **33**:2339–2352.
20. Fink M, Acimovic J, Rezen T, Tansek N, Rozman D: Cholesterogenic lanosterol 14 α -demethylase (CYP51) is an immediate early response gene. *Endocrinology* 2005, **146**:5321–5331.
21. Medina MW, Theusch E, Naidoo D, Bauzon F, Stevens K, Mangravite LM, Kuang Y, Krauss RM: RHOA is a modulator of the cholesterol-lowering effects of statin. *PLoS Genet* 2012, **8**:e1003058.
22. Chen EY, Tan CM, Kou Y, Duan Q, Wang Z, Meirelles GV, Clark NR, Maayan A: Enrichr: interactive and collaborative HTML5 gene list enrichment analysis tool. *BMC Bioinformatics* 2013, **14**:128.
23. Hu Y, Zhang R, Zhang Y, Li J, Grossmann R, Zhao R: In ovo leptin administration affects hepatic lipid metabolism and microRNA expression in newly hatched broiler chickens. *J Anim Sci Technol* 2012, **3**:16.
24. Schölkopf B, Smola AJ: *Learning with Kernels*. Cambridge, MA: The MIT Press; 2002.
25. Schölkopf B, Tsuda K, Vert JP: *Kernel Methods in Computational Biology*. Cambridge, MA: The MIT Press; 2004.
26. Chasman DI, Giulianini F, MacFadyen J, Barratt BJ, Nyberg F, Ridker PM: Genetic determinants of statin-induced low-density lipoprotein cholesterol reduction. *Circ Cardiovasc Genet* 2012, **5**:257–264.
27. Jakobsdottir J, Gorin MB, Conley YP, Ferrell RE, Weeks DE: Interpretation of genetic association studies: markers with replicated highly significant odds ratios may be poor classifiers. *PLoS Genet* 2009, **5**:e1000337.
28. Mantovani R: The molecular biology of the CCAAT-binding factor NF-Y. *Gene* 1999, **239**:15–27.
29. Inoue J, Sato R, Maeda M: Multiple DNA elements for sterol regulatory element-binding protein and NF-Y are responsible for sterol-regulated transcription of the genes for human 3-hydroxy-3-methylglutaryl coenzyme A synthase and squalene synthase. *J Biochem* 1998, **123**:1191–1198.
30. Goldstein JL, Brown MS: Regulation of the mevalonate pathway. *Nature* 1990, **343**:425–430.
31. The GTEx Consortium: The Genotype-Tissue Expression (GTEx) project. *Nat Genet* 2013, **45**:580–585.
32. Schadt EE, Woo S, Hao K: Bayesian method to predict individual SNP genotype from gene expression data. *Nat Genet* 2012, **44**:603–608.
33. Servin B, Stephens M: Imputation-based analysis of association studies: candidate regions and quantitative traits. *PLoS Genet* 2007, **3**:e114.
34. Guan Y, Stephens M: Practical issues in imputation-based association mapping. *PLoS Genet* 2008, **4**:e1000279.
35. Gaujoux R, Seoighe C: A flexible R package for nonnegative matrix factorization. *BMC Bioinformatics* 2010, **11**:367.

36. Karatzoglou A, Smola A, Hornik K, Zeileis A: **kernlab** - An S4 package for kernel methods in R. *J Stat Softw* 2004, **11**:1–20.
37. Sing T, Sander O, Beerenwinkel N, Lengauer T: **ROCR**: visualizing classifier performance in R. *Bioinformatics* 2005, **21**:3940–3941.
38. **Sage Synapse**. <https://www.synapse.org/>.
39. **dbGaP**. <http://www.ncbi.nlm.nih.gov/gap>.

doi:10.1186/s13059-014-0460-9

Cite this article as: Kim *et al.*: Prediction of LDL cholesterol response to statin using transcriptomic and genetic variation. *Genome Biology* 2014 **15**:460.

Submit your next manuscript to BioMed Central and take full advantage of:

- Convenient online submission
- Thorough peer review
- No space constraints or color figure charges
- Immediate publication on acceptance
- Inclusion in PubMed, CAS, Scopus and Google Scholar
- Research which is freely available for redistribution

Submit your manuscript at
www.biomedcentral.com/submit

