

## Regression of warfarin-induced medial elastocalcinosis by high intake of vitamin K in rats

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**Arterial calcification (AC) is generally regarded as an independent risk factor for cardiovascular morbidity and mortality. Matrix Gla protein (MGP) is a potent inhibitor of AC, and its activity depends on vitamin K (VK). In rats, inactivation of MGP by treatment with the vitamin K antagonist warfarin leads to rapid calcification of the arteries. Here, we investigated whether preformed AC can be reversed by a VK-rich diet. Rats received a calcification-inducing diet containing both**

**VK and warfarin (W&K). During a second 6-week period, animals were randomly assigned to receive either W&K (3.0 mg/g and 1.5 mg/g, subsequently), a diet containing a normal (5 µg/g) or high (100 µg/g) amount of VK (either K<sub>1</sub> or K<sub>2</sub>). Increased aortic calcium concentration was observed in the group that continued to receive W&K and also in the group changed to the normal dose of VK and AC progressed. Both the VK-rich diets decreased the arterial calcium content by**

**some 50%. In addition, arterial distensibility was restored by the VK-rich diet. Using MGP antibodies, local VK deficiency was demonstrated at sites of calcification. This is the first study in rats demonstrating that AC and the resulting decreased arterial distensibility are reversible by high-VK intake. (Blood. 2007; 109:2823-2831)**

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### Introduction

Arterial calcification is an important independent risk factor for the development of atherosclerosis, myocardial infarction, stroke, and renal disease.<sup>1,2</sup> Patients with manifest arterial calcification have an unfavorable prognosis compared with patients with no or mild calcification.<sup>3,4</sup> Therefore, the prevention or reversal of arterial calcification may lead to improved patient outcomes.

For a long time it has been thought that calcification was a passive process and the end stage of cardiovascular disease. During the past 10 years, however, it has become clear that several osteoregulatory proteins, both stimulatory and inhibitory, are involved in the calcification of vascular tissue.<sup>5-8</sup> One of the strongest *in vivo* inhibitors of arterial calcification is matrix Gla protein (MGP). MGP was first discovered in bone,<sup>9</sup> but it is mainly produced by vascular smooth muscle cells and chondrocytes. Its function became clear in MGP-deficient mice,<sup>10</sup> which died within 6 to 8 weeks after birth as a result of rupture of the large arteries. Histochemical evaluation demonstrated complete calcification of the elastic fibers in the arterial vessels and a phenotypic change of smooth muscle cells into chondrocytes. MGP acts by direct inhibition of calcium crystal formation and regulates bone morphogenetic protein-2, a growth factor responsible for osteogenic differentiation.<sup>11-13</sup> Murshed et al<sup>14</sup> demonstrated that restoration of MGP exclusively in the vascular smooth muscle cells of the MGP-null mice completely rescued the vascular calcification phenotype. For this effect the MGP needed to be  $\gamma$ -carboxylated because mutating the Gla residues into aspartic acid residues led to the synthesis of nonfunctional MGP and to the death of all animals.

Vitamin K is an essential cofactor in the  $\gamma$ -carboxylation of glutamate residues in a small group of proteins, including MGP.<sup>15</sup> The activity of these vitamin K-dependent or Gla proteins is strictly dependent on the presence of  $\gamma$ -carboxylglutamate (Gla) residues at a number of well-defined positions. The oxidation of vitamin K-hydroquinone (KH<sub>2</sub>) into vitamin K-epoxide (KO) provides the energy required for Gla formation, and the KO formed can be reused after subsequent reduction by the enzyme vitamin K-epoxide reductase (VKOR).<sup>16,17</sup> Coumarin derivatives such as warfarin specifically block VKOR, leading to exhaustion of the available vitamin K stores and to the synthesis of noncarboxylated, inactive Gla proteins. Mainly in the liver, a second pathway for KH<sub>2</sub> formation is present. The key enzyme in this pathway is the NAD(P)H-dependent DT-diaphorase. In extrahepatic tissues, such as the arterial vessel wall, DT-diaphorase activity is low,<sup>18</sup> which explains why high-vitamin K intake effectively counteracts the effect of warfarin in the liver but not in bone<sup>19</sup> and the arterial vessel wall.<sup>20,21</sup> Thus, by subjecting experimental animals to a regimen of warfarin + vitamin K, the synthesis of Gla proteins can be blocked in the extrahepatic tissues, without affecting coagulation factor synthesis in the liver. Using this regimen of warfarin and vitamin K, Price et al<sup>20</sup> showed that this induced medial calcifications of the elastic lamellae in arteries and heart valves of rats within 3 to 5 weeks through inhibition of the  $\gamma$ -glutamyl carboxylation of matrix Gla protein.

Vitamin K consists of 2 forms, namely phylloquinone (vitamin K<sub>1</sub>; K<sub>1</sub>) and the menaquinones (vitamin K<sub>2</sub>; K<sub>2</sub>). It has been reported that K<sub>1</sub> can be converted into vitamin K<sub>2</sub> (specifically

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MK4, menaquinone-4); the accumulation appears to be specific for extrahepatic tissues.<sup>22,23</sup> A recent study by Thijssen et al<sup>24</sup> revealed that menadione (2-methyl-1,4-naphthoquinone) is a product of vitamin K catabolism and the likely intermediate in the synthesis of MK4 that is found in the arterial vessel wall. We have used this arterial calcification model<sup>20</sup> (the calcification-inducing regimen of warfarin and vitamin K) and found that high-vitamin K<sub>2</sub> supplementation was able to inhibit warfarin-induced arterial calcification in rats.<sup>25</sup> Moreover, we and others have reported that the use of coumarin-type anticoagulants is associated with increased cardiac valve calcification.<sup>26,27</sup> Further studies using immunohistochemical analysis with conformation-specific antibodies demonstrated that in calcifying carotid arteries MGP predominantly occurs in the noncarboxylated form, suggesting that the local vitamin K status is suboptimal.<sup>13,28</sup>

The rat arterial calcification model, as developed by Price et al<sup>20</sup> and used by others,<sup>21,25,29</sup> has thus far only looked at the development of arterial calcification. The aim of the present study was to use the rat arterial calcification model to investigate whether maximal MGP activity, ascertained by high-vitamin K intake, may stop the progression or even induce a reversal of warfarin-induced arterial calcification and the associated decrease in arterial distensibility.

## Materials and methods

### Animals and diet

Male Wistar Kyoto rats were purchased from the Maastricht University. Rats were 10 weeks old when entering the study, and all animals were housed in normal cages with free access to water and the indicated foods. Irradiated (900 Gy [0.9 Mrad]) vitamin K-deficient food was from Hope Farms, Woerden, The Netherlands. Vitamins K<sub>1</sub> and K<sub>2</sub> were dissolved in corn oil prior to adding to the vitamin K-deficient food in the required amounts. Warfarin was added directly to the food. All experimental protocols were approved by the Experimental Animal Ethics Committee of the Maastricht University.

To induce vascular calcification, rats (n = 30) received a diet containing warfarin (3 mg/g food) and vitamin K<sub>1</sub> (1.5 mg/g food; the minimal dose required for rats is 0.5 μg/g food), according to the method described earlier by our group.<sup>25</sup> These animals are designated as the W&K group. Control rats (n = 18) received no warfarin and a normal dose of vitamin K<sub>1</sub> (5 μg/g food; this is equivalent to the vitamin K amount in normal standard rat food). From the control group, 6 rats were killed at the start of the experiment to measure the baseline calcium content of the abdominal aorta and left carotid artery. After 6 weeks of treatment, 6 control rats and 6 W&K rats were killed to monitor the effect of treatment. The remaining rats in the W&K group (n = 24) were subdivided into 4 groups of 6 rats for another 6-week treatment. One group continued the W&K diet, whereas warfarin was discontinued in the remaining 3 groups: one group received normal vitamin K<sub>1</sub> (5 μg/g food), one group received high vitamin K<sub>1</sub> (100 μg/g food; the dietary vitamin K requirements for rats are 0.5 μg/g food to maintain normal blood clotting), and the last group received high vitamin K<sub>2</sub> (menaquinone-4, 100 μg/g food). In addition, the remaining 6 control rats continued their diet for another 6 weeks (see Figure 1 for schematic overview).

### Antibodies and chemicals

Monoclonal and polyclonal antibodies against various epitopes of MGP were raised according to standard procedures. The following MGP-derived peptides were used for immunization: amino acid residues 61 to 79 (tMGP), residues 35 to 53 (4 Glu residues; cMGP), and residues 35 to 53 (4 Glu-residues; ucMGP). The corresponding antibodies are designated as poAb-anti-tMGP (recognizing all forms of MGP), moAb-anti-cMGP (recognizing carboxylated MGP; cMGP), and poAb-anti-ucMGP (recogniz-

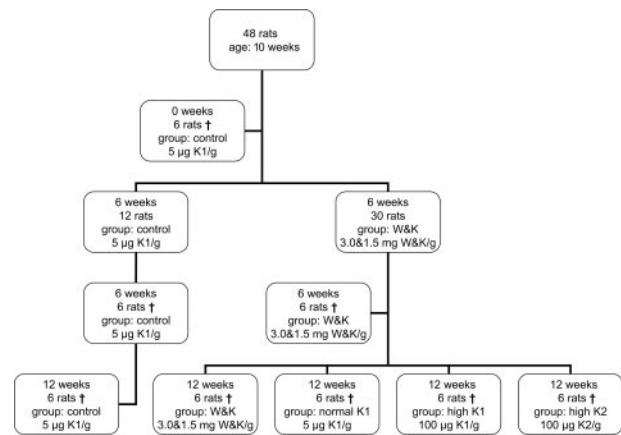


Figure 1. Flow diagram of the protocol used.

ing no-carboxylated MGP; ucMGP), respectively. Vitamin K<sub>1</sub> and warfarin were purchased from Sigma (St Louis, MO); vitamin K<sub>2</sub> (menaquinone-4) was a kind gift from Eisai (Tokyo, Japan). All chemicals were of analytical grade or better.

### Experimental procedures

Rats were anesthetized with sodium pentobarbital. Blood was collected in 105 mM trisodium citrate either by tail vein puncture or from the portal vein (at the end of the experiment), and plasma aliquots were frozen at -80°C. Before collecting all required tissues, the vasculature was perfused with a sterile vasodilating saline solution (150 mM saline, 100 pM sodium nitroprusside) via the portal vein. The aortic arch, thoracic and abdominal aortas, and right and left carotid arteries were dissected and transferred to a physiologic salt solution in a silicon-coated Petri dish, and adipose and connective tissues were carefully removed. The abdominal aorta and left carotid artery were frozen in liquid nitrogen for assessment of the calcium content. The aortic arch and thoracic aorta were fixed in 1% (vol/vol) HEPES-buffered formaldehyde overnight at 4°C for immunohistochemistry. The right carotid artery was used for monitoring the distensibility and compliance.

### Biochemical and immunohistochemical measurements

Tissue calcium was determined after lyophilization and expressed per gram of dry weight, the freeze-dried tissues were extracted with a 10-fold excess (wt/vol) of 10% formic acid (overnight at 4°C), and calcium concentrations were measured using atomic absorption spectrometry (Department of Clinical Chemistry, University Hospital Maastricht, The Netherlands). Immunohistochemistry was performed after embedding the tissues in paraffin and subsequent sectioning (4 μm thick). Each seventh section was used for calcium detection by Von Kossa staining. Each subsequent section was stained for hematoxylin/eosin, macrophages (mouse anti-rat CD68; Serotec, Oxford, United Kingdom), apoptosis using ApopTag apoptosis detection kit (Chemicon, Temecula, CA), poAb-tMGP (5 μg), moAb-cMGP (1 μg), and poAb-ucMGP (1 μg), respectively. Immunostaining was performed using either biotinylated sheep anti-mouse IgG (Amersham Biosciences, Little Chalfont, United Kingdom) or biotinylated swine anti-rabbit IgG (Dako, Glostrup, Denmark) as a second antibody (60 minutes at RT), followed by incubation with avidin-linked alkaline phosphatase complex (30 minutes at RT; Dako); staining was performed by the alkaline phosphatase kit I (staining 5 minutes at RT; Vector Laboratories, Burlingame, CA). Sections were counterstained with hematoxylin and mounted with coverslips. Each antibody staining was performed in one batch.

The relative extent of MGP staining and apoptosis was measured using a microscope coupled to a computerized morphometry system (quantimed 57; Leica, Wageningen, The Netherlands). Three sections (28 μm apart) were used for morphometric analysis, and quantification was expressed as percentage staining of the total arterial medial area. To reliably compare the

different antibodies (anti-tMGP, anti-cMGP, and anti-ucMGP) both microscope and camera adjustments were kept constant.<sup>26,30</sup>

MGP in plasma was measured using a commercially available enzyme-linked immunoabsorbent assay (ELISA)-based assay using a moAb MGP antibody recognizing the n-terminal 3 to 15 sequence of MGP (Biomedica, Vienna, Austria).<sup>28,31</sup>

### Vitamin K and KO determination

Concentrations of vitamin K<sub>1</sub>, K<sub>1</sub>-O, MK4, and MK4-O were analyzed by high-performance liquid chromatography (HPLC) as described previously.<sup>25</sup> Briefly, part of the aorta was weighed and homogenized in ethanol/water (vol/vol) at a ratio of 1:2 using a blender (Ultra Turrax; Janke and Kunkel, Staufen, Germany). Samples were supplemented with 100 ng vitamin K<sub>1</sub><sup>25</sup> (GLSynthesis, Worcester, MA) as an internal standard, extracted with 4 volumes of n-hexane, and prepurified on silica columns as described previously.<sup>32</sup> Quantification of vitamin K was performed by HPLC with fluorescence detection (excitation at 244 nm, emission at 430 nm) after postcolumn reduction on a 10 × 0.2-cm column filled with zinc powder (Riedel-DeHaën, Seelze, Germany) at 40°C. The mobile phase consisted of ethanol/acetonitrile/reduction buffer/water at a ratio (vol/vol) of 360:90:4:3 and was degassed continuously with helium. Reduction buffer contained 1 M ZnCl<sub>2</sub>, 1 M NaOAc, and 1 M AcOH in MeOH.

### Arterial distensibility

The right carotid artery from all animals (t = 12-week point) was used to determine arterial distensibility as described.<sup>33</sup> Artery segments (3–4 mm) were mounted in an arteriograph (Living System Instrumentation, Burlington, VT) in which the arterial diameter could be continuously monitored. Both ends of the vessels were cannulated on 120- to 150-μm wide glass micropipettes and tied with two 17-μm thin nylon threads. Arterial segments were bathed in a 10-mL organ chamber filled with calcium-free physiologic salt solution (composition in mmol/L: NaCl 144, KCl 4.7, MgSO<sub>4</sub> 1.2, KH<sub>2</sub>PO<sub>4</sub> 1.2, HEPES 14.9, and glucose 5.5, pH 7.4) which was maintained at 37°C and gassed with 95% O<sub>2</sub> and 5% CO<sub>2</sub>. After administration of 10 μM Na-nitroprusside to assure maximal vasodilatation, intra-arterial pressure was gradually increased from 10 to 200 mm Hg. Arterial distensibility or the relative change in arterial lumen volume induced by a given increase in pressure, was estimated by:  $DC = \Delta A / A_{n-1} \times \Delta P$  (DC indicates distensibility; A, area; P, pressure).<sup>34</sup>

### Statistical analysis

Values are expressed as mean ± SD. The difference between 2 groups was determined by Wilcoxon ranked nonpaired test. Differences for multiple comparisons were determined by ANOVA with Bonferroni correction. Differences were considered to be significant at *P* less than .05.

## Results

### Arterial calcification

The plasma calcium concentration was not affected by the different regimens and ranged between 2.25 and 2.33 mM (mean ± SD: 2.28 ± 0.03) (see Table 1). During the first 6 weeks of W&K treatment, all 6 rats analyzed in this group displayed a significantly increased aortic calcium content (mean ± SD in μg/mg dry tissue: 0.24 ± 0.02 versus 1.62 ± 0.36; *P* < .001). As is shown in Table 1, aortic calcification further increased when the W&K treatment was continued from week 7 to 12. Remarkably, calcification continued at a comparable rate in animals receiving a normal dose of K<sub>1</sub> during this period. In contrast, high-vitamin K intake (both K<sub>1</sub> and K<sub>2</sub>) not only blocked the progress of further calcium accumulation but also led to a greater than 37% reduction of previously accumulated arterial calcium precipitates within 6 weeks (53% as compared with the 12-week W&K time point). A similar observation was made in the left carotid artery (reduction of 44% compared with the 6-week time point W&K), and there was a good correlation between the calcium content of the abdominal aorta and that of the left carotid artery in the various groups (*r*<sup>2</sup> = 0.85, *P* < .001). In the thoracic aorta, calcification was visualized by Von Kossa staining (Figures 2, 3, and 4). In the control rats (at 0, 6, and 12 weeks) no calcification was detected; however, extensive calcifications were found in all animals receiving the W&K diet (both at 6 and at 12 weeks). Also all rats treated with normal K<sub>1</sub> during weeks 7 to 12 displayed extensive calcifications. In rats treated with high K<sub>1</sub> 1 rat did not have visible calcium precipitates, whereas 5 animals had decreased but still visible calcifications. In the K<sub>2</sub> group, calcium precipitates were absent in 2 rats, whereas in 4 rats remaining calcifications were observed.

### MGP measurements

To investigate matrix Gla protein in relation to calcification of vascular tissue we used conformation-specific antibodies against MGP. With poAb anti-tMGP, we identified MGP in the arteries from control animals, where it was primarily associated with the elastin fibers (data not shown). Subsequent staining with conformation-specific antibodies revealed that virtually all of this MGP consisted of carboxylated (ie, active) MGP (Figure 2). Much higher total MGP concentrations were found, however, in arteries from the W&K group, where it colocalized with the calcium deposits

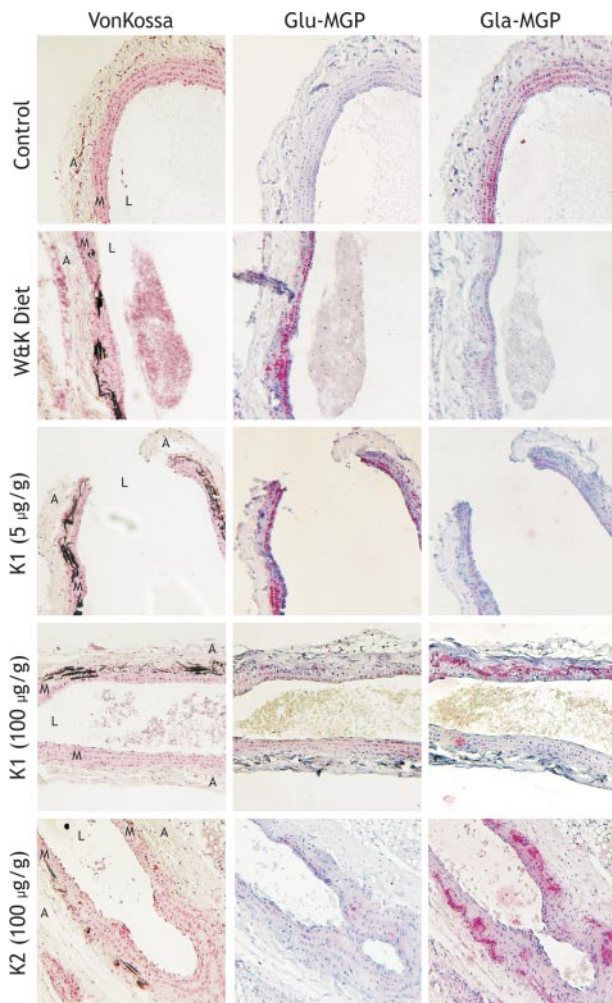
**Table 1. Arterial calcium contents after various treatments**

Diet	Calcium			Total MGP
	Aorta (μg/g)	Carotid artery (μg/g)	Plasma (mmol/L)	Plasma (nmol/L)
<b>Week 0</b>				
Standard chow	0.24 ± 0.02	0.36 ± 0.11	2.29 ± 0.04	6.91 ± 1.21
<b>Week 6</b>				
Standard chow	0.25 ± 0.02	0.34 ± 0.09	2.29 ± 0.05	6.40 ± 1.44
W&K	1.62 ± 0.36*	10.58 ± 6.00*	2.28 ± 0.05	1.83 ± 0.33*
<b>Week 12</b>				
Standard chow	0.28 ± 0.03	0.39 ± 0.08	2.29 ± 0.03	6.79 ± 1.51
W&K	2.40 ± 0.46*	13.01 ± 3.08*	2.30 ± 0.04	1.65 ± 0.79*
Normal K <sub>1</sub>	2.31 ± 0.57*	13.39 ± 2.89*	2.27 ± 0.02	1.93 ± 0.55*
High K <sub>1</sub>	1.02 ± 0.33*†	5.91 ± 4.42*†	2.28 ± 0.03	2.99 ± 0.48*†
High K <sub>2</sub>	1.12 ± 0.44*†	7.58 ± 3.27*†	2.27 ± 0.03	2.63 ± 0.42*†

Calcium was measured in the abdominal aorta, in the left carotid artery, and in plasma. MGP was measured in plasma using the Biomedica assay. All values are expressed as mean ± SD per group of 6 animals.

\*Significant differences (*P* < .01) compared with controls (compared with the same time point).

†Significant differences (*P* < .01) compared with the W&K diet.



**Figure 2. Effect of different dietary treatments on aortic calcification at the 12-week time point in male Wistar Kyoto rats.** Rats ( $n = 6$  per group) were treated with the following dietary regimens; row 1 represents 12 weeks of normal vitamin K diet ( $5 \mu\text{g/g K}_1$ ), row 2 represents 12 weeks of the W&K diet ( $3 \text{ mg/g}$  warfarin and  $1.5 \text{ mg/g}$  vitamin  $\text{K}_1$ ), row 3 represents 6 weeks of normal vitamin K ( $5 \mu\text{g/g K}_1$ ) after 6 weeks of W&K, row 4 represents 6 weeks of high-vitamin  $\text{K}_1$  ( $100 \mu\text{g/g}$ ) diet after 6 weeks of W&K, and row 5 represents 6 weeks of the high-vitamin  $\text{K}_2$  ( $100 \mu\text{g/g}$ ) diet after 6 weeks of W&K. The thoracic aorta segment (between the aortic arch and the renal branch) was removed immediately after killing the animals in each diet group and fixed in 1% buffered formalin. Subsequently, longitudinal sections of each aorta were stained for mineral by von Kossa stain (column 1), ucMGP (column 2), and cMGP (column 3). Red stain indicates MGP, black stain indicates calcium, and blue indicates cell nuclei. Magnification,  $\times 100$ . Acquisition was performed using an Axioskop 40 microscope (Carl Zeiss, Sliedrecht, The Netherlands) equipped with Achroplan  $10\times/0.25$  objective lens and using an E-PI  $10\times/20$  aperture. Pictures were taken using a Canon Powershot G5 (Canon, Hoofddorp, The Netherlands) and corrected for contrast and brightness using Adobe Photoshop CS2 for Windows (Adobe Systems, San Jose, CA).

(Figures 2-3). Also in the arteries from animals treated with low and high vitamin K the total MGP was elevated compared with the controls (Figure 2). Staining with conformation-specific antibodies revealed that in animals from both the W&K group (Figures 2-3) and the normal-dose vitamin K group (Figure 2) most of the MGP occurred in the noncarboxylated (ie, inactive) form, whereas in rats subjected to high-vitamin K treatment (both  $\text{K}_1$  and  $\text{K}_2$ ) the MGP deposits were mostly present in the carboxylated (ie, active) form (Figures 2, 4). Moreover, mainly the noncarboxylated form of MGP colocalized with vascular calcifications. The above-described immunohistochemical staining of MGP was quantified (percentage staining of MGP/total arterial medial layer) and plotted in Figure 5.

Measurement of total MGP in plasma revealed a 4-fold decrease after 6 weeks of warfarin treatment (from  $6.9 \pm 1.2$  to  $1.8 \pm 0.3$

nmol/L) as compared with the control rats. After another 6 weeks of the warfarin diet or normal vitamin  $\text{K}_1$  diet, MGP levels had not changed from the values at 6 weeks in the W&K and normal  $\text{K}_1$  groups. However, a significant rise in plasma MGP was noticed after the subsequent high-vitamin K treatment (Table 1). Staining for macrophages revealed that these were absent in the vascular media layer (Figure 6E-F). However, measuring the rate of apoptosis using TUNEL staining (Figure 6A-D) demonstrated that in the W&K-treated animals significantly more (11%) apoptotic vascular smooth muscle cells were present than in those receiving the control diet ( $< 1\%$ ). During high-vitamin K treatment the rate of apoptosis was significantly lower (4% lower in the  $\text{K}_1$  group and 3% in the  $\text{K}_2$  group) than during W&K ( $P < .02$ ) and normal vitamin  $\text{K}_1$  treatment (7%;  $P < .05$ ).

### Vitamin K measurements

To investigate whether both forms of vitamin K are transported equally well to the arteries, we have measured the arterial vitamin K content following the different food regimens. Control rats had accumulated both  $\text{K}_1$  and  $\text{K}_2$  in their arteries (Table 2); although these animals had received only  $\text{K}_1$ , the tissue concentrations of  $\text{K}_2$  were 2 times higher than those of  $\text{K}_1$ . During the W&K diet, the animals received high doses of  $\text{K}_1$ , and consequently high levels of both  $\text{K}_1$  and  $\text{K}_1\text{O}$  had accumulated in the arteries (Table 2). In this case no  $\text{K}_2$  species were found because warfarin blocks the conversion from  $\text{K}_1$  to  $\text{K}_2$ .<sup>35-37</sup> It is remarkable that, although  $\text{K}_1$  was used (as measured by  $\text{K}_1\text{O}$ ) substantial tissue calcification was observed in this group (see Figure 2). After stopping the warfarin treatment, animals receiving the normal dose of  $\text{K}_1$  showed vascular  $\text{K}_1$  and  $\text{K}_2$  levels that were in the range of control rats. No vitamin K epoxides were found in this group. In animals receiving a high dose of  $\text{K}_1$  the arterial concentrations of both  $\text{K}_1$  and  $\text{K}_2$  were approximately 8-fold higher (Table 2) than after normal-dose  $\text{K}_1$  treatment, and trace amounts of the respective epoxides were found. Rats receiving the high- $\text{K}_2$  diet had accumulated exclusively  $\text{K}_2$  and trace amounts of  $\text{K}_2\text{O}$  (Table 2).

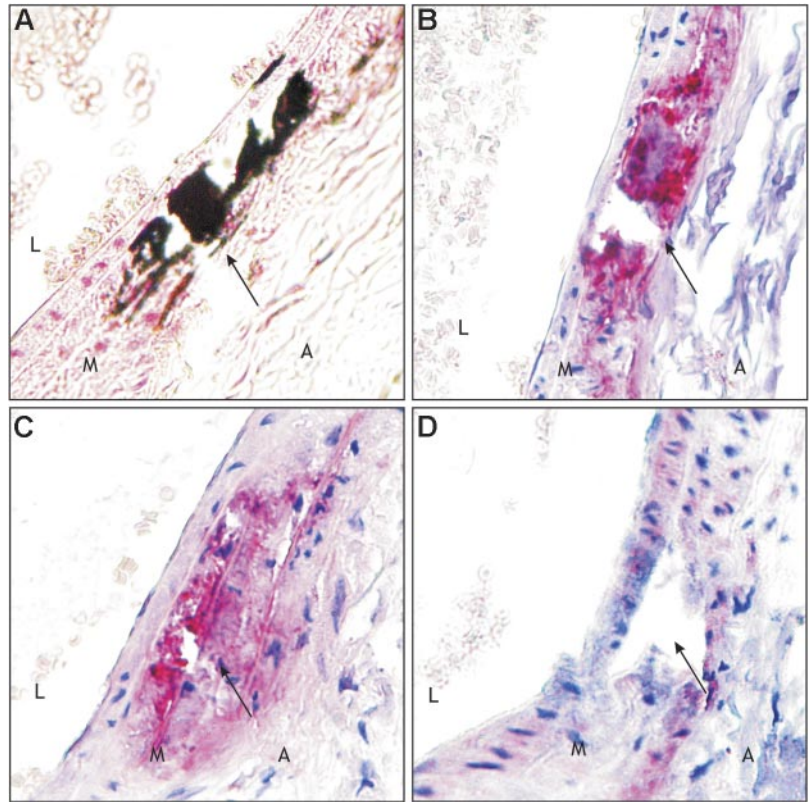
### Mechanical properties of isolated carotid arteries

Figure 7 summarizes the pressure-diameter relations of isolated carotid arteries during maximal vasodilatation (4 groups from the 7- to 12-week experiment). The minimal arterial diameter at low distending pressure (10 mm Hg) was significantly larger in the W&K group when compared with control rats and especially in comparison to the rats treated with either the high- $\text{K}_1$  diet or the high- $\text{K}_2$  diet. Furthermore, within a physiologic pressure range (100-140 mm Hg) the arterial distensibility was significantly smaller in the W&K group than in the control and high-vitamin K groups. At 100 mm Hg, the distensibility averaged  $8.5 \pm 0.5$ ,  $3.6 \pm 0.6$ ,  $7.5 \pm 0.6$ , and  $10.0 \pm 0.7 \times 10^{-3} \text{ mm Hg}^{-1}$  for control, W&K, high  $\text{K}_1$ , and high  $\text{K}_2$ , respectively (significance  $P < .05$  compared with W&K). The maximal diameter at high distending pressure (200 mm Hg) did not differ significantly between the experimental groups ( $1391 \pm 21$ ,  $1381 \pm 19$ ,  $1377 \pm 14$ , and  $1351 \pm 19 \mu\text{m}$  for control, W&K, high  $\text{K}_1$ , and high  $\text{K}_2$ , respectively). Collectively these findings indicate that the W&K treatment increased the arterial stiffness of the arteries and that this was reversed by both the high- $\text{K}_1$  and - $\text{K}_2$  intake.

## Discussion

In this study we provide evidence that warfarin-induced medial vascular calcification in rats is preventable or even reversible by

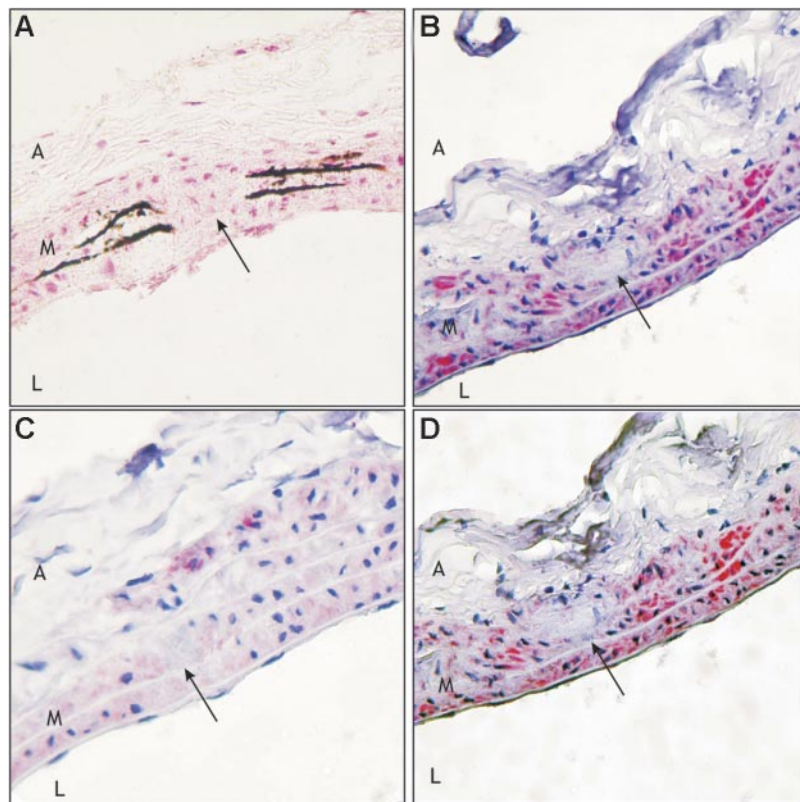
**Figure 3. Effect of W&K treatment (3 mg/g warfarin and 1.5 mg/g vitamin K<sub>1</sub>) on the presence of calcification and MGP at the 12-week time point.** Sections were prepared as described in the legend of Figure 2. Longitudinal sections of each thoracic aorta were stained with von Kossa (A) and immunohistochemically with anti-t-MGP (B), anti-ucMGP (C), and anti-cMGP (D) (see "Materials and methods" for details). It is clearly demonstrated that because of the W&K diet arterial calcification was significantly present. In panel B total MGP is up-regulated in the calcified area. From panel D it can be seen that cMGP is almost absent, whereas significant amounts of the inactive ucMGP are present around the calcified area (C). Arrow indicates same area. Red stain indicates MGP, black stain indicates calcium, and blue indicates cell nuclei. Magnification, × 400. A indicates adventitia; M, media; and L, lumen. Details of image acquisition are provided in the legend of Figure 2.



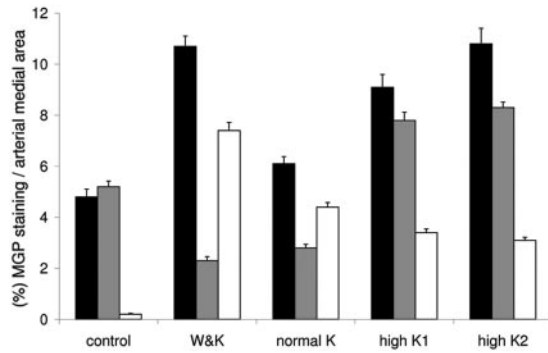
high-vitamin K intake, with a putative role for the vitamin K-dependent protein MGP. Although it is well known that MGP is important in the prevention of calcification,<sup>14,28</sup> its contribution to regression of arterial calcification is a novel finding.

Traditionally, vascular calcification has been thought to be a passive end process and, once it was present, an irreversible

feature. Now it is known that both intimal and medial calcification is an active process with inhibitors and stimulators of calcification. Thus far, research has mainly focused on the prevention or retardation of arterial calcification using lipid-lowering drugs such as statins or bisphosphonates,<sup>38-42</sup> but all failed in regressing existing arterial calcification. Recently, however, it was shown



**Figure 4. Effect of the high-K<sub>2</sub> treatment (100 μg/g vitamin K<sub>2</sub>) on the presence of calcification and MGP at the 12-week time point.** Sections were prepared as described in the legend of Figure 2. Longitudinal sections of each thoracic aorta were stained with von Kossa (A) and immunohistochemically with anti-t-MGP (B), anti-ucMGP (C), and anti-cMGP (D) (see "Materials and methods" for details). It is shown that because of the high-K<sub>2</sub> diet cMGP (D) is up-regulated in the calcified area (A; along the elastic fibers). From panel C it can be seen that ucMGP is almost absent. Arrow indicates same area. Red stain indicates MGP, black stain indicates calcium, and blue indicates cell nuclei. Magnification, × 400. A indicates adventitia; M, media; and L, lumen. Details of image acquisition are provided in the legend of Figure 2.



**Figure 5. Quantification of MGP at the 12-week time point.** Three sections, each 28  $\mu\text{m}$  apart, were measured using a microscope coupled to a computerized morphometry system (for details see "Materials and methods"). Quantification was expressed as the percentage staining of the total arterial medial area. Diets represent 12-week control, W&K (3 mg/g warfarin and 1.5 mg/g vitamin  $\text{K}_1$ ), normal vitamin K diet (5  $\mu\text{g/g}$   $\text{K}_1$ ), high vitamin  $\text{K}_1$  (100  $\mu\text{g/g}$   $\text{K}_1$ ), and high vitamin  $\text{K}_2$  (100  $\mu\text{g/g}$   $\text{K}_2$ ) after 6 weeks of W&K. ■ represent total MGP, ▒ represent cMGP, and □ represent ucMGP. Quantification was performed by 2 independent persons. Bars represent mean values  $\pm$  SEM ( $n = 6$ ).

that medial elastocalcinosis can be reversed,<sup>43,44</sup> suggesting that calcium resorption, like its deposition, is an actively regulated process.

It has been shown previously that arterial calcification can be induced with the warfarin-containing diet.<sup>20,25</sup> Here, we addressed the question of whether progression of further calcification could be stopped and whether existing mineral deposits could be diminished by a high-vitamin K diet in rats. Our experiments indicate that in healthy, nontreated animals a relatively low vitamin K intake is sufficient for complete MGP carboxylation and for

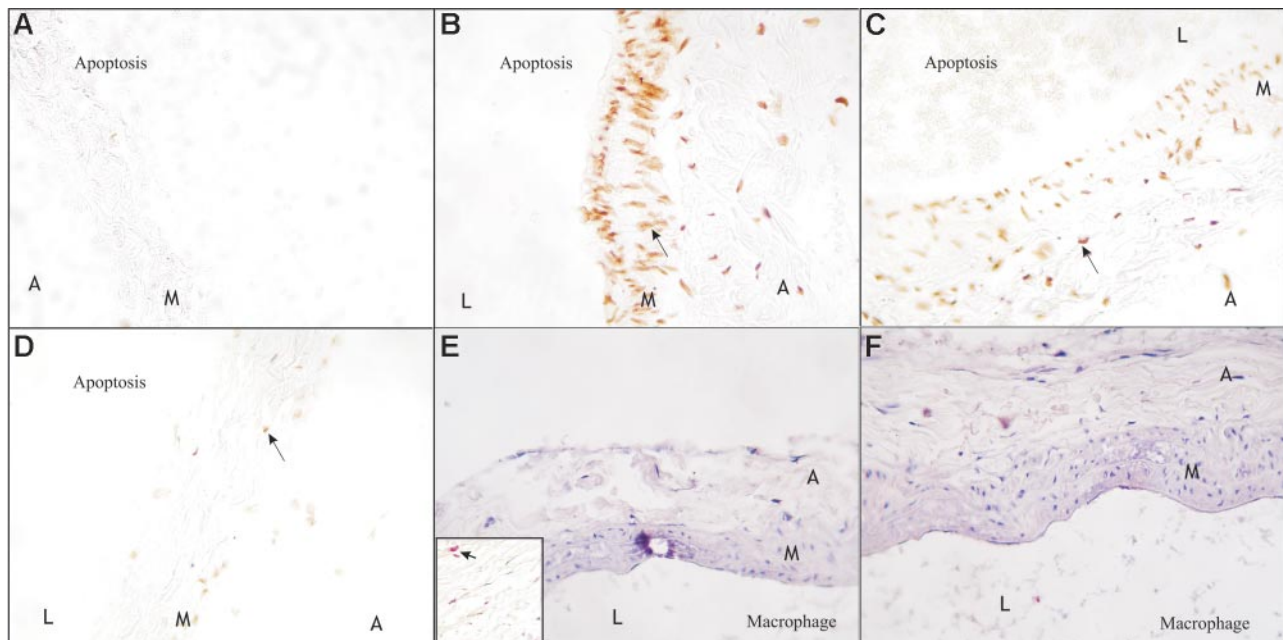
**Table 2. Vitamin K concentrations in the rat aortas at time point of 12 weeks**

Diet	Vitamin K			
	$\text{K}_1$ (ng/g)	$\text{K}_1\text{O}$ (ng/g)	$\text{K}_2$ (MK4) (ng/g)	$\text{K}_2\text{O}$ (MK4) (ng/g)
Control	8.5 $\pm$ 1.9	ND	16.2 $\pm$ 4.1	ND
W&K	531 $\pm$ 196	967 $\pm$ 419	ND	ND
$\text{K}_1$ (5 $\mu\text{g/g}$ )	13.2 $\pm$ 21.1	ND	24.4 $\pm$ 29.3	ND
$\text{K}_1$ (100 $\mu\text{g/g}$ )	69 $\pm$ 84	2.3 $\pm$ 1.9	183 $\pm$ 79	6.5 $\pm$ 2.6
$\text{K}_2$ (100 $\mu\text{g/g}$ )	ND	ND	248 $\pm$ 112	5.2 $\pm$ 4.8

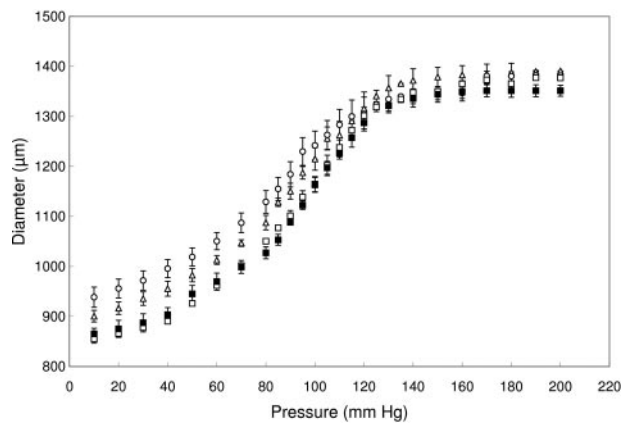
All values are expressed as mean  $\pm$  SD per group of 6 animals. Detection limit for  $\text{K}_1$  and  $\text{K}_2$  (MK4) is 0.05 ng/g. ND means not detectable.

preventing arterial calcification (Figure 2), whereas warfarin-initiated calcium accumulation in the arteries increased accumulation of MGP in these areas. This can be explained by assuming a feedback mechanism by which increased local calcium stimulates MGP expression in an attempt to prevent calcification. It has been shown in cell cultures<sup>45</sup> and vascular tissue<sup>20</sup> that warfarin up-regulates the mRNA expression of MGP. However, under the conditions used in our experiment, this increase in MGP did not prevent calcium deposition in the vascular tissue. Using conformation-specific antibodies, we demonstrated that during warfarin treatment most of the MGP had been synthesized as undercarboxylated, inactive species. The fact that the serum MGP concentration declined to approximately 20% of normal is in agreement with observations by Price et al<sup>20,46</sup> and suggests a different balance between tissue MGP and circulating MGP levels.

Continuation of the warfarin-containing diet between weeks and 12 led to an almost linear increase of the arterial calcium



**Figure 6. Effect of different dietary treatments on apoptotic activity at the 12-week time point.** Sections were prepared as described in the legend of Figure 2. Longitudinal sections of each thoracic aorta were stained by immunohistochemical techniques with an antimacrophage antibody and with a terminal dUTP nick-end labeling (TUNEL) staining for apoptosis (see "Materials and methods" for details). Panel A represents 12 weeks of normal vitamin K diet (5  $\mu\text{g/g}$   $\text{K}_1$ ), panels B and E represent 12 weeks of W&K diet (3 mg/g warfarin and 1.5 mg/g vitamin  $\text{K}_1$ ), panel C represents normal K (5  $\mu\text{g/g}$ ) after 6 weeks of W&K, and panels D and F represent 6 weeks of high vitamin K (100  $\mu\text{g/g}$   $\text{K}_1$  or  $\text{K}_2$ ) after 6 weeks of W&K. Macrophages are absent in the medial layer of aortic tissue, both in rats treated with W&K (E) and high vitamin K (F). Also, in control animals macrophages were absent (data not shown). In panel E a positive control is shown as an inset (arrow indicates macrophage). The W&K-treated animals (B), however, have significantly increased apoptosis of vascular smooth muscle cells (VSMCs) compared with control animals (A), in which apoptosis is hardly measurable. Also in the normal K-treated animals, after 6 weeks of W&K, (C) apoptosis is clearly visible. The rats treated with high vitamin K (D) showed significantly reduced apoptosis as compared with the normal-treated animals (C). See "Results" for details. Magnification,  $\times 400$ . Details of image acquisition are provided in the legend of Figure 2.



**Figure 7. Effects of vitamin K status on the mechanical properties of isolated rat carotid arteries.** The pressure-diameter relation was monitored for animals receiving the control diet ( $n = 6$ ;  $\Delta$ ), those after 12 weeks of the W&K diet ( $n = 6$ ;  $\circ$ ), and animals after 6 weeks of W&K and subsequently 6 weeks of high vitamin K (both  $K_1$  ( $\square$ ) and  $K_2$  ( $\blacksquare$ );  $n = 6$  per group). The arterial diameter is shown as a function of increasing pressure. Data are shown as mean  $\pm$  SD.

content. An unexpected finding was that calcium accumulation also continued in the normal vitamin K group even after warfarin treatment had been stopped. We speculate that the calcium salt precipitates (as identified by Von Kossa staining) induce a high MGP expression level, causing a high local vitamin K requirement which is not met by the normal vitamin K diet. This can be seen in Figures 2 and 3 in which the majority of the newly synthesized MGP is produced in the undercarboxylated, inactive form. This is in agreement with work from Sweatt et al<sup>13</sup> who showed that in aging rats ucMGP was associated with arterial calcification as demonstrated with polyclonal conformation-specific MGP antibodies. The researchers concluded that inactive MGP because of vitamin K deficiency could lead to arterial calcifications.

Arterial calcification could, however, be reversed by high-vitamin K intake. After a 6-week period (weeks 7-12) some 40% of the preformed calcium salts had been removed. In an attempt to find the mechanism underlying this observation, we monitored the presence of macrophages. It is known that bone is resorbed by osteoclastic activity and that in the vessel wall also macrophages can clear hydroxyapatite by phagocytosis.<sup>44,47</sup> Staining for macrophages revealed that the arterial media areas of rats in all groups were free from macrophage infiltration (Figure 6E-F), which can thus be excluded as a possible mechanism of calcium removal in this experiment. Staining for apoptosis, however, demonstrated that during the warfarin treatment apoptosis was up-regulated (Figure 6A-D). It has been shown that apoptosis precedes calcification,<sup>48</sup> and this seems to be the likely mechanism for calcium salt deposition in the W&K animals. VSMC-derived apoptotic vesicles are loaded with calcification inhibitors, including MGP, and these vesicles have prominerizing properties when MGP function is impaired.<sup>49</sup> Here, we demonstrate that high-vitamin K intake is associated with significantly less VSMC apoptosis and with significant regression of arterial calcification. It has been shown that another vitamin K-dependent protein synthesized by VSMCs, growth arrest specific gene-6 protein (gas6), is involved in the survival of VSMCs<sup>50</sup> and in the clearance of apoptotic bodies from the vasculature.<sup>51</sup> Also gas6 requires Gla residues and hence vitamin K for its activity.<sup>52</sup> On the basis of our data we conclude that vitamin K and the vitamin K-dependent protein MGP are involved in the observed regression of

arterial calcification. However, we cannot conclude whether and to which extent other vitamin K-dependent proteins such as gas6 are involved in the observed regression of arterial calcification. Because macrophages were absent in the vascular media during high-vitamin K treatment, we postulate that the calcium deposits were removed by phagocytosis carried out by the surrounding VSMCs under conditions of maximal calcification inhibition provided by the high-vitamin K diet. This is consistent with a paper by Proudfoot et al<sup>53</sup> which reported that phagocytosis is a normal property of VSMCs.

In addition, the regression of arterial calcification was accompanied by restoration of arterial distensibility to a similar level as in the control rats. The fact that  $K_1$  and  $K_2$  (MK4) had similar effects in this model seems to be in contradiction to previous data in which it was demonstrated that  $K_2$  (MK4) is more effective than  $K_1$  in preventing calcification during warfarin treatment.<sup>25</sup> An explanation for this apparent discrepancy may be found in the fact that certain tissues (including the vessel wall) specifically accumulate  $K_2$ , even when the diet contains exclusively  $K_1$ .<sup>54</sup> The conversion of  $K_1$  into MK4 is blocked, however, during warfarin treatment.<sup>35-37</sup> In the experiments performed by Spronk et al<sup>25</sup> as well as in our experiments,  $K_2$  (MK4) or  $K_2$ -O (MK4-O) were nearly absent in arteries from rats treated with W&K. Also in rats fed the normal vitamin  $K_1$  diet, only small amounts of  $K_2$  (MK4) could be identified. In the high- $K_1$  group, however,  $K_1$  had been converted to  $K_2$  to such an extent that in the high- $K_1$  group arterial  $K_2$  had comparable tissue concentrations as in the  $K_2$  (MK4)-treated group. We conclude that at very high intakes of  $K_1$ , (200-fold the daily requirement of the liver) both vitamers may help decrease arterial calcification.

The decreased MGP levels in the plasma of animals with substantial arterial calcifications are consistent with the outcomes of previous studies in rats.<sup>20</sup> Also in humans it was reported that calcification is associated with decreased circulating MGP levels.<sup>55</sup> Both carboxylated and noncarboxylated MGP have a high affinity for hydroxyapatite; hence, the most plausible explanation for this observation is that in the case of arterial mineralization most of the MGP produced is directly bound to the calcium salts and not set free in the circulation. After feeding rats either a high- $K_1$  or a high- $K_2$  (MK4) diet for 6 weeks, their plasma MGP levels had increased significantly. This may be related to the decreased vascular calcium content providing fewer matrixes for MGP binding but also to an increased transport of MGP that had bound to the dissolving matrix. Moreover, it has been reported that the transport of calcium from calcified tissue may occur via a fetuin-MGP-calcium phosphate complex, which has a much longer plasma half-life than free MGP.<sup>56</sup> If complexed MGP is detected in our assay, the slow elimination of such complexes might contribute to the relatively high-MGP concentration in the serum of rats on a high-vitamin K diet.

We measured the arterial distensibility as a clinical parameter of vascular elasticity. The experiment shown in Figure 7 demonstrates that warfarin induced stiffening of the arterial vessel wall. This is consistent with work from Essalihi et al<sup>21</sup> which showed that warfarin treatment resulted in increases of aortic pulse pressure, pulse pressure, and systolic blood pressure. In our model, normal vitamin  $K_1$  in the diet was not capable of affecting arterial distensibility, whereas during the high-vitamin K diet (both  $K_1$  and  $K_2$ ) the vascular properties that were lost by warfarin-induced calcification were restored.

The animal model we used mimics arterial media sclerosis (also known as Mönckeberg sclerosis). Media sclerosis is particularly

common in diabetes mellitus, end-stage renal disease, and aging. Notably, patients with chronic kidney disease (CKD) are at high risk of cardiovascular disease.<sup>57</sup> These patients often receive a high-calcium diet (to complex phosphate), vitamin D, and warfarin (to prevent thrombotic events). It was demonstrated, however, that each of these treatments is associated with an increased risk of arterial calcification.<sup>26,46,49,58</sup> Given that arterial calcifications are predictive of cardiovascular events, regression of arterial calcification may help to reduce the risk of death in patients with CKD and coronary artery disease. Whether increased vitamin K intake could have such an effect in humans has to be investigated. Obviously, this is only possible in patients not receiving oral anticoagulant treatment.

## References

- Zieman SJ, Melenovsky V, Kass DA. Mechanisms, pathophysiology, and therapy of arterial stiffness. *Arterioscler Thromb Vasc Biol.* 2005;25:932-943.
- Doherty TM, Asotra K, Fitzpatrick LA, et al. Calcification in atherosclerosis: bone biology and chronic inflammation at the arterial crossroads. *Proc Natl Acad Sci U S A.* 2003;100:11201-11206.
- Rosenhek R, Binder T, Porenta G, et al. Predictors of outcome in severe, asymptomatic aortic stenosis. *N Engl J Med.* 2000;343:611-617.
- Raggi P, Shaw LJ, Berman DS, Callister TQ. Prognostic value of coronary artery calcium screening in subjects with and without diabetes. *J Am Coll Cardiol.* 2004;43:1663-1669.
- Shao JS, Cai J, Towler DA. Molecular mechanisms of vascular calcification: lessons learned from the aorta. *Arterioscler Thromb Vasc Biol.* 2006;26:1423-1430.
- Bostrom K, Demer LL. Regulatory mechanisms in vascular calcification. *Crit Rev Eukaryot Gene Expr.* 2000;10:151-158.
- Dhore CR, Cleutjens JP, Lutgens E, et al. Differential expression of bone matrix regulatory proteins in human atherosclerotic plaques. *Arterioscler Thromb Vasc Biol.* 2001;21:1998-2003.
- Shanahan CM, Cary NR, Salisbury JR, Proudfoot D, Weissberg PL, Edmonds ME. Medial localization of mineralization-regulating proteins in association with Mönckeberg's sclerosis: evidence for smooth muscle cell-mediated vascular calcification. *Circulation.* 1999;100:2168-2176.
- Price PA, Urist MR, Otawara Y. Matrix Gla protein, a new gamma-carboxyglutamic acid-containing protein which is associated with the organic matrix of bone. *Biochem Biophys Res Commun.* 1983;117:765-771.
- Luo G, Ducey P, McKee MD, et al. Spontaneous calcification of arteries and cartilage in mice lacking matrix GLA protein. *Nature.* 1997;385:78-81.
- Bostrom K, Tsao D, Shen S, Wang Y, Demer LL. Matrix GLA protein modulates differentiation induced by bone morphogenetic protein-2 in C3H10T1/2 cells. *J Biol Chem.* 2001;276:14044-14052.
- Wallin R, Cain D, Hutson SM, Sane DC, Loeser R. Modulation of the binding of matrix Gla protein (MGP) to bone morphogenetic protein-2 (BMP-2). *Thromb Haemost.* 2000;84:1039-1044.
- Sweatt A, Sane DC, Hutson SM, Wallin R. Matrix Gla protein (MGP) and bone morphogenetic protein-2 in aortic calcified lesions of aging rats. *J Thromb Haemost.* 2003;1:178-185.
- Murshed M, Schinke T, McKee MD, Karsenty G. Extracellular matrix mineralization is regulated locally; different roles of two gla-containing proteins. *J Cell Biol.* 2004;165:625-630.
- Shearer MJ. Vitamin K. *Lancet.* 1995;345:229-234.
- Li T, Chang CY, Jin DY, Lin PJ, Khvorova A, Stafford DW. Identification of the gene for vitamin K epoxide reductase. *Nature.* 2004;427:541-544.
- Rost S, Fregin A, Ivaskevicius V, et al. Mutations in VKORC1 cause warfarin resistance and multiple coagulation factor deficiency type 2. *Nature.* 2004;427:537-541.
- Wallin R, Cain D, Sane DC. Matrix Gla protein synthesis and gamma-carboxylation in the aortic vessel wall and proliferating vascular smooth muscle cells—a cell system which resembles the system in bone cells. *Thromb Haemost.* 1999;82:1764-1767.
- Price PA, Williamson MK, Haba T, Dell RB, Jee WS. Excessive mineralization with growth plate closure in rats on chronic warfarin treatment. *Proc Natl Acad Sci U S A.* 1982;79:7734-7738.
- Price PA, Faus SA, Williamson MK. Warfarin causes rapid calcification of the elastic lamellae in rat arteries and heart valves. *Arterioscler Thromb Vasc Biol.* 1998;18:1400-1407.
- Essalihi R, Dao HH, Yamaguchi N, Moreau P. A new model of isolated systolic hypertension induced by chronic warfarin and vitamin K1 treatment. *Am J Hypertens.* 2003;16:103-110.
- Billeter M, Martius C. Über die umwandlung von phylochinon (vitamin K<sub>1</sub>) in vitamin K<sub>2(20)</sub> im tierkörper. *Biochem Z.* 1960;333:430-439.
- Thijssen HH, Drittij Reijnders MJ, Fischer MA. Phylloquinone and menaquinone-4 distribution in rats: synthesis rather than uptake determines menaquinone-4 organ concentrations. *J Nutr.* 1996;126:537-543.
- Thijssen HH, Vervoort LM, Schurgers LJ, Shearer MJ. Menadiene is a metabolite of oral vitamin K. *Br J Nutr.* 2006;95:260-266.
- Spronk HM, Soute BA, Schurgers LJ, Thijssen HH, De Mey JG, Vermeer C. Tissue-specific utilization of menaquinone-4 results in the prevention of arterial calcification in warfarin-treated rats. *J Vasc Res.* 2003;40:531-537.
- Schurgers LJ, Aebert H, Vermeer C, Bultmann B, Janzen J. Oral anticoagulant treatment: friend or foe in cardiovascular disease? *Blood.* 2004;104:3231-3232.
- Koos R, Mahnken AH, Muhlenbruch G, et al. Relation of oral anticoagulation to cardiac valvular and coronary calcium assessed by multislice spiral computed tomography. *Am J Cardiol.* 2005;96:747-749.
- Schurgers LJ, Teunissen KJ, Knapen MH, et al. Novel conformation-specific antibodies against matrix gamma-carboxyglutamic acid (Gla) protein: undercarboxylated matrix Gla protein as marker for vascular calcification. *Arterioscler Thromb Vasc Biol.* 2005;25:1629-1633.
- Howe AM, Webster WS. Warfarin exposure and calcification of the arterial system in the rat. *Int J Exp Pathol.* 2000;81:51-56.
- Lutgens E, Gorelik L, Daemen MJ, et al. Requirement for CD154 in the progression of atherosclerosis. *Nat Med.* 1999;5:1313-1316.
- Schurgers LJ, Teunissen KJ, Knapen MH, et al. Characteristics and performance of an immunosorbent assay for human matrix Gla-protein. *Clin Chim Acta.* 2005;351:131-138.
- Schurgers LJ, Vermeer C. Determination of phylloquinone and menaquinones in food. Effect of food matrix on circulating vitamin K concentrations. *Haemostasis.* 2000;30:298-307.
- Aartsen WM, Hilgers RH, Schiffrers PM, Daemen MJ, De Mey JG, Smits JF. Changes in vascular distensibility during angiotensin-converting enzyme inhibition involve bradykinin type 2 receptors. *J Vasc Res.* 2004;41:18-27.
- Ceiler DL, Nelissen-Vrancken HJ, Smits JF, De Mey JG. Pressure but not angiotensin II-induced increases in wall mass or tone influences static and dynamic aortic mechanics. *J Hypertens.* 1999;17:1109-1116.
- Taggart WV, Matschiner JT. Metabolism of menadione-6,7-3H in the rat. *Biochemistry.* 1969;8:1141-1146.
- Thijssen HHW, Drittij-Reijnders MJ, Fischer MA. Phylloquinone and menaquinone-4 distribution in rats: synthesis rather than uptake determines menaquinone-4 organ concentrations. *J Nutr.* 1996;126:537-543.
- Davidson RT, Foley AL, Engelle JA, Suttie JW. Conversion of dietary phylloquinone to tissue menaquinone-4 in rats is not dependent on gut bacteria. *J Nutr.* 1998;128:220-223.
- Price PA, Faus SA, Williamson MK. Bisphosphonates alendronate and ibandronate inhibit arterial calcification at doses comparable to those that inhibit bone resorption. *Arterioscler Thromb Vasc Biol.* 2001;21:817-824.
- Dao HH, Essalihi R, Graillon JF, Lariviere R, De Champlain J, Moreau P. Pharmacological prevention and regression of arterial remodeling in a rat model of isolated systolic hypertension. *J Hypertens.* 2002;20:1597-1606.
- Raggi P, Davidson M, Callister TQ, et al. Aggressive versus moderate lipid-lowering therapy in hypercholesterolemic postmenopausal women: Beyond Endorsed Lipid Lowering with EBT Scanning (BELLES). *Circulation.* 2005;112:563-571.
- Cowell SJ, Newby DE, Prescott RJ, et al. A randomized trial of intensive lipid-lowering therapy in calcific aortic stenosis. *N Engl J Med.* 2005;352:2389-2397.
- Houslay E, Cowell SJ, Prescott R, et al; Scottish Aortic Stenosis and Lipid Lowering Therapy, Impact on Regression trial Investigators. Progressive coronary calcification despite intensive lipid-lowering therapy: a randomised controlled trial. *Heart.* 2006;92:1207-1212.
- Essalihi R, Dao HH, Gilbert LA, et al. Regression of medial elastocalcinosis in rat aorta: a new vascular function for carbonic anhydrase. *Circulation.* 2005;112:1628-1635.
- Bas A, Lopez I, Perez J, Rodriguez M, Aguilera-Tejero E. Reversibility of calcitriol-induced medial



- artery calcification in rats with intact renal function. *J Bone Miner Res.* 2006;21:484-490.
45. Barone LM, Aronow MA, Tassinari MS, et al. Differential effects of warfarin on mRNA levels of developmentally regulated vitamin K dependent proteins, osteocalcin, and matrix GLA protein in vitro. *J Cell Physiol.* 1994;160:255-264.
  46. Price PA, Faus SA, Williamson MK. Warfarin-induced artery calcification is accelerated by growth and vitamin D. *Arterioscler Thromb Vasc Biol.* 2000;20:317-327.
  47. Nadra I, Mason JC, Philippidis P, et al. Proinflammatory activation of macrophages by basic calcium phosphate crystals via protein kinase C and MAP kinase pathways: a vicious cycle of inflammation and arterial calcification? *Circ Res.* 2005;96:1248-1256.
  48. Proudfoot D, Skepper JN, Hegyi L, Bennett MR, Shanahan CM, Weissberg PL. Apoptosis regulates human vascular calcification in vitro: evidence for initiation of vascular calcification by apoptotic bodies. *Circ Res.* 2000;87:1055-1062.
  49. Reynolds JL, Joannides AJ, Skepper JN, et al. Human vascular smooth muscle cells undergo vesicle-mediated calcification in response to changes in extracellular calcium and phosphate concentrations: a potential mechanism for accelerated vascular calcification in ESRD. *J Am Soc Nephrol.* 2004;15:2857-2867.
  50. Melaragno MG, Cavet ME, Yan C, et al. Gas6 inhibits apoptosis in vascular smooth muscle: role of Axl kinase and Akt. *J Mol Cell Cardiol.* 2004;37:881-887.
  51. Ishimoto Y, Ohashi K, Mizuno K, Nakano T. Promotion of the uptake of PS liposomes and apoptotic cells by a product of growth arrest-specific gene, gas6. *J Biochem.* 2000;127:411-417.
  52. Hasanbasic I, Rajotte I, Blostein M. The role of gamma-carboxylation in the anti-apoptotic function of gas6. *J Thromb Haemost.* 2005;3:2790-2797.
  53. Proudfoot D, Davies JD, Skepper JN, Weissberg PL, Shanahan CM. Acetylated low-density lipoprotein stimulates human vascular smooth muscle cell calcification by promoting osteoblastic differentiation and inhibiting phagocytosis. *Circulation.* 2002;106:3044-3050.
  54. Ronden JE, Drittij-Reijnders MJ, Vermeer C, Thijssen HH. Intestinal flora is not an intermediate in the phylloquinone- menaquinone-4 conversion in the rat. *Biochim Biophys Acta.* 1998;1379:69-75.
  55. Jono S, Ikari Y, Vermeer C, et al. Matrix Gla protein is associated with coronary artery calcification as assessed by electron-beam computed tomography. *Thromb Haemost.* 2004;91:790-794.
  56. Price PA, Thomas GR, Pardini AW, Figueira WF, Caputo JM, Williamson MK. Discovery of a high molecular weight complex of calcium, phosphate, fetuin, and matrix gamma-carboxyglutamic acid protein in the serum of etidronate-treated rats. *J Biol Chem.* 2002;277:3926-3934.
  57. Qunibi WY. Reducing the burden of cardiovascular calcification in patients with chronic kidney disease. *J Am Soc Nephrol.* 2005;16(suppl 2):S95-S102.
  58. Goodman WG, London G, Amann K, et al. Vascular calcification in chronic kidney disease. *Am J Kidney Dis.* 2004;43:572-579.