Long-term Exposure to $\text{PM}_{2.5}$ and Incidence of Acute Myocardial Infarction

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<th>Citation</th>
<th>Madrigano, Jaime, Itai Kloog, Robert Goldberg, Brent A. Coull, Murray A. Mittleman, and Joel Schwartz. 2013. Long-term exposure to pm2.5 and incidence of acute myocardial infarction. Environmental Health Perspectives 121(2): 192-196.</th>
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<td>Published Version</td>
<td>doi:10.1289/ehp.1205284</td>
</tr>
<tr>
<td>Citable link</td>
<td><a href="http://nrs.harvard.edu/urn-3:HUL.InstRepos:11011815">http://nrs.harvard.edu/urn-3:HUL.InstRepos:11011815</a></td>
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Long-term Exposure to PM$_{2.5}$ and Incidence of Acute Myocardial Infarction

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**Background:** A number of studies have shown associations between chronic exposure to particulate air pollution and increased mortality, particularly from cardiovascular disease, but fewer studies have examined the association between long-term exposure to fine particulate air pollution and specific cardiovascular events, such as acute myocardial infarction (AMI).

**Objective:** We examined how long-term exposure to area particulate matter affects the onset of AMI, and we distinguished between area and local pollutants.

**Methods:** Building on the Worcester Heart Attack Study, an ongoing community-wide investigation examining changes over time in myocardial infarction incidence in greater Worcester, Massachusetts, we conducted a case–control study of 4,467 confirmed cases of AMI diagnosed between 1995 and 2003 and 9,072 matched controls selected from Massachusetts resident lists. We used a prediction model based on satellite aerosol optical depth (AOD) measurements to generate both exposure to particulate matter ≤ 2.5 μm in diameter (PM$_{2.5}$) at the area level (10 × 10 km) and the local level (100 m) based on local land use variables. We then examined the association between area and local particulate pollution and occurrence of AMI.

**Results:** An interquartile range (IQR) increase in area PM$_{2.5}$ (0.59 μg/m$^3$) was associated with a 16% increase in the odds of AMI (95% CI: 1.04, 1.29). An IQR increase in total PM$_{2.5}$ (area + local, 1.05 μg/m$^3$) was weakly associated with a 4% increase in the odds of AMI (95% CI: 0.96, 1.11).

**Conclusions:** Residential exposure to PM$_{2.5}$ may best be represented by a combination of area and local PM$_{2.5}$, and it is important to consider spatial gradients within a single metropolitan area when examining the relationship between particulate matter exposure and cardiovascular events.

**Key Words:** air pollution. Environ Health Perspect 121:192–196 (2013). http://dx.doi.org/10.1289/ehp.1205284 [Online 29 November 2012]

Several studies have shown associations between chronic exposure to particulate air pollution and increased mortality, particularly from cardiovascular disease (Dockery et al. 1993; Pope et al. 2004; Puett et al. 2009). Fewer studies, however, have examined the association between long-term exposure to fine particulate air pollution, such as particulate matter ≤ 2.5 μm in diameter (PM$_{2.5}$), and specific cardiovascular outcomes, such as acute myocardial infarction (AMI). A systematic review of the association between air pollution and the incidence of MI concluded that the evidence for long-term effects, in contrast to short-term effects, of air pollution on MI risk is limited and few conclusions could be drawn (Bhaskaran et al. 2009). This may be in part because of the limited number of AMIs in many cohort studies.

Furthermore, spatial gradients within metropolitan areas are increasingly being identified as important in the association between particulate air pollution and health outcomes. Findings suggest that spatial gradients within cities might be as large, or larger, as those between cities (Hoek et al. 2002; Jerrett et al. 2005). In one of the few cohort studies that has investigated long-term exposure to PM$_{2.5}$ and incidence of cardiovascular events, a larger association with AMI was found for an exposure increase of 10 μg/m$^3$ within cities than between cities (Miller et al. 2007). The hazard ratio for AMI did not reach statistical significance, but this study had limited statistical power because of the relatively small number (n = 584) of events. This limitation is a common problem for even large cohort studies; the incidence of AMI in a decade is not high enough to produce a large number of cases. In such circumstances, case–control studies are an attractive alternative.

We previously found an association between traffic particles and occurrence of AMI in case–control studies within a single metropolitan area (Tonne et al. 2007, 2009). Our earlier analyses included indicators of traffic as a proxy for long-term exposure to traffic pollutants as well as a latent-variable approach to model residential exposure to traffic particles. Hence, it did not capture any effects of particles other than primary traffic particles. To gain a better understanding of how long-term exposure to area particulate matter affects the onset of AMI, and to distinguish between area and local pollutants, we examined both of these measures simultaneously in our analysis. In the present study, we used a PM$_{2.5}$-prediction model based on satellite aerosol optical depth (AOD) measurements (Kloog et al. 2011). The model generates area particulate air pollution predictions in addition to local particulate pollution based on local land use variables, both of which are assigned according to residential address. We then examined the association between both area and local particulate pollution and incidence of AMI using a case–control study design.

**Methods**

**Study population.** Cases of AMI included in this study were drawn from the Worcester Heart Attack Study, an ongoing community-wide investigation examining changes over time in the incidence and case-fatality rates of independently confirmed cases of AMI in residents of the greater Worcester, Massachusetts, area who were hospitalized with MI at all area medical centers. The details of this study have been described previously (Floyd et al. 2009; Goldberg et al. 1988, 1999). In brief, during the 5 years under study for the present investigation (1995, 1997, 1999, 2001, and 2003), the medical records of the 11 acute care general hospitals serving residents of the Worcester metropolitan area were searched for patients with a possible discharge diagnosis of AMI. The records were reviewed and validated according to diagnostic criteria described previously (Floyd et al. 2009; Goldberg et al. 1988), and at least two of the following criteria were required for inclusion in the original study: a suggestive clinical history, increased serum biomarker levels above each hospital’s normal range, and serial electrocardiographic findings indicative of AMI. The present

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We thank the participating hospitals in the Worcester, Massachusetts, metropolitan area whose cooperation made this study possible.

This work was supported by the National Institutes of Health (grant ROI HL35434), and the U.S. Environmental Protection Agency (EPA; grant RD 8347980). The contents of this article are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. EPA. Further, the U.S. EPA does not endorse the purchase of any commercial products or services mentioned in the publication.

The authors declare they have no actual or potential competing financial interests.

Received 29 March 2012; accepted 29 September 2012.
In a second stage, we estimated exposures on days when AOD measures were not available (due to cloud coverage or snow, for example). A model was fit with a smooth function of latitude and longitude and a random intercept for each cell (similar to universal kriging) that takes advantage of associations between grid cell AOD values and PM$_{2.5}$ from monitors located elsewhere and associations with available AOD values in neighboring grid cells.

To validate our model, the data set was repeatedly randomly divided into 90% and 10% splits. Predictions for the held-out 10% of the data were made from the model fit of the remaining 90% of the data. This "out of sample" process was repeated 10 times and cross-validated $R^2$ values were computed. The first stage calibrations resulted in high out-of-sample 10-fold cross-validated $R^2$ (mean out-of-sample $R^2 = 0.85$). Even for location-day combinations without AOD data (the second stage models), our model performance was excellent (mean out-of-sample $R^2 = 0.81$). Importantly, these $R^2$ are for daily observations, rather than monthly or yearly values. To check for bias we regressed the measured PM$_{2.5}$ values against the predicted values in each site on each day.

To estimate traffic particle exposures at the local level, we used local (100 m) land use terms (distance to primary highways, distance to point source emissions, population density, percent of open spaces, elevation, and traffic density) to model the difference between the 10 × 10 km grid cell predictions and monitored values. We regressed the residuals for each monitor against local land use characteristics for each monitor and a smooth function of traffic density. The local PM$_{2.5}$ term provides an estimate of traffic-related local particulate pollution that is spatio temporally correlated with PM$_{2.5}$. Finally, as an estimate of the total outdoor PM$_{2.5}$ exposure at residential location, we summed the local and area PM$_{2.5}$ terms.

**Covariates**. Because our exposure varied spatially, confounding by spatially varying covariates was an issue. We obtained area-based measures of socioeconomic status (SES) from the year 2000 census at the block group level (U.S. Census Bureau 2000b). The following SES measures were obtained: proportion of the population with 1999 income below the federally defined poverty level, median household income in 1999, and percentage of persons ≥ 25 years of age whose highest degree was less than a high school diploma or its equivalent. Census block groups have a population of about 1,500 individuals and are defined by the Census Bureau as small statistical subdivisions of counties with generally stable boundaries, designed to have relatively homogeneous demographic and economic characteristics (U.S. Census Bureau 2000a). Census block group data on poverty have been shown to be a relatively sensitive measure of socioeconomic inequalities in health outcomes (Krieger et al. 2002).

Individual lifestyle factors, such as dietary patterns, obesity, and level of exercise, may be correlated with place of residence. Although such lifestyle factors were unavailable for the cases and controls in our study, we attempted to control for such factors by proxy. Obesity prevalence, as well as fruit and vegetable consumption, have been associated with distance to large supermarkets (defined as having > 50 employees) in metropolitan areas (Michimsky and Wimberly 2010), whereas access to parks, walking and jogging trails, and enjoyable scenery have been associated with physical activity behavior (Brownson et al. 2001). ArcGIS version 10.1 (ESRI, Redlands, CA) was used to calculate the straight-line distance between residential addresses and large supermarkets. Locations of large supermarkets were available from the 2006 InfoUSA Business Listing File from ESRI’s Business Analyst Extension. Data on recreation areas was downloaded from the MassGIS web site (MassGIS 2012).

**Statistical analysis**. We first ran logistic regression models adjusted only for the matching factors—age, sex, and section of the study area. Although we matched on 10-year age groups, we included age in our models as a continuous, linear term, thus controlling more finely for this covariate. We also included all higher-order (2- and 3-way) interaction terms for the matching factors in our models. Next, we included measures of block group population density and SES, distance to the nearest large supermarket, and distance to nearest recreation area in our models. Finally, we used generalized estimating equations (GEEs) assuming an exchangeable correlation structure within census block group and census tract to account for any remaining correlation among subjects in the same block group (or census tract) not captured by model covariates. We ran two sets of models: the first with separate terms for area and local PM$_{2.5}$, and the second with a term for their sum. In addition, we repeated GEE models restricted to first (vs. any) AMI, and after stratifying by section of the study area, and by time period (1995, 1997, and 1999; or 2001 and 2003). All models were conducted using PROC GENMOD in SAS version 9.2 (SAS Institute Inc., Cary, NC).

**Results**. Exposure and covariate information by study area section for cases and controls is presented in Table 1. Figure 1 shows the residential location for our study subjects according to their 10 × 10 km pollution grid cell. Exposure was divided into two parts: a) area PM$_{2.5}$ predicted for the 10 × 10 km grid cell that each case or control lived in, and b) local PM$_{2.5}$ from the local land use prediction model. In the year
2000, the interquartile range (IQR) for area PM$_{2.5}$ was 0.6 $\mu g/m^3$, and the IQR for local PM$_{2.5}$ was 1.1 $\mu g/m^3$. Area PM$_{2.5}$ was highest in section 2 of our study area, but there was more variability in this exposure metric in sections 1 and 3 (Table 1). Local PM$_{2.5}$ (and the variability of local PM$_{2.5}$ estimates) was highest in section 1. We also examined the degree to which exposure was correlated with area-based measures of SES in control subjects. There was moderate correlation between area PM$_{2.5}$ and percent poverty within a census block group ($r = 0.35$), but a small inverse correlation with local PM$_{2.5}$ ($r = -0.07$), resulting in a weak correction with total PM$_{2.5}$ ($r = 0.1$).

In our models adjusted only for matching factors, exposure to area PM$_{2.5}$ was associated with occurrence of AMI. This association was robust to additional adjustment for population density, SES, distance to a large supermarket, and distance to a recreation area, although slightly attenuated (Table 2). An IQR increase in area PM$_{2.5}$ (0.59 $\mu g/m^3$) was associated with a 16% increase in the odds of AMI (95% CI: 1.04, 1.29). IQR increases in local PM$_{2.5}$ (1.08 $\mu g/m^3$) and total PM$_{2.5}$ (1.05 $\mu g/m^3$) were weakly associated with occurrence of AMI after adjusting for area PM$_{2.5}$ and other covariates (Table 2). Estimates from models with an exchangeable correlation structure for census block group or tract were not materially different. Restricting the outcome to first (vs. any) AMI had little influence on associations; however, estimates varied somewhat among the three study area sections and when stratified according to time period (Table 3).

**Discussion**

In the present analysis, we observed an association between long-term exposure to area PM$_{2.5}$, a regional air pollutant, and occurrence of AMI. Although several studies have found associations between long-term exposure to PM$_{10}$ or PM$_{2.5}$ and cardiovascular disease mortality (Dockery et al. 1993; Krewski et al. 2009; Miller et al. 2007; Puett et al. 2009), few have looked at specific outcomes such as AMI. In two prospective studies of women, one across the United States and one in the Northeast and Midwest regions of the country, elevated, but not statistically significant, hazard ratios were found for incident MI in association with an increase of 10 $\mu g/m^3$ of PM$_{2.5}$, with exposure based on either nearest monitor (Miller et al. 2007) or a spatiotemporal regression model (Puett et al. 2009). The relatively small number of incident cases in the two studies (<1,000 in each) may partly explain these findings. In contrast, the present study included >4,000 incident cases of AMI.

Previous analyses (Tonne et al. 2007, 2009) of the Worcester Heart Attack Study, a population-based case–control study, indicated that exposure to traffic particles was associated with occurrence of AMI. In the present study, we found an association between the occurrence of AMI and exposure to regional PM$_{2.5}$.

**Figure 1.** Map of the study area (Worcester, MA) showing the residential location of subjects (cases and controls) with a sample mean PM$_{2.5}$ ($\mu g/m^3$) 10 × 10 km pollution grid for the year 2000.

**Table 1.** Characteristics of cases and controls by study section [mean ± SD or n (%)].
while controlling for fine-scale variation in particulate air pollution that may be due to local traffic. We modeled exposure of PM$_{2.5}$ based on daily measurements of AOD in 32 grid cells across Worcester County. The use of actual spatially resolved measurements is an important advantage over land use regression (LUR), which is calibrated using space- and time-limited monitoring data, and our model performed better in out-of-sample validation than reported previously in other LUR-based models (Kloog et al. 2011). LUR models are calibrated only at measuring sites; our model benefits by incorporating physical measurements (via satellite data) over the entire spatial domain. In addition, satellite AOD data may be used to fit LUR models in locations without ground monitors, and may reduce bias due to non-random placement of monitors.

We separated estimates for local- and area-level pollution in our modeling. The first phase used the model developed by Kloog et al. (2011) to estimate average PM$_{2.5}$ concentrations on a 10 km grid. In the second phase, we took the residuals between the actual monitored value in each grid and the predicted mean value for each grid, which presumably reflect the influence of local conditions near each monitoring site, and regressed them against land use terms within 100 m of the monitor to account for the effects of these local sources. This model was then used to estimate local particle concentrations at the addresses of study participants. Because the land use regression is fit to the difference between the monitored value and the grid cell prediction, this local contribution is independent of the grid cell value, allowing us to examine the different sources of particle exposure with less collinearity in our model. A unique advantage of this approach is that it allows us to look at these exposure metrics separately and together, allowing for a best estimate of a subject’s residential outdoor PM$_{2.5}$ exposure. Because the measure of total PM$_{2.5}$ comprised two estimates with different spatial variability, it had little correlation with area SES characteristics, such as percent families living in poverty, and therefore the association between this metric and AMI may suffer less from residual confounding.

In the northeastern United States, PM$_{2.5}$ is composed predominantly of secondary organics and sulfate aerosols. Sulfate aerosols are formed from the oxidation of sulfur dioxide (SO$_2$) emitted from fossil fuel combustion, and it is estimated that 70% of the SO$_2$ emissions in the United States are from electricity-generating facilities (U.S. Environmental Protection Agency 2009). Formation of secondary organic aerosols is not as fully understood as that of particulate sulfate, but a portion of their formation is attributed to aromatic hydrocarbon precursors under nitrogen oxide (NO$_x$)-limiting conditions, and NO$_x$ is, like SO$_2$, also emitted from fossil fuel combustion, including motor vehicle exhaust. Prior work in this cohort was focused on traffic-related air pollution, which was measured using exposure proxies and a latent variable model (Tonne et al. 2007, 2009). However, in the present analysis we were able to estimate personal exposure to total PM$_{2.5}$, which was not solely due to traffic.

![Table 2. Relative odds (OR [95% CI]) of AMI among cases and controls.](image)

<table>
<thead>
<tr>
<th>Model</th>
<th>Area PM$_{2.5}$</th>
<th>Local PM$_{2.5}$</th>
<th>Total PM$_{2.5}$</th>
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<tbody>
<tr>
<td>Area PM$_{2.5}$ only</td>
<td>1.15 (1.09, 1.21)</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Area PM$<em>{2.5}$ and local PM$</em>{2.5}$</td>
<td>1.16 (1.10, 1.22)</td>
<td>1.03 (1.00, 1.06)</td>
<td>1.04 (1.01, 1.08)</td>
</tr>
<tr>
<td>Area PM$<em>{2.5}$ and local PM$</em>{2.5}$</td>
<td>1.12 (1.06, 1.18)</td>
<td>1.03 (1.00, 1.07)</td>
<td>1.04 (1.00, 1.07)</td>
</tr>
<tr>
<td>GEE models with exchangeable correlation within census block group</td>
<td>1.14 (1.01, 1.29)</td>
<td>1.03 (0.97, 1.10)</td>
<td>1.04 (0.96, 1.11)</td>
</tr>
<tr>
<td>GEE models with exchangeable correlation within census tract</td>
<td>1.18 (1.04, 1.35)</td>
<td>1.03 (0.98, 1.09)</td>
<td>1.03 (0.97, 1.10)</td>
</tr>
</tbody>
</table>

OR per IQR of pollutant; the IQR was 0.59 μg/m$^3$ for area PM$_{2.5}$, 1.08 μg/m$^3$ for local PM$_{2.5}$, and 1.05 μg/m$^3$ for total PM$_{2.5}$.

![Table 3. Relative odds (OR [95% CI]) of AMI among cases and controls.](image)

<table>
<thead>
<tr>
<th>Stratification factor</th>
<th>Area PM$_{2.5}$</th>
<th>Local PM$_{2.5}$</th>
<th>Total PM$_{2.5}$</th>
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<tr>
<td>AMI order</td>
<td>First AMI</td>
<td>1.19 (1.06, 1.33)</td>
<td>1.04 (1.00, 1.09)</td>
</tr>
<tr>
<td>Any AMI</td>
<td>1.16 (1.04, 1.29)</td>
<td>1.03 (0.97, 1.10)</td>
<td>1.04 (0.97, 1.11)</td>
</tr>
<tr>
<td>Study section</td>
<td>1</td>
<td>1.24 (1.04, 1.48)</td>
<td>1.01 (0.96, 1.06)</td>
</tr>
<tr>
<td>2</td>
<td>1.18 (1.04, 1.35)</td>
<td>1.06 (0.98, 1.14)</td>
<td>1.06 (0.98, 1.13)</td>
</tr>
<tr>
<td>3</td>
<td>1.06 (0.83, 1.34)</td>
<td>1.11 (0.99, 1.24)</td>
<td>1.10 (0.99, 1.23)</td>
</tr>
<tr>
<td>Study period</td>
<td>1995, 1997, 1999</td>
<td>1.10 (0.98, 1.24)</td>
<td>1.03 (0.98, 1.08)</td>
</tr>
<tr>
<td>2001, 2003</td>
<td>1.18 (1.05, 1.32)</td>
<td>1.00 (0.96, 1.03)</td>
<td>1.00 (0.96, 1.05)</td>
</tr>
</tbody>
</table>

OR per IQR of pollutant; the IQR was 0.59 μg/m$^3$ for area PM$_{2.5}$, 1.08 μg/m$^3$ for local PM$_{2.5}$, and 1.05 μg/m$^3$ for total PM$_{2.5}$.

Evidence for such mechanistic pathways exists in both the toxicology and epidemiology literature. Studies of apolipoprotein E-deficient...
composition of AOD particles. In addition, our models used to predict exposures by the separate covariate was an advantage of this study. Models used to predict exposures for controls in the earlier study period, which may be a function of combined spatial scales may provide a better estimate of total PM$_{2.5}$ exposure for these subjects, leading to a downward bias of our results.

Conclusions

After accounting for local pollution exposure, long-term exposure to area PM$_{2.5}$ was associated with the occurrence of AMI in this population-based study. The association between total PM$_{2.5}$ and AMI occurrence was weaker, but this metric of combined spatial scales may provide a better estimate of total PM$_{2.5}$ exposure at an individual’s residence. This study adds to the growing body of literature on long-term regional particulate pollution and cardiovascular morbidity, and highlights the importance of examining pollutant variability within a single metropolitan area, rather than solely focusing on comparisons across large spatial scales.

References


