



**QUEEN'S
UNIVERSITY
BELFAST**

The effect of CYP4F2, VKORC1 and CYP2C9 in influencing coumarin dose. A single patient data meta-analysis in more than 15,000 individuals

Danese, E., Sara, R., Montagnana, M., Tagetti, A., Langae, T., Borgiani, P., Ciccacci, C., Carcas, A. J., Borobia, A. M., Tong, H. Y., Davila Fajardo, C., Rodrigues Botton, M., Bourgeois, S., Deloukas, P., Caldwell, M. D., Burmester, J. K., Berg, R. L., Cavallari, L. H., Drozda, K., ... Fava, C. (2018). The effect of CYP4F2, VKORC1 and CYP2C9 in influencing coumarin dose. A single patient data meta-analysis in more than 15,000 individuals. *Clinical Pharmacology and Therapeutics*. Advance online publication. <https://doi.org/10.1002/cpt.1323>

Published in:

Clinical Pharmacology and Therapeutics

Document Version:

Peer reviewed version

Queen's University Belfast - Research Portal:

[Link to publication record in Queen's University Belfast Research Portal](#)

Publisher rights

© 2018 American Society for Clinical Pharmacology and Therapeutics. This work is made available online in accordance with the publisher's policies. Please refer to any applicable terms of use of the publisher.

General rights

Copyright for the publications made accessible via the Queen's University Belfast Research Portal is retained by the author(s) and / or other copyright owners and it is a condition of accessing these publications that users recognise and abide by the legal requirements associated with these rights.

Take down policy

The Research Portal is Queen's institutional repository that provides access to Queen's research output. Every effort has been made to ensure that content in the Research Portal does not infringe any person's rights, or applicable UK laws. If you discover content in the Research Portal that you believe breaches copyright or violates any law, please contact openaccess@qub.ac.uk.

Open Access

This research has been made openly available by Queen's academics and its Open Research team. We would love to hear how access to this research benefits you. – Share your feedback with us: <http://go.qub.ac.uk/oa-feedback>

The effect of *CYP4F2*, *VKORC1* and *CYP2C9* in influencing coumarin dose. A single patient data meta-analysis in more than 15,000 individuals.

Elisa Danese,^{1*} Sara Raimondi,^{2*} Martina Montagnana,¹ Angela Tagetti,² Taimour Langaee,³ Paola Borgiani,⁴ Cinzia Ciccacci,⁴ Antonio J. Carcas,⁵ Alberto M. Borobia,⁵ Hoi Y Tong,⁵ Cristina Dávila-Fajardo,⁶ Mariana Rodrigues Botton,⁷ Stephane Bourgeois,⁸ Panos Deloukas,⁹ Michael D. Caldwell,¹⁰ Jim K. Burmester,¹¹ Richard L. Berg,¹² Larisa H. Cavallari,³ Katarzyna Drozda,¹³ Min Huang,¹⁴ Li-Zi Zhao,¹⁴ Han-Jing Cen,¹⁵ Rocio Gonzalez-Conejero,¹⁶ Vanessa Roldan¹⁶, Yusuke Nakamura,¹⁷ Taisei Mushiroda,¹⁷ Inna Y. Gong,¹⁸ Richard B. Kim,¹⁸ Keita Hirai,¹⁹ Kunihiko Itoh,¹⁹ Carlos Isaza,²⁰ Leonardo Beltrán,^{20,21} Enrique Jiménez-Varo,²² Marisa Cañadas-Garre,²³ Alice Giontella,² Marianne Kristiansen Kringen,²⁴ Kari Bente Foss Haug,²⁵ Hye Sun Gwak,²⁶ Kyung Eun Lee,²⁷ Pietro Minuz,² Ming Ta Michael Lee,²⁸ Steven A. Lubitz,²⁹ Stuart Scott,³⁰ Cristina Mazzaccara,³¹ Lucia Sacchetti,³¹ Ece Genç,³² Mahmut Özer,³² Anil Pathare,³³ Rajagopal Krishnamoorthy,³⁴ Andras Paldi,³⁵ Virginie Siguret,³⁶ Marie-Anne Loriot,³⁷ Vijay Kumar Kutala,³⁸ Guilherme Suarez-Kurtz,³⁹ Jamila Perini,⁴⁰ Josh C. Denny,⁴¹ Andrea H. Ramirez,⁴² Balraj Mittal,⁴³ Saurabh Singh Rathore,⁴³ Hersh Sagreiya,⁴⁴ Russ Altman,⁴⁴ Mohamed Hossam A. Shahin,⁴⁵ Sherief I. Khalifa,⁴⁶ Nita A. Limdi,⁴⁷ Charles Rivers,⁴⁷ Aditi Shendre,⁴⁸ Chrisly Dillon,⁴⁷ Ivet M. Suriapranata,⁴⁹ Hong-Hao Zhou,⁵⁰ Sheng-Lan Tan,⁵¹ Vacis Tatarunas,⁵² Vaiva Lesauskaite,⁵² Yumao Zhang,⁵³ Anke H. Maitland-van der Zee,^{53,54} Talitha I. Verhoef,⁵⁵ Anthonius de Boer,⁵⁶ Monica Taljaard,⁵⁷ Carlo Federico Zambon,⁵⁸ Vittorio Pengo,⁵⁹ Jieying Eunice Zhang,⁶⁰ Munir Pirmohamed,⁶⁰ Julie A. Johnson,^{3*} and Cristiano Fava^{2*}

Affiliations

¹Clinical Biochemistry Section, Department of Neurological, Biomedical and Movement Sciences, University of Verona, Italy; ²General Medicine and Hypertension Unit, Department of Medicine, University of Verona, Italy; ³Department of Pharmacotherapy and Translational Research, Center for Pharmacogenomics, College of Pharmacy, University of Florida, Gainesville, Florida, USA; ⁴Department of Biomedicine and Prevention, Genetics Section, University of Rome “Tor Vergata” Rome, Italy; ⁵Clinical Pharmacology Department, La Paz University Hospital. School of Medicine, Universidad Autónoma de Madrid, Spain. IdiPAZ. Spanish Clinical Research Network-SCReN; ⁶Department of Clinical Pharmacy, San

Cecilio University Hospital, Institute for Biomedical Research, IBS, Granada, Spain; ⁷Departamento de Genética, Universidade Federal do Rio Grande do Sul, Porto Alegre, Brazil; ⁸William Harvey Research Institute, Barts & the London Medical School, Queen Mary University of London, London EC1M 6BQ, UK; ⁹Princess Al-Jawhara Al-Brahim Centre of Excellence in Research of Hereditary Disorders (PACER-HD), King Abdulaziz University, Jeddah, Saudi Arabia; ¹⁰Center for Hyperbaric Medicine and Tissue Repair, Marshfield Clinic, Marshfield, WI, USA; ¹¹Grants Office Gundersen Health System La Crosse, WI, USA; ¹²Clinical Research Center, Marshfield Clinic Research Foundation, Marshfield, WI, USA; ¹³Department of Pharmacy Practice, University of Illinois at Chicago, Chicago, Illinois, USA; ¹⁴School of Pharmaceutical Sciences, Sun Yat-Sen University, Guangzhou, China; ¹⁵Guangzhou Women and children's Medical Center, China; ¹⁶Hospital Universitario Morales Meseguer. Centro Regional de Hemodonación Universidad de Murcia, Spain; ¹⁷Research Group for Pharmacogenomics, RIKEN Center for Integrative Medical Sciences, Yokohama, Japan; ¹⁸Division of Clinical Pharmacology, Department of Medicine, University of Western Ontario, London, Ontario, Canada; ¹⁹Department of Clinical Pharmacology & Genetics, School of Pharmaceutical Sciences, University of Shizuoka, 52-1, Yada, Suruga-ku, Shizuoka 422-8526, Japan; ²⁰Faculty of Health Sciences, Laboratory of Medical genetics, Universidad Tecnológica de Pereira, Colombia; ²¹Faculty of Health Sciences, Unidad Central del Valle del Cauca, Colombia; ²²Clinical Laboratory Department. Hospital La Línea, Spain; ²³Centre for Public Health. School of Medicine, Dentistry and Biomedical Sciences. Queen's University Belfast, Belfast, BT9 7AB. Northern Ireland, United Kingdom; ²⁴Department of Pharmacology, Oslo University Hospital, Ullevål, Oslo, Norway. Center for Psychopharmacology, Diakonhjemmet Hospital, Oslo, Norway; ²⁵Department of Medical Biochemistry, Oslo University Hospital, Ullevål, Oslo, Norway; ²⁶College of Pharmacy and Division of Life and Pharmaceutical Sciences, Ewha Womans University, Seoul 120-750, Korea; ²⁷College of Pharmacy, Chunbuk National University, Cheongju-si, Korea; ²⁸Genomic Medicine Institute, Geisinger Health System, Danville, PA, USA and National Center for Genome Medicine, Institute of Biomedical Sciences, Academia Sinica, Taipei, Taiwan; ²⁹Cardiac Arrhythmia Service & Cardiovascular Research Center, Massachusetts General Hospital, Boston, Massachusetts, USA; ³⁰Department of Genetics and Genomic Sciences, Icahn School of Medicine at Mount Sinai, New York, NY 10029, USA; ³¹CEINGE– Biotecnologie Avanzate s.c.ar.l., Napoli, Italy, Dipartimento di Medicina Molecolare e Biotecnologie Mediche, Università di Napoli Federico II, Napoli, Italy; ³²Department of Pharmacology, Yeditepe University, Turkey; ³³College of Medicine & Health Sciences, Sultan Qaboos University, Muscat, Oman; ³⁴INSERM, UMR_S 763, Paris, France; ³⁵Ecole Pratique des Hautes Etudes, UMRS_951, Genethon, Evry, France; ³⁶Sorbonne Paris Cité, INSERM UMR-S-1140, Université Paris Descartes, Paris, France and Assistance Publique Hôpitaux de Paris, Hôpital Lariboisière, Service d'Hématologie Biologique, Paris, France; ³⁷Sorbonne Paris Cité, INSERM UMR-S-1147, Université Paris Descartes, Paris, France and Assistance Publique Hôpitaux de Paris, Hôpital Européen Georges Pompidou, Service de Biochimie UF Pharmacogénétique et Oncologie Moléculaire, Paris, France; ³⁸Department of Clinical Pharmacology & Therapeutics, Nizam's Institute of Medical Sciences, Punjagutta, Hyderabad, India; ³⁹Coordenação de Pesquisa, Instituto Nacional de Câncer, Rio de Janeiro, RJ, Brazil; ⁴⁰Research Laboratory of Pharmaceutical Sciences, West Zone State University - UEZO, Rio de Janeiro, Brazil; ⁴¹Department of Medicine and Department of Biomedical Informatics, Vanderbilt University in Nashville, TN, USA; ⁴²Department of Medicine, Vanderbilt University in Nashville, TN, USA; ⁴³Department of Biotechnology Babasaheb Bhimrao Ambedkar University Lucknow-226025 India; ⁴⁴Department of Genetics, Stanford University School of Medicine, Stanford, CA 94305, USA; ⁴⁵Department of Pharmacotherapy and Translational Research, Center for Pharmacogenomics, College of Pharmacy, University of Florida, Gainesville, Florida, USA; ⁴⁶College of Pharmacy, Gulf Medical University, Ajman, United Arab Emirates; ⁴⁷Department of Neurology, University of Alabama at Birmingham, 1235 Jefferson Tower, 625 19th Street South, Birmingham AL 35294-0021; ⁴⁸Department of Epidemiology, Richard M. Fairbanks School of Public Health, Indiana University Purdue University Indianapolis; ⁴⁹Mochtar Riady Institute for Nanotechnology, Universitas Pelita Harapan, Lippo Karawaci, Tangerang, Banten, Indonesia; ⁵⁰Institute of Clinical Pharmacology, Central South University; ⁵¹Department of Pharmacy, Xiangya Second Hospital, Central South University; ⁵²Laboratory of Molecular Cardiology, Institute of Cardiology, Lithuanian University of Health Sciences; ⁵³Division of Pharmacoepidemiology and Clinical Pharmacology, Faculty of Science, Utrecht University, PO; ⁵⁴Department of Respiratory Medicine, Academic Medical Center, University of Amsterdam, Amsterdam, The Netherlands; ⁵⁵Department of Applied Health Research, University College London, London, UK; ⁵⁶Division of Pharmacoepidemiology and Clinical Pharmacology, Utrecht Institute for Pharmaceutical

Sciences, Utrecht University, Utrecht, The Netherlands; ⁵⁷Ottawa Hospital Research Institute, Clinica Epidemiology Program and Department of Epidemiology and Community Medicine, University of Ottawa, Ottawa, Ontario, Canada; ⁵⁸Department of Medicine-DIMED, University of Padua, Padua, Italy; ⁵⁹Department of Cardiac, Thoracic and Vascular Sciences, University of Padua, Padua, Italy; ⁶⁰Wolfson Centre for Personalised Medicine, Department of Molecular and Clinical Pharmacology, University of Liverpool, Liverpool, UK.

*E.D. and S.R. contributed equally to the work

*J.A.J. and C.F. contributed equally to the work

Correspondence and requests for reprints to:

Cristiano Fava, MD, PhD

Department of Medicine,

Division of General Medicine and Hypertension,

Piazzale L.A. Scuro 10,

37134 Verona, Italy.

Tel: +39 45 8124414;

fax: +39 45 8027465;

e-mail: cristiano.fava@univr.it

cristiano.fava@med.lu.se

Conflict of interest: There are no competing interests to declare.

Funding

P.D. is supported by British Heart Foundation (BHF) grant RG/14/5/30893; this study forms part of the research themes contributing to the translational research portfolio of Barts Cardiovascular Biomedical Research Centre which is funded by the National Institute.

The study was supported by a grant by CARIVERONA foundation.

Keywords: coumarin drugs; pharmacogenetics; *CYP4F2*; *VKORC1*; *CYP2C9*; meta-analysis; predictive models.

Running title: Meta-analysis of *CYP4F2* and coumarin dose.

ABSTRACT

The *CYP4F2* gene is known to influence mean coumarin dose. The aim of the present study was to undertake a meta-analysis at individual patients' level to capture the possible effect of ethnicity, gene-gene interaction or other drugs on the association and to verify if inclusion of *CYP4F2**3 variant into dosing algorithms improves the prediction of mean coumarin dose. We asked the authors of our previous meta-analysis (30 articles) and of 38 new articles retrieved by a systematic review to send us individual patients' data. The final collection consists 15,754 patients split into a derivation and validation cohort. The *CYP4F2**3 polymorphism was consistently associated with an increase in mean coumarin dose (+9% (95%CI 7-10%)), with a higher effect in females, in patients taking acenocoumarol and in Whites. The inclusion of the *CYP4F2**3 in dosing algorithms slightly improved the prediction of stable coumarin dose. New pharmacogenetic equations potentially useful for clinical practice were derived.

INTRODUCTION

Coumarins have proved to be effective in the treatment of thromboembolic disease and despite the introduction of direct oral anticoagulants, they remain one of the most widely prescribed family of drugs worldwide.¹

The narrow therapeutic index and high inter-individual variability in therapeutic dose make coumarin therapy difficult to manage. Many studies have showed two genes, *CYP2C9* and *VKORC1*, that are associated with variation in warfarin, phenprocoumon and acenocoumarol maintenance doses requirement and have suggested some clinical benefits from genotype-guided dosing.² On the basis of such data, the Food and Drug Administration (FDA) has updated the label for warfarin twice, advising that two variants in the *CYP2C9* gene (C144R and I359L) and one in the *VKORC1* gene (G-1639A) might be taken into consideration when initiating warfarin therapy (Warfarin (Coumadin) product labeling, FDA. http://www.accessdata.fda.gov/drugsatfda_docs/label/2011/009218s107lbl.pdf).

Although there have been contradictory results in randomized clinical trials (RCTs) about the utility of genotype-guided dosing of coumarin drugs when compared with either standard clinical care or clinical algorithms,³⁻⁵ a recent RCT in patients undergoing elective hip or knee arthroplasty⁶ showed superiority of genetic dosing compared with clinical dosing. Some but not all meta-analyses have also shown an improvement in clinical endpoints such as bleeding events.^{3,7-11} Moreover, none of the trials included in the meta-analyses included *CYP4F2**3 polymorphism (1347C>T; c.1297G>A; p.Val433Met; rs2108622), whose effect on coumarin dose was discovered later when compared with *CYP2C9* and *VKORC1*.¹²

Our previous meta-analysis performed on aggregate data from 30 studies, showed that *CYP4F2* variation was associated with nearly 8% higher coumarin doses in T allele carriers. Indeed, a possible gene-gene interaction and an effect of race on the genetic effect was detected.¹³ Despite the low effect size, *CYP4F2* is currently regarded as the third most influential genetic locus with respect to coumarin drug maintenance dose. Older studies, which compared pharmacogenetic algorithms

with either clinical-based algorithms or fixed dose approach, did show a possible improvement in prediction only in selected subgroups.^{14,15} The incorporation of *CYP4F2* into existing models might improve the accuracy of dose prediction with coumarins.^{16,17} Recently, the Clinical Pharmacogenetics Implementation Consortium updated the guidelines for *CYP2C9* and *VKORC1* genotypes and warfarin dosing including evidence from the published literature for the non-synonymous variant *CYP4F2**3 (1347C>T; c.1297G>A; p.Val433Met; rs2108622) which was found to be significantly associated with altered dose requirements for coumarin anticoagulants.² In order to clarify the actual clinical utility of including the *CYP4F2* polymorphism into pharmacogenetic dosing algorithms, some essential information is needed. Thus, we performed a meta-analysis at individual patients' level to understand the real effect size of this polymorphism and to test how much either a possible gene-gene interaction or the effect of ethnicity or other covariates could modify the pharmacogenetic association and prove to be useful in creating new pharmacogenetic equations. We hereby provide the largest meta-analysis of *CYP2C9*, *VKORC1* and *CYP4F2* polymorphisms affecting the dose of warfarin and acenocoumarol in samples collected from 25 different countries, including more than 15,000 participants treated with coumarin drugs. New pharmacogenetic equations potentially useful for clinical practice have been derived for different ethnic groups.

RESULTS

Characteristics of included studies

Starting from the 30 articles included in our previous meta-analysis (search from inception till August 2011), individual patient data were obtained from 19 studies.^{12,18-35} From one co-author we obtained an additional dataset related to an article not previously included because no data about the *CYP4F2* polymorphism were present in the original publication.³⁶ From the group of 38 articles retrieved from the new search (from September 1, 2011 to September 14, 2016), individual patient data were obtained from 18 studies.^{16,17,37-52}

Thus, 38 articles were included in the present work from authors who agreed to share individual patient data: 20 from the first systematic search, 18 from the second systematic search. Data from one study were divided into two distinct cohorts according with the main author subdivision of sample into discovery and validation cohorts.⁴⁶ Moreover, data from two studies had been collected in one cohort.^{16,43} Finally, data from one study was divided into two cohorts, one cohort treated with acenocoumarol and the other with phenprocoumon treatment.⁴⁴ This resulted in 39 cohorts were considered for the meta-analysis including a total of 15,754 patients. Characteristics of the individual studies are summarized in **Table 1**. Thirty-one cohorts examined the association between *CYP4F2* polymorphism and the maintenance dose of warfarin, 7 cohorts evaluated this association for acenocoumarol and one for phenprocoumon. Information on *CYP4F2*, *VKORC1* and *CYP2C9*3* genotyping were available for all 39 cohorts, while *CYP2C9*2* genotype was recorded for 35 out of the 39 (89.7%) cohorts. All studies but one¹⁹ included both male and female participants with a minimum of 24% males. One study selected very elderly patients (mean age 86.7 years).³⁵ Data on BMI and drugs known to potentially interfere with warfarin were available for 31 and 27 cohorts respectively. All studies were published between 2006 and 2016.

Association between *CYP4F2*3* polymorphism and stable coumarin dose

Figure 1 shows the forest plot for the difference in log dose of warfarin for subjects with at least one T-allele (CT+TT) *CYP4F2* as compared to wild-type (CC) subjects, according to a dominant model. The estimated effect size was 0.09 (95%CI 0.07 to 0.10), corresponding to a 9% increase in mg/week (95%CI 7-10%). The funnel plot (see **Figure S1**) is compatible with no effect of bias on publication.

Separate estimates for CT and TT *CYP4F2* genotypes are reported in **Figure S2**: the estimated effect size for CT vs CC subjects is 0.07 (95%CI 0.06 to 0.08), corresponding to a 7% increase in mg/week; while for TT vs CC subjects it is 0.17 (95%CI 0.15 to 0.19), corresponding to a 19% increase in mg/week. In **Table 2** the analysis of the available subgroups highlights that the effect of

the *CYP4F2**3 polymorphism is significant in Whites and Asians but not in Blacks and other ethnic groups. Moreover, there was a significant difference by gender for the effect of the *CYP4F2* polymorphism on coumarin dose (the effect is significantly higher in females) and by type of coumarin drugs (the effect was lower for warfarin as compared to acenocoumarol). No significant difference in the effects of smoking, target INR, adjustment for other drugs, consistency of genotype frequencies with the HW equilibrium, quality score and other polymorphisms was found (**Table 2**). The figures for the different meta-analyses in subgroups are presented in **Supplementary Figure S3 and S4**.

Stable coumarin dose predictive model

Table 3 presents the predictive model for logarithm of stable coumarin dose according to patients' clinical and genetics characteristics. As statistical test for model fit (R^2) is reported for both the test and validation cohorts. Looking at our calculated model on the whole dataset, adjusted R^2 was slightly higher for models including *CYP4F2**3 polymorphisms than for models without *CYP4F2**3 for all the ethnic groups except Blacks (for warfarin dose, adjusted R^2 for models with and without *CYP4F2**3 polymorphism were, respectively, 0.51 and 0.50 for Whites; 0.43 and 0.42 for Asians; 0.27 and 0.27 for Blacks). For cohorts that included Black patients, addition of the *CYP2C9**5 SNP to the models did not result in substantial improvement of the adjusted R^2 (**Table 3**). Further prediction models also including concomitant drugs (amiodarone, etc.) and smoking habits are presented in **Supplementary Table S1**.

Beta coefficients for single gene and gene-gene interaction are presented in **Table 4** for each ethnicity and drug subgroups.

The effect of potentially interacting drugs could be evaluated only on a subsample of the cohorts and is presented in **Supplementary Table S2**. Patients taking amiodarone or drugs classified as CYP inhibitors required a lower dose whereas patients taking CYP inducers required a higher dose of coumarin drugs. If the effect of the drugs was considered, the beta estimate for *CYP4F2* and the

other SNPs varied slightly but remained significant for most analyses. No significant interaction between SNPs and drugs were detectable apart from *CYP2C9*2* and rifampin and all CYP inhibitors and all CYP inducers in Whites consuming acenocoumarol. Another weak but nominally significant interaction was present between *CYP2C9*2* and statin or aspirin in Black patients on chronic warfarin therapy (**Supplementary Table S2**).

DISCUSSION

In our previous meta-analysis on the effect of the *CYP4F2* rs2108622 (1347C>T; c.1297G>A; p.Val433Met; *CYP4F2*3*) we found that the estimated effect size was nearly 10%. In this individual patient data meta-analysis we have not only confirmed this finding in a larger cohort of primary studies that include all the available study-specific covariates, but can add other important findings. Contrary to what was found in the first meta-analysis, a slight but significant effect of gender was so identified such that males had a lower effect of the T-allele when compared to females. Indeed, a higher dose of coumarin drugs was needed in carriers of the T-allele if they were Whites or Asians but not in Blacks or in other ethnic groups (Indians, Browns from Brazil, Egyptians), but the latter is probably a reflection of the lower sample size. We also identified differences between different coumarin drugs: patients taking acenocoumarol and carrying the T-allele needed a higher dose of the drug when compared with patients taking warfarin and carrying the same polymorphism.

There was no effect of other possible important covariates, such as smoking, age and indication for coumarin, and no interactions with the other relevant polymorphisms were found.

Evaluation of the beta estimate of the tested SNPs, confirmed that the larger effect is due to the *VKORC1* followed by *CYP2C9*, while *CYP4F2* had a limited effect size.

Looking at primary studies, the large majority of them are in line with the results of the meta-analysis and only 4 out of the 39 have a central point of the estimate below the 0 line. Even the point estimate for the effect of *CYP4F2* is not so different between primary studies. the extremes

being the study performed by Borgiani with a +0.26 estimate and the one by Isaza with a -0.05 which however have a 95%CI which is around to +0.07, not far from our total effect size (slightly less than 10%).^{18,48}

However, the funnel plot shows a certain asymmetry, almost significant when analysed using Egger's. It is therefore possible that unpublished negative studies could affect the real estimate of the effect of the *CYP4F2**3 polymorphism.

Differently from our previous meta-analysis, we could add also drug as moderating parameters at least in some subgroups and, as expected, this evaluation decreased heterogeneity.

The functionality of the *CYP4F2* polymorphism has been shown in relation to the production of 20-HETE derived by arachidonic acid and in differences in mRNA production by liver cells in carriers of different alleles.⁵³

The interaction of the *CYP4F2* polymorphism with sex is not unexpected: also in other studies exploring other cardiovascular actions, some CYP polymorphisms have shown a differential effect in males and females probably due to an interaction with either androgens or estrogens.⁵⁴ Even in animal models these differences are evident, at least for blood pressure determination.⁵⁴

Due to our large sample size, we could calculate and subsequently validate different prediction models, that included the effect of the *CYP4F2**3, the other well-known polymorphisms of *CYP2C9* and *VKORC1*, and the other covariates differentiating the effect of gender and ethnicity and obtaining discrete coefficient of determinations that indicate a good fit of the models. Other predictive pharmacogenetics equations estimating coumarin dose have been developed using large samples sizes,^{14,15} but both the International Warfarin Pharmacogenetics Consortium and the "Warfarin dosing" equations used only *CYP2C9* and *VKORC1* genetic variation to estimate warfarin dose and the R² estimate for the final model (which also included amiodarone), obtaining values of 0.47 and 0.53 respectively. These results are in line with our data for white subjects but our results are more generalizable since multiple cohorts from Europe were also included. In fact, Gage's equation is derived from a more homogeneous group of patients collected in 3 centers in the

US (St. Louis, San Antonio and Gainesville) with a 4th trial included in the validation cohort.¹⁴ By contrast, the *International Warfarin Pharmacogenetics Consortium* (IWPC) collected 21 research groups from 9 different countries and finally include only patients with a target INR between 2-3 (n=5,052). Their final model was not divided according to ethnicity but instead the ethnicity variable was added in the model. Indeed, outlier patients were excluded from the final analysis. It is worth mentioning that the final sample size of our study is more than 2 times the previous studies for warfarin and we have also calculated predictive models for acenocoumarol.

Even if newer anticoagulants have substantially changed clinical practice especially in developed countries, the use of coumarin drugs is still widespread in the world, so that equations like the one derived from our study will be clinically useful for many years. The importance of genotype has been further shown in the ENGAGE AF-TIMI 48 trial, which compared the clinical efficacy of edoxaban, a direct oral anticoagulant, with warfarin, in a pre-specified genetic sub-analysis. Stratification of patients according to *CYP2C9* and *VKORC1* polymorphisms revealed that the three groups identified, normal responders, sensitive responders, and highly sensitive responders, the last group were found to spend a greater proportion of time over-anticoagulated compared with normal responders, but only for the first 90 days of treatment.⁵⁵

RCTs using not only the *CYP2C9* and *VKORC1* polymorphism but also the *CYP4F2* polymorphism have recently been performed. In non-valvular atrial fibrillation no apparent advantage was found for the group randomized to genotype base dose⁵⁶ but in a recent trial in patients aged 65 years or older initiating warfarin for elective hip or knee arthroplasty conducted at 6 US medical centers, genotyping reduced the combined risk of major bleeding, INR of 4 or greater, venous thromboembolism, or death.⁶

In another trial that compared a genotype-guided algorithm vs physician management for the initiation of acenocoumarol, a higher proportion of patients in the genetic group reached and maintained a steady dose than patients randomized to routine practice when starting oral anticoagulation.⁵⁷

Limitations and strengths of the study

Our individual-data meta-analysis has limitations. First, although we applied a sensitive search strategy for the retrieval of potentially eligible studies, we cannot rule out the possibility that some relevant studies might not have been included. Indeed, not all the potentially eligible studies were added to the meta-analysis because the authors did not share individual patient' data. Second, adjustment for certain covariates such as amiodarone was possible in only a limited sample of patients. The quality score of the included studies was heterogeneous, ranging from 3 to 7 (median: 5), but this did not affect *CYP4F2**3–coumarin dose association, since we found no statistically significant difference in the estimates for studies with lower and higher quality score. Finally, our genotyping-based algorithms in Blacks have low predictivity even including the *CYP2C9**5 polymorphism, probably because we could not include more variants in *CYP2C9* that were demonstrated to be especially important in this ethnic group.² Since the exclusion of specific *CYP2C9* variants from the dosing algorithm in Blacks can lead to overdosing, we would recommend against the use of the specific dosing algorithms in patients of African ancestry² until more specific algorithms have been developed.

Strengths of our collaborative study are the large sample size with several ethnic groups allowing for generalizability of the results and the possibility to have equations not only for warfarin but also for acenocoumarol based on a quite large sample size. The heterogeneity was low possibly because most of the variables associated with mean coumarin dose have been considered in our models.

Conclusion

In conclusion, we have undertaken the largest individual patient data meta-analysis, including the *CYP4F2* polymorphism, in patients taking warfarin or other coumarin drugs. Our data show that the *CYP4F2* rs2108622 polymorphism affects the dose requirements of these drugs in Whites and Asians but not in Blacks or other ethnic groups. We also provide reliable prediction models that can

guide physicians to estimate the stable dose of warfarin according to genotypes, anthropometric and demographic factors, ethnicity, and the use of other drugs.

METHODS

Search strategy and eligibility criteria

The 30 articles included in our previous meta-analysis were considered all potentially eligible for the present study.¹³ To expand our search to articles published after the date fixed for final inclusion in the previous meta-analysis, we searched Medline and Web of Science from September 1, 2011 to September 14, 2016 by applying the same search algorithm used previously (see Supplementary material) and found 38 additional studies that could potentially be included (see flow diagram) according to the inclusion criteria (see Supplementary material). All 68 studies evaluated for inclusion were clinical cohort or cross-sectional studies that have performed genotyping of *CYP4F2* in combination with *CYP2C9* (at least one out of the two variants of interest) and/or *VKORC1* in coumarin treated patients. As per our previous study, we considered the following polymorphisms: rs2108622 (1347C>T; 1297G>A; p.Val433Met; CYP4F2*3) for *CYP4F2*, rs1799853 (430C>T) and rs1057910 (1075A>C) for *CYP2C9* (also known as *CYP2C9*2* and *CYP2C9*3*); rs9923231 (-1639 G>A) for *VKORC1*. In relation to the latter variant, we also included data from studies that used the two alternative polymorphisms: rs9934438 (1173C>T) in the *VKORC1* gene which is in complete linkage disequilibrium (LD) with the reference polymorphism and rs10871454 (-1168C>T) located in the Syntaxin 4 A-placental (*STX4A*) gene, flanking the *VKORC1* gene, which showed a LD of 0.99 with the reference polymorphism.

In our previous analysis, consistent with published studies, the performance of our regression was low, especially in Blacks, where an effect of other SNPs especially in *CYP2C9* is considered important. Thus, in the 5 cohorts where at least the *CYP2C9*5* variant was available we repeated the analysis by adding this polymorphism.

Data collection

We asked the first/last or corresponding authors of the retrieved primary studies to participate in a collaborative meta-analysis on individual patient data. Authors who were willing to collaborate were finally included if their original database contained the following mandatory data for single patients: sex, age, race, genotypes, indication for coumarin therapy, INR target, type of coumarin used and maintenance dose. Additional information on body weight, height and use of interacting drugs were also recorded when available. Each cohort has been assigned to one single study unless otherwise specified. For studies containing overlapping samples we considered the first published study or the one that enrolled the largest number of patients. Data were harmonized into a pooled database. Two researchers (ED and MM) cross-checked trial details provided by the authors against published articles. Any inconsistencies were discussed with the original trialists and corrections were made when appropriate. As for our previous meta-analysis, we graded the quality of epidemiologic studies in general, applying items taken from the Newcastle–Ottawa Quality Assessment Scale for Cohort Studies indicators specific to the quality of genetic association studies, and indicators specific for coumarin (e.g., stable anticoagulation). Quality assessment also included departure from Hardy–Weinberg equilibrium, that was calculated by the Chi Square test in controls. We applied a scale with a maximum score of 7 points (see supplementary material for details).

Statistical analysis

Two-stage analysis for the association between CYP4F2*3 polymorphism and stable coumarin dose

We calculated study-specific estimates, with 95% Confidence Intervals (CI), for the difference in log dose of coumarin for subjects with at least one *CYP4F2* T-allele (CT+TT) compared to wild-type (CC) subjects, according to a dominant model. Separate estimates for CT and TT genotypes were also calculated as a sensitivity analysis. These study-specific estimates were obtained by fitting general linear models with log dose of coumarin as the dependent variable and *CYP4F2*3*

polymorphism as the independent variable. All the models were adjusted for available study-specific covariates, including: age, sex, race, BMI, smoking status, indication for coumarin treatment, INR target, concomitant drugs, *CYP2C9**2 and *3 polymorphisms, and *VKORC1* polymorphism.

Following the two-stage analysis approach, we pooled study-specific estimates with random-effects models, using the DerSimonian and Laird method (see Supplementary methods for reference). We evaluated homogeneity among study-specific estimates by the Q statistic and I^2 , which represents the percentage of total variation across studies that is attributable to heterogeneity rather than to chance (see Supplementary methods for reference). We performed meta-regression analysis to assess the influence on Summary Estimates (SE) of different study features: type of drugs (acenocoumarol/warfarin), sex, ethnicity (Whites/Asians/Blacks/Others), INR target (<2.5/2.5/>2.5), current smoking status, study adjustment for concomitant drugs (yes/no), deviation from Hardy-Weinberg (HW) equilibrium, quality score (<5/≥5), *CYP2C9**2/*3 (wild-type/any polymorphism) and *VKORC1* (wild-type/any polymorphism). When significant differences according to specific study factors were suggested by meta-regression, stratified analyses were performed for *CYP4F2**3-coumarin dose association on subgroups of significant factors.

We assessed possible participation bias by drawing funnel plots and by Egger's test (see Supplementary methods for reference).

P-values <0.05 were considered statistically significant for all the tests apart from the Q statistic, where p-values<0.10 were considered statistically significant. The analysis was carried out using the SAS (version 9.4) and STATA (version 13) software.

Stable coumarin dose predictive model

Due to significant differences in coumarin dose and *CYP4F2**3 association for different drugs and ethnic groups, the individual data analysis on the pooled dataset was always reported for each type of drug (acenocoumarol/warfarin) and for each ethnic group.

For each ethnic and drug subgroup, we randomly chose 2/3 of patients as the “derivation cohort” for developing dose-prediction models, while the remaining 1/3 of the patients constituted the “validation cohort,” which was used for testing the final selected model. In order to keep a large sample size for prediction model construction, we included covariates which were available in the majority of studies (Table 1): age, BMI, sex, indication for treatment, *CYP4F2**3, *CYP2C9**2, *3 and *5 (for Blacks), and *VKORC1* polymorphisms, by using general linear models with log dose of coumarin as dependent variable. To use an additive genetic model, we coded the number of variant alleles at each locus as 0, 1, or 2. Sensitivity analyses were also conducted on the whole cohort of subjects by including further available covariates collected in a smaller number of studies (concomitant drugs, especially amiodarone, and smoking status), to assess their role in stable coumarin dose prediction. The coefficient of determination (R^2) was calculated both for the main prediction model on the “derivation cohort” and for models included in sensitivity analyses. We applied the scores obtained from the main prediction model to the validation data set and also calculated the R^2 .

For the sake of comparison, we also applied scores obtained from two previously published models for warfarin dose prediction^{14,15} to our validation cohort and converted the scores to units of mg/week. In order to correctly compare our proposed model with each of the two previously published models, R^2 was calculated on the subset of subjects for whom both scores could be calculated on the basis of available data. In order to assess the importance of *CYP4F2**3 on warfarin dose prediction in our data, we also compared dose predictions from our pharmacogenetic model including *CYP4F2**3 in the whole dataset with that from our model excluding *CYP4F2**3 by using the adjusted R^2 as defined by Darlington (see Supplementary methods for reference).

Gene-gene and gene-drug interactions were investigated by adding an interaction term to the main prediction model fitted on the whole cohort of subjects (for each drug/ethnicity subgroup), in order to have the largest sample size to test for interaction. Moreover, we performed subgroup analyses

according to the use or not of specific concomitant drugs, to evaluate whether the change in coumarin dose associated with specific gene polymorphisms were modified by concomitant drugs. P-values <0.05 were considered statistically significant. The analyses were carried out using SAS (version 9.4) software.

Study Highlights:

- In this single-patient meta-analysis we confirm that *CYP4F2*3* influences mean coumarin dose especially in females, in patients taking acenocoumarol and in Whites.
- New pharmacogenetics equations potentially useful for clinical practice have been derived for different ethnic groups.

Acknowledgments

E.D., S.R., M.M., J.A.J, A.T., C.F. contributed to study concept and design. A.T., A.G., M.M., E.D. performed systematic search, extraction and tabulation of data. T.L., P.B., C.C., A.J.C., A.M.B., H.Y.T., C.D-F. M.R.B., S.B., P.D., M.D.C., J.K.B., R.L.B., L.H.C., K.D., M.H., L-Z.Z., H-J.C., R.G-C., V.R., Y.N., T. M., I.Y.G. R.B.K., K.H., K.I., C.I., L.B., E.J-V., M.C-G, M.K.K., K.B.F.H, H.S.G., K.E.L., M.T.M.L., S.A.L., S.S., C.M., L.S., E.G., M.Ö., A.P., R.K., A.P., V.S., M-A.L., V.K.K., G.S-K., J.P., J.C.D., A.H.R., B.M., S.S.R., H.S., R.A., M.H.A.S, S.I.K., N.A.L., C.R., A.S., C.D., I.M.S., H-H.Z., S-L.T., V.T., V.L., Y.Z., A.H.M-vdZ, T.I.V., A.dB., M.T., C.F.Z., V.P., J.E.Z., M.P. & J.A.J contributed to acquisition of genotyping or phenotypic data. E.D., S.R., A.G., P.M. contributed to statistical analysis and interpretation of the data. E.D., S.R, C.F., J.A.J contributed to drafting of the manuscript. All authors contributed to critical revision of the manuscript.

References

1. FDA Institute for Safe Medication Practices (2016). Quarter Watch Monitoring FDA

MedWatch Reports. Annual Report Issue. (2016).

2. Johnson, J. A. *et al.* Clinical Pharmacogenetics Implementation Consortium (CPIC) Guideline for Pharmacogenetics-Guided Warfarin Dosing: 2017 Update. *Clin. Pharmacol. Ther.* 102, 397–404 (2017).
3. Stergiopoulos, K. & Brown, D. L. Genotype-guided vs clinical dosing of warfarin and its analogues: meta-analysis of randomized clinical trials. *JAMA Intern. Med.* 174, 1330–8 (2014).
4. Pirmohamed, M. *et al.* A Randomized Trial of Genotype-Guided Dosing of Warfarin. *N. Engl. J. Med.* 369, 2294–303 (2013).
5. Kimmel, S. E. *et al.* A Pharmacogenetic versus a Clinical Algorithm for Warfarin Dosing. *N. Engl. J. Med.* 369, (2013).
6. Gage, B. F. *et al.* Effect of Genotype-Guided Warfarin Dosing on Clinical Events and Anticoagulation Control Among Patients Undergoing Hip or Knee Arthroplasty. *JAMA* 318, 1115 (2017).
7. Li, X. *et al.* Clinical benefits of pharmacogenetic algorithm-based warfarin dosing: meta-analysis of randomized controlled trials. *Thromb. Res.* 135, 621–9 (2015).
8. Franchini, M., Mengoli, C., Cruciani, M., Bonfanti, C. & Mannucci, P. M. Effects on bleeding complications of pharmacogenetic testing for initial dosing of vitamin K antagonists: a systematic review and meta-analysis. *J. Thromb. Haemost.* 12, 1480–7 (2014).
9. Shi, C. *et al.* Pharmacogenetics-Based versus Conventional Dosing of Warfarin: A Meta-Analysis of Randomized Controlled Trials. *PLoS One* 10, e0144511 (2015).
10. Belley-Cote, E. P. *et al.* Genotype-guided versus standard vitamin K antagonist dosing algorithms in patients initiating anticoagulation. A systematic review and meta-analysis. *Thromb. Haemost.* 114, 768–77 (2015).
11. Wang, Z.-Q. *et al.* Pharmacogenetics-based Warfarin Dosing Algorithm Decreases Time to Stable Anticoagulation and the Risk of Major Hemorrhage. *J. Cardiovasc. Pharmacol.* 65, 364–370 (2015).

12. Caldwell, M. D. *et al.* CYP4F2 genetic variant alters required warfarin dose. *Blood* 111, 4106–4112 (2008).
13. Danese, E. *et al.* Impact of the CYP4F2 p.V433M Polymorphism on Coumarin Dose Requirement: Systematic Review and Meta-Analysis. *Clin. Pharmacol. Ther.* 92, 746–756 (2012).
14. Gage, B. *et al.* Use of Pharmacogenetic and Clinical Factors to Predict the Therapeutic Dose of Warfarin. *Clin. Pharmacol. Ther.* 84, 326–331 (2008).
15. Consortium, I. W. P. *et al.* Estimation of the Warfarin Dose with Clinical and Pharmacogenetic Data. *N. Engl. J. Med.* 360, 753–764 (2009).
16. Borobia, A. M. *et al.* An acenocoumarol dosing algorithm using clinical and pharmacogenetic data in Spanish patients with thromboembolic disease. *PLoS One* 7, e41360 (2012).
17. Rathore, S. S. *et al.* Therapeutic dosing of acenocoumarol: proposal of a population specific pharmacogenetic dosing algorithm and its validation in north Indians. *PLoS One* 7, e37844 (2012).
18. Borgiani, P. *et al.* CYP4F2 genetic variant (rs2108622) significantly contributes to warfarin dosing variability in the Italian population. *Pharmacogenomics* 10, 261–266 (2009).
19. Pérez-Andreu, V. *et al.* Pharmacogenetic relevance of CYP4F2 V433M polymorphism on acenocoumarol therapy. *Blood* 113, 4977–9 (2009).
20. Perini, J. A., Struchiner, C. J., Silva-Assunção, E. & Suarez-Kurtz, G. Impact of CYP4F2 rs2108622 on the stable warfarin dose in an admixed patient cohort. *Clin. Pharmacol. Ther.* 87, 417–20 (2010).
21. Sagreiya, H. *et al.* Extending and evaluating a warfarin dosing algorithm that includes CYP4F2 and pooled rare variants of CYP2C9. *Pharmacogenet. Genomics* 20, 407–13 (2010).
22. Shahin, M. H. A. *et al.* Genetic and nongenetic factors associated with warfarin dose requirements in Egyptian patients. *Pharmacogenet. Genomics* 21, 130–135 (2011).
23. Suriapranata, I. M. *et al.* Genetic factors associated with patient-specific warfarin dose in ethnic

- Indonesians. *BMC Med. Genet.* 12, 80 (2011).
24. Wells, P. S. et al. A regression model to predict warfarin dose from clinical variables and polymorphisms in CYP2C9, CYP4F2, and VKORC1: Derivation in a sample with predominantly a history of venous thromboembolism. *Thromb. Res.* 125, e259–e264 (2010).
 25. Zambon, C.-F. et al. VKORC1, CYP2C9 and CYP4F2 genetic-based algorithm for warfarin dosing: an Italian retrospective study. *Pharmacogenomics* 12, 15–25 (2011).
 26. Zhang, J. E. et al. Effects of CYP4F2 genetic polymorphisms and haplotypes on clinical outcomes in patients initiated on warfarin therapy. *Pharmacogenet. Genomics* 19, 781–9 (2009).
 27. Lee, M. T. M. et al. Genetic determinants of warfarin dosing in the Han-Chinese population. *Pharmacogenomics* 10, 1905–13 (2009).
 28. Botton, M. R., Bandinelli, E., Rohde, L. E. P., Amon, L. C. & Hutz, M. H. Influence of genetic, biological and pharmacological factors on warfarin dose in a Southern Brazilian population of European ancestry. *Br. J. Clin. Pharmacol.* 72, 442–50 (2011).
 29. Cavallari, L. H. et al. Genetic and Clinical Predictors of Warfarin Dose Requirements in African Americans. *Clin. Pharmacol. Ther.* 87, 459–464 (2010).
 30. Cen, H.-J. et al. CYP4F2 rs2108622: a minor significant genetic factor of warfarin dose in Han Chinese patients with mechanical heart valve replacement. *Br. J. Clin. Pharmacol.* 70, 234–40 (2010).
 31. Cha, P.-C. et al. Genome-wide association study identifies genetic determinants of warfarin responsiveness for Japanese. *Hum. Mol. Genet.* 19, 4735–44 (2010).
 32. Gong, I. Y. et al. Prospective evaluation of a pharmacogenetics-guided warfarin loading and maintenance dose regimen for initiation of therapy. *Blood* 118, 3163–71 (2011).
 33. Kringen, M. K. et al. Genetic variation of VKORC1 and CYP4F2 genes related to warfarin maintenance dose in patients with myocardial infarction. *J. Biomed. Biotechnol.* 2011, 739751 (2011).
 34. Lubitz, S. A. et al. Comparative performance of gene-based warfarin dosing algorithms in a

- multiethnic population. *J. Thromb. Haemost.* 8, 1018–26 (2010).
35. Pautas, E. et al. Genetic factors (VKORC1, CYP2C9, EPHX1, and CYP4F2) are predictor variables for warfarin response in very elderly, frail inpatients. *Clin. Pharmacol. Ther.* 87, 57–64 (2010).
 36. Aquilante, C. et al. Influence of coagulation factor, vitamin K epoxide reductase complex subunit 1, and cytochrome P450 2C9 gene polymorphisms on warfarin dose requirements. *Clin. Pharmacol. Ther.* 79, 291–302 (2006).
 37. Pathare, A. V et al. Warfarin pharmacogenetics: polymorphisms of the CYP2C9, CYP4F2, and VKORC1 loci in a genetically admixed Omani population. *Hum. Biol.* 84, 67–77 (2012).
 38. Pavani, A. et al. Optimization of warfarin dose by population-specific pharmacogenomic algorithm. *Pharmacogenomics J.* 12, 306–11 (2012).
 39. Ramirez, A. H. et al. Predicting warfarin dosage in European-Americans and African-Americans using DNA samples linked to an electronic health record. *Pharmacogenomics* 13, 407–18 (2012).
 40. Shendre, A. et al. Race-Specific Influence of CYP4F2 on Dose and Risk of Hemorrhage among Warfarin Users. *Pharmacotherapy* 36, 263–272 (2016).
 41. Tan, S.-L. L. et al. Cytochrome P450 oxidoreductase genetic polymorphisms A503V and rs2868177 do not significantly affect warfarin stable dosage in Han-Chinese patients with mechanical heart valve replacement. *Eur. J. Clin. Pharmacol* 69, 1769–1775 (2013).
 42. Tatarunas, V. et al. The effect of CYP2C9, VKORC1 and CYP4F2 polymorphism and of clinical factors on warfarin dosage during initiation and long-term treatment after heart valve surgery. *J. Thromb. Thrombolysis* 37, 177–85 (2014).
 43. Tong, H. Y. et al. A new pharmacogenetic algorithm to predict the most appropriate dosage of acenocoumarol for stable anticoagulation in a mixed Spanish population. *PLoS One* 11, e0150456 (2016).
 44. Van Schie, R. M. F. van, Aoussar, A., Meer, F. J. M. van der, Boer, A. de & Maitland-van der

- Zee, A. H. Evaluation of the effects of single-nucleotide polymorphisms in CYP3A4 and CYP4F2 on stable phenprocoumon and acenocoumarol maintenance doses. *J. Thromb. Haemost.* 11, 1200–1203 (2013).
45. Bourgeois, S. et al. A multi-factorial analysis of response to warfarin in a UK prospective cohort. *Genome Med.* 8, 2 (2016).
46. Cerezo-Manchado, J. J. et al. Creating a genotype-based dosing algorithm for acenocoumarol steady dose. *Thromb. Haemost.* 109, 146–153 (2013).
47. Hirai, K. et al. Plasma vitamin K concentrations depend on CYP4F2 polymorphism and influence on anticoagulation in Japanese patients with warfarin therapy. *Thromb. Res.* 135, 861–6 (2015).
48. Isaza, C. A. et al. Factores genéticos y ambientales asociados con la respuesta a warfarina en pacientes colombianos. *Biomedica* 30, 410–20 (2010).
49. Jiménez-Varo, E., Cañadas-Garre, M., Garcés-Robles, V., Gutiérrez-Pimentel, M. J. & Calleja-Hernández, M. Á. Extrapolation of acenocoumarol pharmacogenetic algorithms. *Vascul. Pharmacol.* 74, 151–157 (2015).
50. Lee, K.-E. et al. Effects of CYP4F2 gene polymorphisms on warfarin clearance and sensitivity in Korean patients with mechanical cardiac valves. *Ther. Drug Monit.* 34, 275–82 (2012).
51. Mazzaccara, C. et al. Warfarin anticoagulant therapy: a Southern Italy pharmacogenetics-based dosing model. *PLoS One* 8, e71505 (2013).
52. Özer, M. et al. Impact of Genetic Factors (CYP2C9, VKORC1 and CYP4F2) on Warfarin Dose Requirement in the Turkish Population. *BASIC Clin. Pharmacol. Toxicol.* 112, 209–214 (2013).
53. Zhang, J. E. et al. Effect of Genetic Variability in the CYP4F2, CYP4F11, and CYP4F12 Genes on Liver mRNA Levels and Warfarin Response. *Front. Pharmacol.* 8, 323 (2017).
54. Fava, C., Ricci, M., Melander, O. & Minuz, P. Hypertension, cardiovascular risk and polymorphisms in genes controlling the cytochrome P450 pathway of arachidonic acid: A sex-specific relation? *Prostaglandins Other Lipid Mediat.* 98, 75–85 (2012).

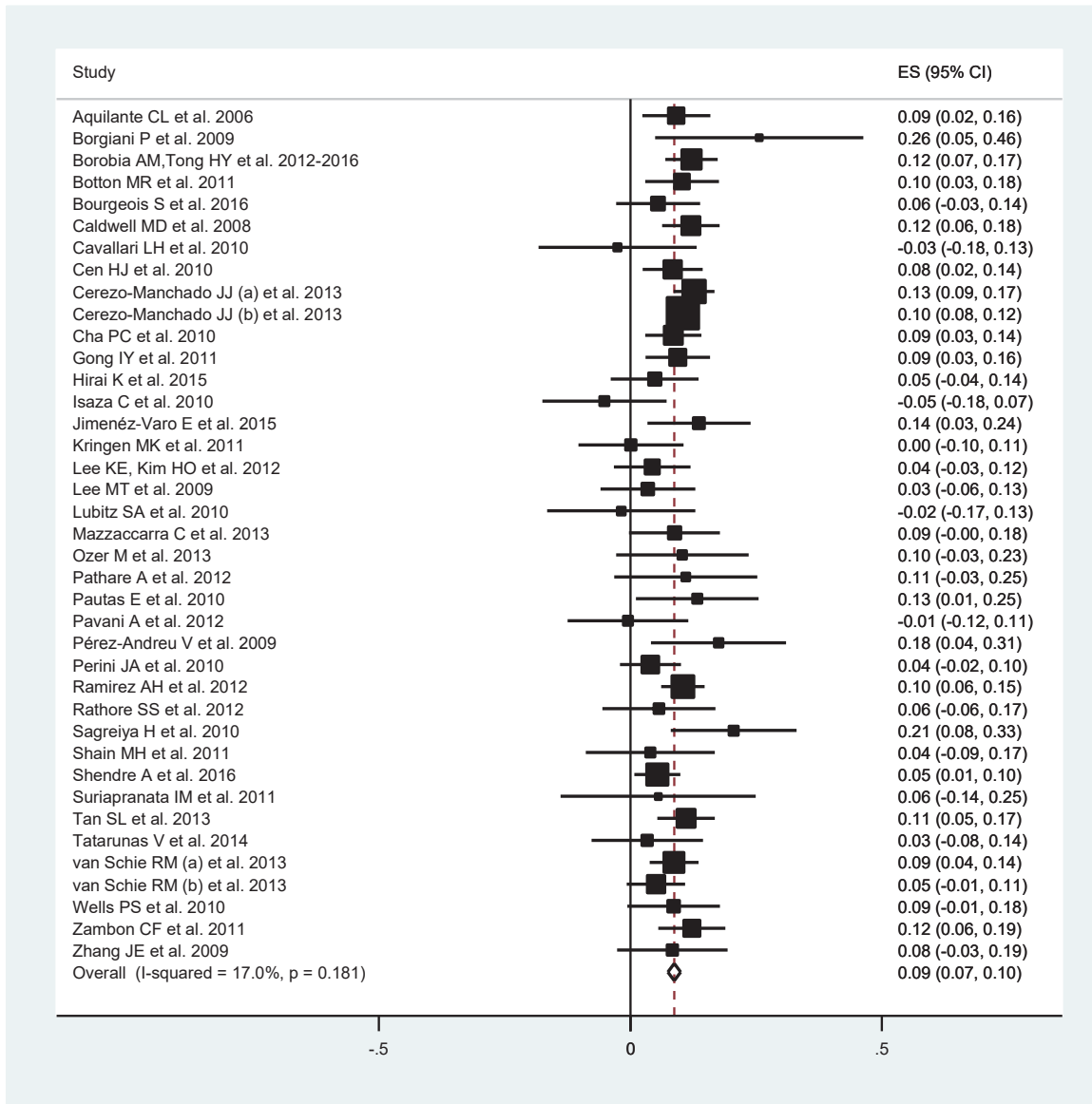
55. Mega, J. L. et al. Genetics and the clinical response to warfarin and edoxaban: findings from the randomised, double-blind ENGAGE AF-TIMI 48 trial. *Lancet (London, England)* 385, 2280–7 (2015).
56. Pengo, V. et al. A Randomized Trial of Pharmacogenetic Warfarin Dosing in Naïve Patients with Non-Valvular Atrial Fibrillation. *PLoS One* 10, e0145318 (2015).
57. Cerezo-Manchado JJ, Roldán V, Corral J, et al. Genotype-guided therapy improves initial acenocoumarol dosing: Results from a prospective randomised study. *Thromb. Haemost.* 2016;115(1):117–125.

Figures legends

Figure 1. Forest plot for the difference in logarithm of stable coumarin dose* for subjects with CYP4F2 polymorphism (CT+TT) compared to subjects with CYP4F2 wild-type (CC), according to dominant model.

Figure 1. Flow diagram.

Figure 1. Forest plot for the difference in logarithm of stable coumarin dose* for subjects with CYP4F2 polymorphism (CT+TT) compared to subjects with CYP4F2 wild-type (CC), according to dominant model



CI=Confidence Intervals; ES=Estimate

* exp(ES) gives the relative percentage difference as weekly dose in mg

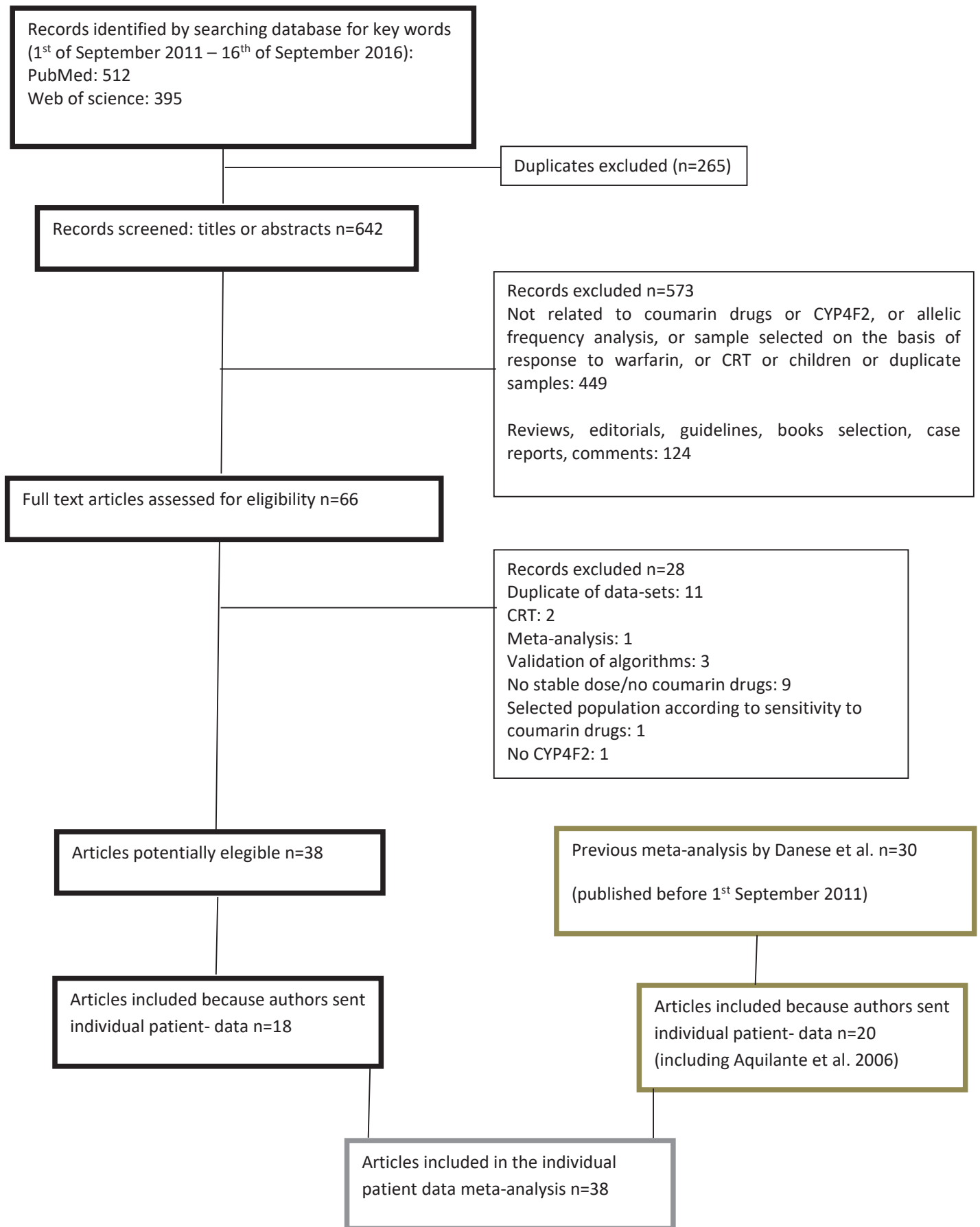


Table 1. Descriptive characteristics of studies included in the analysis

First author (ref)	PY	Country	Ethnicity	Subjects, n	Males (%)	Age, years (mean±sd)	Drug	INR target	Gene polymorphisms	Available confounders*
Aquilante CL ³⁶	2006	Florida (USA)	Whites (93%) Blacks (7%)	344	300 (87%)	69±11	Warfarin	2.5-3.5	CYP2C9*2, CYP2C9*3, CYP2C9*5, VKORC1, CYP4F2	Age, BMI, sex, smoking, indication for treatment
Borgiani P ¹⁸	2009	Italy	Whites	141	75 (53%)	69±12	Warfarin	2.0-4.0	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2	Age, sex, indication for treatment
Borobia AM, ¹⁶ Tong HY ⁴³	2012-2016	Spain	Whites (Spanish)	679	345 (51%)	68±13	Acenocumarol	2.0-3.0	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2	Age, BMI, sex, smoking, indication for treatment, other drugs
Botton MR ²⁸	2011	Brazil	Whites	279	155 (57%)	63±14	Warfarin	1.8-3.5	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2 [^]	Age, BMI, sex, smoking, other drugs
Bourgeois S ⁴⁵	2016	UK	Whites	217	119 (55%)	71±11	Warfarin	2.0-4.0	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2	Age, BMI, sex, smoking, indication for treatment, other drugs
Caldwell MD ¹²	2008	Wisconsin (USA)	Whites	429	252 (59%)	69±11	Warfarin	2.0-3.5	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2	Age, BMI, sex, indication for treatment, other drugs
Cavallari LH ²⁹	2010	Illinois (USA)	Blacks	208	57 (27%)	56±16	Warfarin	2.0-4.0	CYP2C9*2, CYP2C9*3, CYP2C9*5, VKORC1, CYP4F2	Age, BMI, sex, smoking, indication for treatment, other drugs
Cen HJ ³⁰	2010	China	Asians	221	103 (47%)	45±12	Warfarin	1.5-3.0	CYP2C9*3, VKORC1, CYP4F2	Age, BMI, sex, other drugs
Cerezo-Manchado JJ (a) ⁴⁶	2013	Spain	Whites	943	459 (49%)	75±9	Acenocumarol	2.0-3.5	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2	Age, sex, indication for treatment, other drugs
Cerezo-Manchado JJ (b) ⁴⁶	2013	Spain	Whites	3882	1916 (49%)	74±10	Acenocumarol	2.0-3.5	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2 [^]	Age, sex, indication for treatment, other drugs
Cha PC ³¹	2010	Japan	Asians	440	293 (77%)	68±11	Warfarin	1.5-3.0	CYP2C9*3, VKORC1, CYP4F2	Age, BMI, sex, indication for treatment, other drugs

Gong IY ³²	2011	UK	Whites (95%) Blacks (3%) Asians (2%)	167	96 (57%)	60±18	Warfarin	2.0-3.0	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2	Age, sex, indication for treatment
Hirai K ⁴⁷	2015	Japan	Asians	217	143 (66%)	68±10	Warfarin	1.5-3.0	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2	Age, sex, indication for treatment
Isaza C ⁴⁸	2010	Colombia	Hispanic	145	72 (50%)	55±15	Warfarin	2.0-3.0	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2 [^]	Age, BMI, sex, indication for treatment
Jiménez-Varo E ⁴⁹	2014-2015	Spain	Whites	162	89 (55%)	73±9	Acenocumarol	2.0-3.0	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2 [^]	Age, BMI, sex, smoking, indication for treatment, other drugs
Kringen MK ³³	2011	Norway	Whites	105	87 (83%)	60±9	Warfarin	1.9-3.6	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2	Age, sex, other drugs
Lee KE ⁵⁰	2012	Korea	Asians	188	62 (33%)	59±10	Warfarin	2.0-3.0	CYP2C9*3, VKORC1, CYP4F2	Age, BMI, sex, smoking, other drugs
Lee MT ²⁷	2009	China	Asians	233	130 (56%)	63±13	Warfarin	1.7-3.0	CYP2C9*3, VKORC1, CYP4F2	Age, BMI, sex, indication for treatment, other drugs
Lubitz SA ³⁴	2010	New York (USA)	Whites (68%) Blacks (20%) Asians (12%)	155	97 (63%)	69±14	Warfarin	2.0-3.0	CYP2C9*2, CYP2C9*3, CYP2C9*5, VKORC1, CYP4F2	Age, BMI, sex, smoking, indication for treatment, other drugs
Mazzaccara C ⁵¹	2013	Italy	Whites	256	142 (55%)	67±11	Warfarin	1.6-3.9	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2	Age, BMI, sex, indication for treatment, other drugs
Ozer M ⁵²	2013	Turchia	Whites	107	53 (50%)	54±14	Warfarin	1.5-3.0	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2	Age, BMI, sex, smoking, indication for treatment
Pathare A ³⁷	2012	Oman	Asians	188	88 (47%)	51±17	Warfarin	2.0-3.0	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2	Age, BMI, sex, smoking, indication for treatment, other drugs
Pautas E ³⁵	2010	France	Whites	272	65 (24%)	87±6	Warfarin	2.5	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2	Age, sex, other drugs
Pavani A ³⁸	2012	India	Indians	207	108 (52%)	40±13	Warfarin	2.0-3.5	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2	Age, BMI, sex
Perez-Andreu V ¹⁹	2009	Spain	Whites	100	100 (100%)	65±6	Acenocumarol	2.0-3.0	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2	Age

Perini JA ²⁰	2010	Brazil	Whites (50%) Brown (30%) Blacks (20%)	390	186 (48%)	54±15	Warfarin	2.0-3.5	CYP2C9*2, CYP2C9*3, CYP2C9*5, VKORC1, CYP4F2 [^]	Age, BMI, sex, smoking, indication for treatment, other drugs
Ramirez AH ³⁹	2012	Tennessee (USA)	Whites	1029	586 (57%)	65±15	Warfarin	1.6-3.5	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2	Age, BMI, sex, smoking, indication for treatment, other drugs
Rathore SS ¹⁷	2012	India	Indians	217	145 (67%)	39±12	Acenocumarol	2.0-3.5	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2 [^]	Age, BMI, sex, smoking
Sagreiya H ²¹	2010	California (USA)	Whites (75%) Asians (17%) Blacks (8%)	101	58 (57%)	64±15	Warfarin	1.8-3.5	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2	Age, BMI, sex, smoking, indication for treatment, other drugs
Shain MH ²²	2011	Egypt	Egyptians	188	84 (44%)	48±15	Warfarin	1.5-3.0	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2	Age, BMI, sex, smoking, indication for treatment
Shendre A ⁴⁰	2016	Alabama (USA)	Whites (58%) Blacks (41%) Asians (1%)	1169	610 (52%)	61±16	Warfarin	1.8-3.2	CYP2C9*2, CYP2C9*3, CYP2C9*5, VKORC1, CYP4F2	Age, BMI, sex, smoking, indication for treatment, other drugs
Suriapranata IM ²³	2011	Indonesia	Asians	85	48 (56%)	57±11	Warfarin	1.5-2.5	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2	Age, BMI, sex, smoking, indication for treatment, other drugs
Tan SL ⁴¹	2013	China	Asians	317	95 (30%)	45±10	Warfarin	1.8-3.0	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2	Age, BMI, sex
Tatarunas V ⁴²	2014	Lithuania	Whites	189	118 (62%)	65±11	Warfarin	2.0-3.5	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2	Age, BMI, sex, smoking, other drugs
van Schie RM (a) ⁴⁴	2013	Netherlands	Whites	568	328 (58%)	70±11	Other (phenprocumon)	2.0-3.5	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2	Age, BMI, sex, indication for treatment, other drugs
van Schie RM (b) ⁴⁴	2013	Netherlands	Caucasians	397	217 (55%)	73±9	Acenocumarol	2.0-3.5	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2	Age, BMI, sex, indication for treatment, other drugs
Wells PS ²⁴	2010	Canada	Caucasians	246	136 (55%)	61±14	Warfarin	2.0-3.0	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2	Age, BMI, sex, smoking, indication for treatment,

										other drugs
Zambon CF ²⁵	2011	Italy	Caucasians	371	231 (62%)	73±9	Warfarin	2.5	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2	Age, BMI, sex, smoking, indication for treatment
Zhang JE ²⁶	2009	UK	Caucasians	202	120 (59%)	66±14	Warfarin	2.0-3.0	CYP2C9*2, CYP2C9*3, VKORC1, CYP4F2	Age, BMI, sex, smoking, indication for treatment, other drugs

PY=Publication Year

* Covariates with less than 20% of missing data are here indicated and used in the multivariate analysis

^ CYP2F4 not in HW equilibrium

Table 2. Subgroup analyses of association studies of the *CYP4F2* polymorphism on coumarin dose requirements

Variable	Subgroup (N studies)	Difference* (95%CI)	I ² (Q test p-value)	Meta-regression p-value
Ethnicity	Whites (26)	0.10 (0.08; 0.11)	15% (0.25)	0.002
	Asians (10)	0.08 (0.05; 0.11)	0% (0.85)	
	Blacks (5)	0.05 (-0.04; 0.14)	21% (0.28)	
	Others (5) [^]	0.01 (-0.05; 0.06)	0% (0.72)	
Drug	Acenocumarol (7)	0.11 (0.09; 0.13)	13% (0.33)	0.03
	Warfarin (31)	0.08 (0.06; 0.09)	9% (0.33)	
Sex	Males (39)	0.07 (0.06; 0.09)	16% (0.20)	0.03
	Females (38)	0.10 (0.08; 0.12)	19% (0.16)	
INR target	<2.5 (11)	0.08 (0.05; 0.11)	0% (0.79)	Reference
	2.5 (23)	0.09 (0.07; 0.11)	22% (0.17)	0.42
	>2.5 (18)	0.08 (0.06; 0.10)	0% (0.49)	0.93
Smoking	No (21)	0.09 (0.07; 0.11)	0% (0.68)	0.74
	Yes (12)	0.07 (-0.02; 0.15)	33% (0.12)	
Other drugs considered	No (7)	0.08 (0.03; 0.12)	47% (0.08)	0.72
	Yes (32)	0.09 (0.08; 0.10)	10% (0.31)	
HW equilibrium	No (6)	0.08 (0.04; 0.12)	53% (0.06)	0.92
	Yes (33)	0.09 (0.07; 0.10)	9% (0.33)	
Quality score	<5	0.08 (0.06; 0.10)	29% (0.11)	0.46
	≥5	0.09 (0.08; 0.11)	6% (0.39)	
CYP2C9	CYP2C9 *1*1	0.08 (0.07; 0.10)	18% (0.18)	0.73
	CYP2C9 *1*2/ *1*3/*2*2/*2*3/*3*3	0.09 (0.06; 0.12)	25% (0.10)	
VKORC11	VKORC1 GG	0.08 (0.06; 0.10)	4% (0.40)	0.13
	VKORC 1 AA/AG	0.10 (0.08; 0.11)	10% (0.30)	

* difference in logarithm of stable coumarin dose of subjects with *CYP4F2* polymorphism (CT+TT) compared to subjects with *CYP4F2* wild-type (CC), according to dominant model

[^] includes Indian, Egyptian, Brown, Hispanic

Table 3. Predictive model for logarithm of stable coumarin dose according to patients' clinical and genetics characteristics. Statistical test for model fit (R^2) is reported both for the test and validation cohorts

WHITES								
Variable	Acenocoumarol				Warfarin			
	Parameter estimate (95%CI)	P-value	R ² test (N=2744)	R ² validation (N=1410)	Parameter estimate (95%CI)	P-value	R ² test (N=3016)	R ² validation (N=1532)
Intercept	4.069 (3.883; 4.256)	<0.0001	0.33	0.28	3.981 (3.887; 4.075)	<0.0001	0.51	0.52
Age*	-0.014 (-0.015; -0.012)	<0.0001			-0.009 (-0.010; -0.008)	<0.0001		
BMI*	-0.002 (-0.006; 0.002)	0.28			0.010 (0.008; 0.012)	<0.0001		
Male sex	0.014 (-0.024; 0.052)	0.47			0.123 (0.098; 0.148)	<0.0001		
Indication for treatment [^]	0.000 (-0.042; 0.042)	0.98			-0.043 (-0.069; -0.017)	0.001		
<i>CYP2C9</i> *2 1-allele	-0.190 (-0.232; -0.147)	<0.0001			-0.231 (-0.261; -0.202)	<0.0001		
<i>CYP2C9</i> *2 2-alleles	-0.359 (-0.484; -0.234)	<0.0001			-0.513 (-0.600; -0.426)	<0.0001		
<i>CYP2C9</i> *3 1-allele	-0.394 (-0.446; -0.342)	<0.0001			-0.387 (-0.425; -0.350)	<0.0001		
<i>CYP2C9</i> *3 2-alleles	-1.214 (-1.522; -0.907)	<0.0001			-1.316 (-1.502; -1.131)	<0.0001		
<i>VKORC1</i> AG	-0.291 (-0.332; -0.249)	<0.0001			-0.266 (-0.292; -0.240)	<0.0001		
<i>VKORC1</i> AA	-0.762 (-0.816; -0.708)	<0.0001			-0.666 (-0.704; -0.629)	<0.0001		
<i>CYP4F2</i> CT	0.018 (-0.022; 0.058)	0.39			0.073 (0.047; 0.098)	<0.0001		
<i>CYP4F2</i> TT	0.100 (0.041; 0.159)	0.0009			0.191 (0.147; 0.235)	<0.0001		

ASIANS

Variable	Acenocoumarol				Warfarin			
	Parameter estimate	P-value	R ² test (N=0)	R ² validation (N=0)	Parameter estimate	P-value	R ² test (N=292)	R ² validation (N=146)
Intercept	-	-	-	-	3.484 (3.112; 3.855)	<.0001	0.45	0.42
Age *	-	-			-0.005 (-0.008; -0.001)	0.02		
BMI*	-	-			0.014 (0.004; 0.023)	0.004		
Male sex	-	-			0.058 (-0.050; 0.167)	0.29		
Indication for treatment^	-	-			-0.027 (-0.139; 0.084)	0.63		
CYP2C9*2 1-allele	-	-			-0.114 (-0.351; 0.124)	0.35		
CYP2C9*2 2-alleles	-	-			-	-		
CYP2C9*3 1-allele	-	-			-0.224 (-0.428; -0.020)	0.03		
CYP2C9*3 2-alleles	-	-			-1.065 (-1.717; -0.412)	0.002		
VKORC1 AG	-	-			-0.422 (-0.574; -0.271)	<.0001		
VKORC1 AA	-	-			-0.827 (-0.975; -0.679)	<.0001		
CYP4F2 CT	-	-			0.117 (0.003; 0.231)	0.04		
CYP4F2 TT	-	-			0.124 (-0.075; 0.324)	0.22		

BLACKS								
Variable	Acenocoumarol				Warfarin			
	Parameter estimate	P-value	R ² test (N=0)	R ² validation (N=0)	Parameter estimate	P-value	R ² test (N=534)	R ² validation (N=288)
Intercept	-	-			3.875 (3.692; 4.061)	<0.0001		
Age*	-	-			-0.009 (-0.011; -0.006)	<0.0001		
BMI*	-	-			0.010 (0.007; 0.015)	<0.0001		
Male sex	-	-			0.152 (0.086; 0.219)	<0.0001		
Indication for treatment [^]	-	-			-0.090 (-0.160; -.0183)	0.01		
CYP2C9*2 1-allele	-	-			-0.007 (-0.149;0.133)	0.93		
CYP2C9*2 2-alleles	-	-			-	-		
CYP2C9 *3 1-allele	-	-	-	-	-0.469 (-0.666;-0.270)	<0.0001	0.30	0.22
CYP2C9 *3 2-alleles	-	-			-	-		
CYP2C9 *5 1-allele	-	-			-0.436 (-0.736;-0.137)	0.005		
CYP2C9 *5 2-alleles	-	-			-	-		
VKORC1 AG	-	-			-0.284 (-0.585; -0.020)	0.07		
VKORC1 AA	-	-			-0.281 (-0.588;-0.020)	<0.0001		
CYP4F2 CT	-	-			-0.0382 (-0.124; 0.050)	0.40		
CYP4F2 TT	-	-			0.300 (-0.068; 0.664)	0.11		

CI= Confidence Interval

Note: Due to significant heterogeneity, separate models are reported for different ethnic groups and drugs

* Estimate for 1 unit increase; ^ Estimate for the following indication for treatment: fibrillation/flutter, cardiomyopathy/LV dilation, post orthopedic

Table 4. Beta coefficients (p-values) for single genes and gene-gene interaction.

Ethnicity	Drug	N subjects (N studies)	<i>CYP4F2</i>	<i>CYP2C9</i>	<i>VKORC1</i>	<i>CYP4F2*CYP2C9</i>	<i>CYP4F2*VKORC1</i>	<i>CYP2C9*VKORC1</i>
Whites	Acenocumarol	4154 (5)	0.08 (0.0002)	-0.22 (<0.0001)	-0.40 (<0.0001)	-0.02 (0.51)	-0.03 (0.21)	-0.01 (0.79)
	Warfarin	4548 (15)	0.08 (0.0001)	-0.30 (<0.0001)	-0.38 (<0.0001)	-0.001 (0.96)	0.02 (0.37)	-0.01 (0.55)
Asians	Acenocumarol	0 (0)	NE	NE	NE	NE	NE	NE
	Warfarin	438 (8)	0.10 (0.34)	-0.26 (0.05)	-0.46 (<0.0001)	0.12 (0.36)	-0.08 (0.48)	-0.004 (0.98)
Blacks	Acenocumarol	0 (0)	NE	NE	NE	NE	NE	NE
	Warfarin	815 (5)	0.04 (0.30)	-0.20 (0.0004)	-0.27 (<0.0001)	0.004 (0.97)	-0.02 (0.82)	0.02 (0.83)
Others	Acenocumarol	0 (0)	NE	NE	NE	NE	NE	NE
	Warfarin	701 (7)	-0.08 (0.13)	-0.19 (0.003)	-0.27 (<0.0001)	0.07 (0.31)	0.09 (0.13)	-0.05 (0.48)
All	All	11,435 (29)	0.07 (<0.0001)	-0.24 (<0.0001)	-0.37 (<0.0001)	0.02 (0.21)	0.02 (0.23)	-0.02 (0.12)

NE= Not estimated

Note: ethnicity- and drug-specific models are adjusted by study, age, sex, BMI and indication for treatment. The final model is also adjusted by ethnicity and drug. For each gene, the reference category is the gene polymorphism according to the dominant model (heterozygous+variant homozygous vs wt). For the analysis on Blacks, *CYP2C9* included, beyond *2 and *3, also *5 polymorphism.