



# Association between PM<sub>2.5</sub> and cardiovascular disease: A case-control study in Shanghai, China

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## ABSTRACT

**Background:** Evidence on the association between PM<sub>2.5</sub> exposure and cardiovascular disease (CVD) is limited. We conducted a large-scale case-control study in Shanghai, China, to investigate the association between PM<sub>2.5</sub> exposure and CVD.

**Objectives:** To assess the association between PM<sub>2.5</sub> exposure and CVD (CREPL) and to explore the association between PM<sub>2.5</sub> exposure and CVD by sex, age, and education level.

**Methods:** CREPL cases and controls (frequency matched by sex, age, and education level) were recruited between July 2017 and July 2018 at Tianjin, China. Average PM<sub>2.5</sub> concentration for each case and control was calculated based on the residential address during the 12 months before diagnosis. We used conditional logistic regression to estimate the odds ratios (ORs) and 95% confidence intervals (CIs) for the association between PM<sub>2.5</sub> exposure and CVD.







**Table 3**

ORs (95% CIs) for cardiovascular mortality associated with PM<sub>2.5</sub> exposure (10 μg / m<sup>3</sup> increase) separately for each sex and for age-adjusted and age- and sex-adjusted (n = 364 cases).

Exposure	Unadjusted	p-value	Adjusted <sup>a</sup>	p-value
4-year difference	1.17 (1.00, 1.37)*	0.048	1.12 (0.93, 1.34)	0.246
2-year difference	1.08 (0.98, 1.20)	0.135	1.06 (0.94, 1.19)	0.339
1-year difference	1.06 (0.98, 1.14)	0.135	1.04 (0.95, 1.14)	0.374
Female	0.99 (0.93, 1.06)	0.814	0.99 (0.91, 1.07)	0.713
Secular	1.11 (1.03, 1.20)*	0.009	1.13 (1.03, 1.23)*	0.010
Trend	1.04 (0.97, 1.12)	0.299	1.07 (0.98, 1.17)	0.115
Female	1.03 (0.96, 1.11)	0.388	1.03 (0.95, 1.12)	0.467
Female 2-year difference	1.08 (0.98, 1.19)	0.131	1.08 (0.97, 1.21)	0.169
Secular 2-year difference	1.07 (0.97, 1.19)	0.191	1.10 (0.98, 1.24)	0.118
Female 4-year difference	1.18 (1.01, 1.38)*	0.033	1.22 (1.02, 1.46)*	0.027

Note: <sup>a</sup> Crude odds ratios (ORs) and 95% confidence intervals (CIs) for cardiovascular mortality associated with PM<sub>2.5</sub> exposure (10 μg / m<sup>3</sup> increase) are shown for each sex and for age-adjusted and age- and sex-adjusted (n = 364 cases). \* ORs are statistically significant (α = 0.05).

CI: 1.03, 1.23; p = 0.010) and for females (OR = 1.22; 95% CI: 1.02, 1.46; p = 0.027). Differences between age-adjusted and age- and sex-adjusted ORs are shown in Table 3.

Unadjusted and adjusted ORs (95% CIs) for cardiovascular mortality associated with PM<sub>2.5</sub> exposure (10 μg / m<sup>3</sup> increase) are shown in Table 4. Estimated effects for each exposure window are shown in Table 4. Estimated effects for each exposure window are shown in Table 4. Estimated effects for each exposure window are shown in Table 4.

Female cardiovascular mortality associated with PM<sub>2.5</sub> exposure (OR (95% CI) for 1-year difference: 1.12 (95% CI: 0.93, 1.34; p = 0.246) (Table 3). Estimated effects for each exposure window are shown in Table 4. Estimated effects for each exposure window are shown in Table 4.

**4. Discussion**

In this case-control study, we evaluated associations between CREPL and all-cause PM<sub>2.5</sub> exposure and cardiovascular mortality. We found CREPL associated with all-cause mortality for each PM<sub>2.5</sub> difference 4-year difference, and for each 2-year difference.

**Table 4**

Estimated effects [ORs (95% CIs)] for cardiovascular mortality associated with 10 μg / m<sup>3</sup> increase in PM<sub>2.5</sub> after 1-year difference (1-year difference) and 2-year difference (2-year difference) (n = 364 cases).

Exposure	Unadjusted	p-value	Adjusted <sup>a</sup>	p-value
1-year difference	1.08 (0.99, 1.17)	0.059	1.07 (0.98, 1.17)	0.157
Female	0.97 (0.91, 1.05)	0.457	0.97 (0.90, 1.06)	0.522
Secular	1.14 (1.05, 1.24)*	0.003	1.15 (1.04, 1.27)*	0.005
Trend	1.04 (0.96, 1.12)	0.390	1.07 (0.98, 1.17)	0.151
Female	1.05 (0.97, 1.14)	0.197	1.05 (0.96, 1.15)	0.278

Note: <sup>a</sup> Crude odds ratios (ORs) and 95% confidence intervals (CIs) for cardiovascular mortality associated with PM<sub>2.5</sub> exposure (10 μg / m<sup>3</sup> increase) are shown for each sex and for age-adjusted and age- and sex-adjusted (n = 364 cases). \* ORs are statistically significant (α = 0.05).

**4.1. Subject recruitment and determination of exposure windows**

Subjects were recruited from a population-based case-control study of cardiovascular mortality associated with PM<sub>2.5</sub> exposure (Cohen et al., 2015; Esch et al., 2016; Lacey et al., 2013; Pedersen et al., 2016; Schreiner et al., 2015). Here, EPL was used to determine exposure windows. Other studies using CREPL, such as the case-control study of cardiovascular mortality associated with PM<sub>2.5</sub> exposure (Cohen et al., 2015), used a 1-year difference in exposure as the exposure window. Using a 1-year difference in exposure as the exposure window is a common approach in case-control studies.

Key findings from this study are that EPL associated with cardiovascular mortality. In addition, we found that EPL associated with cardiovascular mortality. In addition, we found that EPL associated with cardiovascular mortality. In addition, we found that EPL associated with cardiovascular mortality.

4.2. Estimation of maternal exposure

Measurement factors are sensitive to the choice of factors. Feasible as, the standard deviation of the measurement error is assumed, but the measurement error is assumed to be independent of the true value. Because, the measurement error is assumed to be independent of the true value, the measurement error is assumed to be independent of the true value.

Estimate of the dose-response relationship is affected by the choice of the exposure metric. The effect of the exposure metric on the dose-response relationship is affected by the choice of the exposure metric.

Standard LUR models are used to estimate the exposure. The standard LUR models are used to estimate the exposure. The standard LUR models are used to estimate the exposure.

For example, after the adjustment, the absolute risk increases, the standard deviation of the measurement error is assumed to be independent of the true value.

4.3. Associations between PM2.5 and CREPL

The dose-response relationship of PM2.5 is assessed using the following methods: [PubMed (http://pubmed.ncbi.nlm.nih.gov/), EMBASE (http://www.embase.com), Web of Science (http://www.scopus.com)] following the PRISMA 2015 flow diagram. The search criteria are: [(fine particulate OR PM2.5) AND (cancer OR respiratory OR asthma)]. The search was defined in the databases, including PubMed and EMBASE and Web of Science and Scopus, and added to the search list. The search ended 20 October 2018. The search was conducted using the following criteria: PM2.5 and EPL (Eisen et al., 2014; Ha et al., 2018; Sa et al., 2018).

Eisen et al. (2014) estimated a relative risk (RR) of 0.92, p < 0.001 for the association between the daily average of PM2.5 and the risk of asthma. Ha et al. (2018) estimated a IQR (3.0 μg / m³) increase in the daily average of PM2.5 concentration was associated with a 1.13-fold increase in the risk of asthma (adjusted, HR = 1.13; 95% CI: 1.03, 1.24); a further 97% increase in the daily average of PM2.5 concentration was associated with a 1.18-fold increase in the risk of asthma. However, the HRs for the association between the daily average of PM2.5 concentration and the risk of asthma were not statistically significant. In a case-control study, Sa et al. (2018) estimated a 1.03-fold increase in the risk of asthma for each 3-day average of PM2.5 concentration increase (OR = 1.03, 95% CI: 1.00, 1.06).

Our findings are consistent with the previous studies. However, the results are based on the data from the standard LUR models. The findings are based on the data from the standard LUR models.

4.4. Strengths and limitations

The strengths of this study include the use of standard LUR models to estimate the exposure. The strengths of this study include the use of standard LUR models to estimate the exposure.

The limitations of this study include the use of standard LUR models to estimate the exposure. The limitations of this study include the use of standard LUR models to estimate the exposure.

5. Conclusions

This study found a positive association between the daily average of PM2.5 and the risk of asthma. This study found a positive association between the daily average of PM2.5 and the risk of asthma.

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Declarations of interest

N e.

Appendix A. Supplementary data

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