**The association of plasma lipids with white blood cell counts: Results from the Multi-Ethnic Study of Atherosclerosis**

**Lai: lipids and leukocyte counts**

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**Abstract**

**Background.** Previous studies have demonstrated that elevated cholesterol results in increased white blood cells in mouse models. However, there is insufficient evidence to support this in humans. We, therefore, investigated the relationship of plasma lipids with white blood cell counts (basophils, eosinophils, monocytes, neutrophils and lymphocytes) in the Multi-Ethnic Study of Atherosclerosis (MESA).

**Methods and Results.** The analysis included 2873 MESA participants at visit 5 with a complete white blood count and differential analysis. The cross-sectional association of total cholesterol, LDL cholesterol, HDL cholesterol and triglyceride levels with different white blood cell counts was analyzed by multivariable linear regression. After adjusting sociodemographic and confounding factors including red blood cells counts, platelet counts, use of lipid-lowering medication, CVD risk factors and other lipid measures, a 1-SD increment in total cholesterol and LDL cholesterol was associated with 2.8% and 2.3% (both $p < 0.001$) lower total white blood cell counts, and 1.7% and 1.4% lower (both $p < 0.05$) monocyte counts, respectively. The same increment in ln-transformed triglyceride levels was associated with 2.3% higher total white blood cell counts, 2.9% higher lymphocyte counts and 2.7% lower monocyte counts (all $p < 0.001$), while HDL cholesterol was associated with 1.5% lower total white blood cell counts ($p = 0.018$).

**Conclusions.** Whilst significant associations were observed, the heterogenous and modest nature of the relationships between plasma lipid levels and white blood cell populations make it hard to support the hypothesis that lipids are in the causal pathway for leukogenesis.

**Keywords:** lipids and lipoproteins, cholesterol, triglycerides

## Introduction

Leukocytes play important roles in immune regulation and tissue homeostasis[1]. Despite studies in animal models demonstrating a link between dyslipidaemia and increased leucocytosis, the impact of high plasma lipid levels on white blood cell counts in humans is poorly understood. Whilst a positive correlation between high plasma cholesterol levels and increased monocyte numbers has been demonstrated in humans[2], the correlation with neutrophil counts is not clear. Moreover, increased cellular cholesterol levels has been demonstrated to increase proliferation[3, 4] and inflammatory responses[5] in T lymphocytes.

With respect to animal models, Murphy, et al. [6] showed that accumulation of cholesterol in hematopoietic stem progenitor cells in apoE$^{-/-}$ mice increased responsiveness to IL-3 and granulocyte-macrophage colony-stimulating factor. This resulted in progenitor cell proliferation, leading to neutrophilia and monocytosis. Hypercholesterolaemia can also increase circulating levels of C-X-C motif ligand 1 (CXCL1), and increase expression of C-X-C chemokine receptor type 2 (CXCR2) in neutrophils, thereby inducing neutrophil release from bone marrow[7]. While this is true in mice, such changes have yet to be reported in humans with hypercholesterolaemia. Indeed, a study of children with familial hypercholesterolaemia reported no difference in neutrophil counts[8].

While an association between serum cholesterol levels and platelet counts has been described in the United States National Health and Nutritional Examination Survey (NHANES)[9], data on the association of different plasma lipid levels with white blood cell counts is lacking. As both increased lipids and the number of myeloid cells can have an impact on cardiovascular disease (CVD) risk, it is important to determine and understand the interactions between these factors. We therefore investigated the relationship of different lipid measures with different types of white blood cell counts, and whether there were any sex or racial/ethnic differences in the relationship, using data from the Multi-Ethnic Study of Atherosclerosis (MESA)[10].

## Materials and Methods

*Study participants*

The Multi-Ethnic Study of Atherosclerosis (MESA) was designed to investigate the prevalence, risk factors and progression of subclinical cardiovascular disease (CVD) in a multi-ethnic cohort. Details of the study have been described previously[10]. Briefly, the study recruited 6814 men and women aged 45-84 years from four different ethnic groups, non-Hispanic whites, African American, Hispanic American and Asian (predominantly of Chinese descent), between July 2000 and August 2002. These participants were recruited from six different US communities (Baltimore, MD; Chicago, IL; Forsyth County, NC; Los Angeles County, CA; New York, NY, and St. Paul, MN) and were all free of clinically apparent CVD at baseline (exam 1). The study was approved by the institutional review boards at all participating centres and undertaken in accordance with the Declaration of Helsinki and Good Clinical Practice Guidelines. Informed written consent was obtained from all participants. This study was approved by the UNSW Human Research Advisory Panel (HC180331).

The participants underwent four follow up assessments (exams 2-5) over a period of 10 years. Total white blood cell and subfraction counts were measured only at exam 5 (2010-2012). Of the 6814 participants at baseline exam 1, 4716 participants attended exam 5, 2890 of whom had their white blood cell counts measured. After excluding 17 participants with missing data in one or more measures of plasma lipids (total cholesterol, HDL cholesterol, LDL cholesterol and triglycerides) at exam 5, a total of 2873 participants were included in the analysis.

*Lipid and white blood cell measurements*

Venous blood samples were collected after a 12-hour fast by certified technicians using standardised venepuncture procedures. Total cholesterol, HDL cholesterol, LDL cholesterol and triglycerides, as well as basophil, eosinophil, lymphocyte, monocyte, neutrophil and total white

blood cell counts, were measured as described previously[11, 12]. Apolipoprotein E (*APOE*) genotype was estimated from single nucleotide polymorphisms rs429358 and rs7412 as described previously[13]. Serum glucose was measured by rate reflectance spectrophotometry using thin film adaptation of the glucose oxidase method. Diabetes was defined as fasting blood glucose ≥7.0 mmol/L (126 mg/dL) or use of hypoglycemic medication[14]. Serum creatinine was measured via rate reflectance spectrophotometry and calibrated to the standardised creatinine measurements obtained at the Cleveland Clinic Research Laboratory (Cleveland, OH). Estimated glomerular filtration rate (eGFR) was calculated from serum creatinine using the Chronic Kidney Disease Epidemiology Collaboration (CKD-EPI) Creatinine Equation[15].

*Other covariates of interest*

At MESA exam 5, information about demographics, socioeconomic status, medication, dietary and alcohol intake, smoking status, pack-years of smoking and physical activity were collected via self-reported questionnaire. History of CVD was defined as the presence of an adjudicated hard CVD event, including myocardial infarction, resuscitated cardiac arrest, and stroke prior to, or at the time of, exam 5. History of coronary revascularization was defined as having percutaneous coronary intervention or coronary artery bypass grafting prior to, or at the time of, exam 5. Details of the CVD and coronary revascularization event ascertainment has been described previously[16, 17].

The height and weight of participants was measured to the nearest 0.1 cm and 0.5 kg, respectively, with participants wearing light clothing and no shoes. Body mass index (BMI) was calculated by dividing the height in metres squared by the weight in kilograms. Waist and hip circumference were measured in centimetres using a steel measuring tape. Resting blood pressure was measured in the right arm after 5 min in the seated position using an automated oscillometric method (Dinamap) and appropriate cuff size. Readings were taken three times, with the last two

values averaged to obtain the blood pressure reading that was used for analysis. Hypertension was defined as blood pressure ≥140/90 mmHg or taking antihypertensive medication[18].

*Statistical analysis*

SPSS 24 (IBM, Armonk, NY) and STATA 14.0 (StataCorp, College Station, TX) were used for statistical analysis. For variables with a skewed distribution (including triglycerides and different types of white blood cell counts), the data was presented as median (interquartile range) and subjected to natural logarithmic (ln) transformation before analysis to improve normality. For cell counts with a zero value, such as basophils and eosinophils, a constant of 1 was added to the values before ln-transformation.

Multivariable linear regression analysis was performed using robust standard error estimation with each lipid measure (total cholesterol, HDL cholesterol, LDL cholesterol and triglycerides) as independent predictor variables, and basophil, eosinophil, lymphocyte, monocyte, neutrophil and total white blood cell counts as the dependent variables. The regression coefficient (B) was estimated as the ln-transformed cell counts per one SD unit increase in lipid levels. In model 1, data were adjusted for age, sex, and race/ethnicity. In model 2, data were further adjusted for BMI, family income, smoking, pack-years of smoking, current alcohol use, physical activity, hypertension, diabetes, use of any lipid-lowering medication, eGFR, *APOE* genotype, history of CVD and history of coronary revascularization. In model 3, data were further adjusted for total cholesterol, HDL cholesterol, LDL cholesterol, and triglycerides, where appropriate. In model 4, data were further adjusted for other blood cell count related variables, including red blood cell and platelet counts, where appropriate. In all the analysis, no multi-collinearity issue was detected (all variance inflation factors < 3.0).

Analysis of diagnostic residual plots suggested the normality of the model residuals was improved after ln-transformation of total white blood cell, monocyte and lymphocyte counts, but

not for basophil, eosinophil and neutrophil counts. For these three blood cell types, ln-transformation was used in the main analysis to be consistent with other blood cell types and a previous MESA study[12]. Therefore, a sensitivity analysis was performed without ln-transformation for basophil, eosinophil and neutrophil counts. In another sensitivity analysis, the above analyses were repeated after further excluding 1158 participants taking lipid-lowering medication.

In a separate analysis, we assessed the non-linear relationship of lipid measures with different types of white blood cell counts using the STATA command "mvrs" which uses regression splines to model potentially nonlinear relationships. We allowed the relationship for the lipid exposure of interest to be nonlinear while assuming that the relationships of other confounding variables with different white blood cell counts were linear. In two situations where nonlinearity was present the approximate knot positions were used to fit linear regression analyses within strata defined by these thresholds.

P for the interaction with sex and race/ethnicity was estimated by including the interaction term in the regression model in the full sample after adjustment for the main effects of the covariates. However, as the number of Chinese Americans was too small to make inferences about interaction, Chinese Americans were excluded from analysis of race/ethnicity interaction. Subgroup analysis was performed if there was a significant interaction. A two-tailed $p < 0.05$ was considered to be statistically significant.

## Results

### Baseline Characteristics

As shown in Supplementary Table 1, participants included in this analysis were younger, less likely to be Chinese Americans, and more likely to be Hispanic Americans, compared to those participants not included in this study. Table 1 shows baseline characteristics of the 2873 participants. The cohort consisted of 42.8% non-Hispanic white Americans, 0.9% Chinese-

Americans, 27.9% African-American and 28.3% Hispanic-Americans. The mean age was 69.5 years and 52.9% were women. Supplementary Figure 1 shows the distribution of different blood counts with and without ln-transformation. The mean total cholesterol, HDL cholesterol and LDL cholesterol levels were 180.8, 55.0 and 104.4 mg/dL respectively, whereas the median triglyceride levels were 93 mg/dL (Table 1). The median total white blood cell counts levels were 5.8 x $10^3$/ μL (Table 1).

**Association of total cholesterol levels with cell counts**

In the fully adjusted model, a higher total cholesterol level was associated with a lower ln-transformed total white blood cell count after adjusting for all confounding factors (B = -0.028, p <0.001, Model 4) with a 2.8% lower cell count per one SD increase in total cholesterol level (Table 2). When assessing different white blood cell types, a higher total cholesterol level was also significantly associated with a lower ln-transformed monocyte count (B = -0.017, p = 0.034, Model 4, Table 2), with a 1.7% lower cell count per one SD increase in total cholesterol level, but not other types of white blood cell counts. In the sensitivity analysis, whereby participants taking lipid-lowering medications were excluded, a higher total cholesterol level was also significantly associated with lower ln-transformed total white blood cell counts, but the association between total cholesterols and ln-transformed monocyte counts was lost (p =0.004 and 0.153 respectively, Table 3). In all the above analyses, no significant interaction with sex and race/ethnicity was observed.

In a separate analysis, we assessed the non-linear association of total cholesterol levels with total white blood cell counts. The regression spline analysis suggested that the association may be somewhat steeper at lower total cholesterol levels, and flatter at higher total cholesterol levels, with a threshold at approximately 155 mg/dL (Table 4). However, such non-linear association was not found after excluding participants taking lipid-lowering medications. No non-linear association was found for the different types of white blood cell counts.

In all above analyses, similar results were obtained when assessing basophil, eosinophil and neutrophil counts without ln-transformation, except that a borderline significant association was found between total cholesterol levels and un-transformed neutrophil counts was found after excluding participants taking lipid-lowering medications ($p = 0.043$, Supplementary Tables 2 and 3).

**Association of HDL cholesterol levels with cell counts**

A higher HDL cholesterol level was significantly associated with a lower ln-transformed total white blood cell count in the full adjustment model ($B = -0.016$, $p = 0.018$), with a 1.5% lower count per one SD increase in HDL cholesterol level (Table 2). When analysing different white blood cell types, no significant association was found after full adjustment. In the sensitivity analysis after excluding participants taking lipid-lowering medications, a higher HDL cholesterol level was also significantly associated with a lower ln-transformed total white blood cell count ($p = 0.033$, Table 3), but no significant association was found for the different types of white blood cell counts. In all the above analyses, no significant interaction with sex and race/ethnicity was found.

In all above analyses, similar non-significant results were obtained when assessing basophil, eosinophil and neutrophil counts without ln-transformation (Supplementary Tables 2 and 3). No non-linear association was found with total white blood cell counts and different types of white blood cell counts.

**Association of LDL cholesterol levels with cell counts**

A higher LDL cholesterol level was significantly associated with a lower ln-transformed total white blood cell count in the full adjustment model ($B = -0.023$, $p < 0.001$), with a 2.3% lower cell count per one SD increase in LDL cholesterol level (Table 2). When assessing different white blood cell types, a higher LDL cholesterol level was also significantly associated with a lower ln-transformed monocyte count in the full adjustment model ($B = -0.014$. $p = 0.047$), with a 1.4%

lower cell count per one SD increase in LDL cholesterol level, but not other types of white blood cell counts. In a sensitivity analysis after excluding participants taking lipid-lowering drugs, a higher LDL cholesterol level was still significantly associated with a lower ln-transformed total white blood cell count ($p = 0.004$, Table 3), whereas the association between LDL cholesterol levels and ln-transformed monocyte counts was lost. In all the above analyses, no significant interaction with sex and race/ethnicity was found.

In a separate analysis, we assessed the non-linear association of LDL cholesterol levels with total white blood cell counts. The regression spline analysis suggested that the association may be somewhat steeper at lower LDL cholesterol levels, and flatter at higher LDL cholesterol levels, with a threshold at approximately 125 mg/dL (Table 4). However, such non-linear association was not found after excluding participants taking lipid-lowering medications. No non-linear association was found for the different types of white blood cell counts.

In all above analyses, similar results were obtained when assessing basophil, eosinophil and neutrophil counts without ln-transformation, except that a borderline significant association was found between LDL cholesterol levels and un-transformed neutrophil counts was found after excluding participants taking lipid-lowering medications ($p = 0.049$, Supplementary Tables 2 and 3).

**Association of triglyceride levels with cell counts**

A higher ln-transformed triglyceride level was significantly associated with a higher ln-transformed total white blood cell count in the full adjustment model ($\beta = 0.023$, $p < 0.001$, Table 2) with a 2.3% higher cell count per one SD increase in ln-transformed triglyceride level. A significant interaction with race/ethnicity was found ($p = 0.005$), but not with sex. The association was significant only in African Americans, ($p < 0.001$), but not in non-Hispanic white Americans and Hispanic Americans (Supplementary Table 4). When assessing different types of white blood cell counts, a higher ln-transformed triglyceride level was associated with a higher ln-transformed

lymphocyte count (B = 0.029, $p < 0.001$) and a lower ln-transformed monocyte count (B= -0.028, $p < 0.001$) in the full adjustment model (Table 2), with a 2.9% higher lymphocyte count and a 2.7% lower monocyte count per one SD increase in ln-transformed triglyceride level. No significant interaction with sex and race/ethnicity was found. No significant association was found between triglyceride levels and other types of white blood cell counts.

In the sensitivity analysis after excluding participants taking lipid-lowering drugs, a higher ln-transformed triglyceride level was still significantly associated with a higher ln-transformed total white blood cell count, a higher lymphocyte count and a lower ln-transformed monocyte count (p = 0.001, 0.008 and 0.008 respectively, Table 3). No significant interaction with sex or race/ethnicity was found.

In all above analyses, similar non-significant results were obtained when assessing basophil, eosinophil and neutrophil counts without ln-transformation (Supplementary Tables 2 and 3). No non-linear association was found with total white blood cell counts and different types of white blood cell counts.

**Discussion.**

Using data from MESA, this study examined the relationships between various plasma lipids and a range of white blood cell counts in a multi-ethnic cohort. After adjusting for relevant co-variates, higher total cholesterol, HDL cholesterol and LDL cholesterol levels were all modestly associated with lower white blood cell counts among all participants, or after excluding participants on lipid-lowering medications. When analysing different types of white blood cell counts, higher triglyceride levels were also robustly and modestly associated with higher lymphocyte counts, but lower monocyte counts. The results of this study in the main analysis and different sensitivity analyses are summarised in Table 5.

Elevated cholesterol levels have been demonstrated to promote monocytosis in mice due to cholesterol accumulation and proliferation of hematopoietic stem progenitor cells (HSPCs)[6, 8, 19]. Recently, van der Valk, et al. [20] reported that cholesterol accumulation can occur in human HSPCs and results in a myeloid differentiation bias *in vitro*. This study also reported increased glucose uptake in the bone marrow of subjects with familial hypercholesterolemia, suggesting increased bone marrow progenitor proliferation, although a statistically significant increase in monocyte, lymphocyte or neutrophil counts was not observed. Increased bone marrow glucose uptake, together with monocytosis and leukocytosis has been described in patients with familial dysbetalipoproteinaemia[21].

The effect of triglycerides on CVD risk is well established[22, 23]. However, our analysis found that monocyte counts were lower in people with high plasma triglyceride levels. This reduced monocyte count could be due to increased migration of monocytes into peripheral tissues under condition of elevated triglycerides. Saja, et al. [24] demonstrated in a murine model of hypertriglyceridaemia, increased binding of $Gr1^{low}$ monocytes to the endothelium and extravasation into the subendothelial space. This resulted in depletion of monocytes from the circulation and accumulation of macrophages in the heart, liver, and kidney. Our analysis also suggests a modest association of higher triglyceride levels with higher lymphocyte counts. We are not clear about the underlying mechanism. However, as lymphocytes comprise a heterogenous group of cells, further studies are needed to identify which type of lymphocytes are affected by elevated triglyceride levels and whether there is any causal relationship.

Neutrophils play an important role in atherosclerosis. They accumulate preferentially in the shoulder regions of atherosclerotic plaques in mice, where there is also a high density of monocytes[7, 25, 26]. This is consistent with atherosclerotic lesion size in mice being positively correlated with neutrophil counts, suggesting a potential role of neutrophils in atherosclerotic lesion development[7]. Indeed, several studies have shown that hypercholesterolaemia induces neutrophilia

in mice[6, 27, 28]. Similarly, a cross-sectional analysis by Huang, et al. [29] looking at the effect of hyperlipidaemia, smoking and BMI on peripheral differential leukocyte counts in humans also showed a positive correlation between LDL cholesterol and neutrophil counts. However, we did not find a significant association between lipid levels and neutrophil numbers. Indeed, children with familial hypercholesterolaemia have normal neutrophil counts despite their high cholesterol levels[8].

Whilst the present study takes the advantage of a large well-characterised sample of with a multi-ethnic study design, there are some limitations. There was an under-representation of Chinese Americans in the present study, compared to the original parent cohort. Therefore, we could not assess ethnic differences for Chinese Americans. White blood cell profiles were only measured at exam 5 and not at baseline exam 1. As such, we could not assess the temporal relationship between changes in lipid measures and change in white blood cell counts. Additionally, a number of the positive associations found in this study were modest, and this may explain why the results were non-significant in some of the alterative or sensitivity analyses. We could not exclude the possibility of false positive results due to multiple comparisons. However, the use of different sensitivity analyses may help to identify more robust association. The current analysis was not able to take into account the potential confounding effect of medications that may affect white blood cell counts and inflammation status. As this was an observational study, further investigations are needed to determine the underlying mechanism of the associations and their clinical significance. Nevertheless, the current study is the largest study with multi-ethnic study design to assess the relationship between lipid measures and different white blood cell counts.

In conclusion, this study suggests modest associations between lipid levels and circulating leukocyte counts. Further studies in other clinical settings are needed to confirm our findings. Whilst significant relationships were observed, the relative contribution of lipids and inflammatory factors in driving atherosclerosis remains an open question.

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**Disclosures**

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**Table 1.** Baseline characteristics of participants

| Characteristics | n | Estimate |
|---|---|---|
| Age, year | 2873 | 69.5 ± 9.3 |
| Women | 2873 | 1519 (52.9%) |
| Annual family income (US$) | 2760 | |
| <30,000 | | 922 (33.4%) |
| 30,000 - 74,999 | | 1161 (42.1%) |
| >= 75,000 | | 677 (24.5%) |
| BMI, kg/m$^2$ | 2870 | 29.3 ± 5.7 |
| Smoking | 2848 | |
| Never | | 1157 (40.6%) |
| Former | | 1436 (50.4%) |
| Current | | 255 (9.0%) |
| Pack-years of smoking | 2813 | 11.8 ± 20.5 |
| Current alcohol use | 2853 | 1266 (44.4%) |
| Physical activity, MET-hours/weeks | 2847 | 90.8 ± 109.1 |
| Hypertension | 2871 | 1780 (62.0%) |
| Lipid-lowering medication | 2873 | 1158 (40.3%) |
| One or more *APOE* E4 alleles | 2719 | 720 (26.5%) |
| eGFR, mL/min/1.73 m$^2$ | 2873 | 79.3 ± 18.2 |
| Diabetes | 2873 | 596 (20.7%) |
| History of CVD | 2854 | 105 (3.7%) |
| History of coronary revascularization | 2871 | 123 (4.3%) |
| Lipid profile | | |
| Total cholesterol, mg/dL | 2873 | 180.8 ± 37.5 |
| HDL cholesterol, mg/dL | 2873 | 55.0 ± 16.5 |
| LDL cholesterol, mg/dL | 2873 | 104.4 ± 32.6 |
| Triglycerides, mg/dL | 2873 | 93 (70 – 130) |
| Blood cell counts | | |
| Basophils, $\times 10^3/\mu L$ | 2873 | 0.00 (0.00 - 0.04) |
| ln (basophils, $\times 10^3/\mu L$) | 2873 | 0.023 ± 0.040 |
| Eosinophils, $\times 10^3/\mu L$ | 2873 | 0.1 (0.1 - 0.2) |
| ln (eosinophils, $\times 10^3/\mu L$) | 2873 | 0.152 ± 0.106 |
| Lymphocytes, $\times 10^3/\mu L$ | 2873 | 1.7 (1.3 - 2.1) |
| ln (lymphocytes, $\times 10^3/\mu L$) | 2873 | 0.519 ± 0.355 |
| Monocytes $\times 10^3/\mu L$ | 2873 | 0.4 (0.3 - 0.6) |
| ln (monocytes, $\times 10^3/\mu L$) | 2872 | -0.826 ± 0.377 |
| Neutrophils, $\times 10^3/\mu L$ | 2873 | 3.4 (2.7 - 4.3) |
| ln (neutrophils, $\times 10^3/\mu L$) | 2873 | 1.21 ± 0.39 |
| Total white blood cells, $\times 10^3/\mu L$ | 2873 | 5.8 (4.8 – 7.0) |
| ln (total white blood cells, $\times 10^3/\mu L$) | 2873 | 1.76 ± 0.29 |
| Red blood cells, $\times 10^6/\mu L$ | 2873 | 4.48 ± 0.49 |
| Platelets, $\times 10^3/\mu L$ | 2868 | 228.4 ± 62.5 |

Data are expressed as mean ± SD, n (%), or median (interquartile range).

*APOE,* apolipoprotein E; BMI, body mass index; eGFR, estimated glomerular filtration rate; HDL, high density lipoprotein; LDL, low density lipoprotein, MET, metabolic equivalent.

**Table 2.** Association of lipid levels with different types of white blood cell counts

| Lipid measures | Model 1 | | Model 2 | | Model 3 | | Model 4 | |
|---|---|---|---|---|---|---|---|---|
| | B (95% CI) | p-value | B (95% CI) | p-value | B (95% CI) | p-value | B (95% CI) | p-value |
| **White blood cell count** | | | | | | | | |
| Total cholesterol | -0.024 (-0.035, -0.013) | <0.001 | -0.007 (-0.020, 0.005) | 0.255 | -0.019 (-0.034, -0.004) | 0.013 | -0.028 (-0.042, -0.014) | <0.001 |
| HDL cholesterol | -0.051 (-0.063, -0.040) | <0.001 | -0.027 (-0.039, -0.015) | <0.001 | -0.015 (-0.028, -0.002) | 0.029 | -0.016 (-0.028, -0.003) | 0.018 |
| LDL cholesterol | -0.017 (-0.029, -0.006) | 0.003 | -0.004 (-0.016, 0.008) | 0.516 | -0.014 (-0.027, -0.001) | 0.031 | -0.023 (-0.035, -0.011) | <0.001 |
| Triglyceride | 0.053 (0.043, 0.064) | <0.001 | 0.032 (0.021, 0.043) | <0.001 | 0.029 (0.017, 0.042) | <0.001 | 0.023 (0.011, 0.035) | <0.001 |
| **Basophil count** | | | | | | | | |
| Total cholesterol | 0.001 (-0.001, 0.002) | 0.222 | 0.001 (-0.001, 0.002) | 0.506 | 0.000 (-0.005, 0.004) | 0.950 | -0.001 (-0.003, 0.001) | 0.538 |
| HDL cholesterol | -0.001 (-0.003, 0.001) | 0.247 | -0.001 (-0.003, 0.001) | 0.167 | 0.000 (-0.002, 0.002) | 0.712 | -0.001 (-0.003, 0.002) | 0.602 |
| LDL cholesterol | 0.001 (-0.001, 0.002) | 0.283 | 0.000 (-0.001, 0.002) | 0.645 | 0.000 (-0.002, 0.002) | 0.809 | -0.001 (-0.002, 0.001) | 0.420 |
| Triglyceride | 0.002 (0.000, 0.003) | 0.016 | 0.002 (0.000, 0.004) | 0.011 | 0.002 (0.000, 0.004) | 0.042 | 0.002 (0.000, 0.004) | 0.056 |
| **Eosinophil count** | | | | | | | | |
| Total cholesterol | -0.002 (-0.005, 0.002) | 0.376 | -0.001 (-0.005, 0.004) | 0.695 | -0.002 (-0.007, 0.004) | 0.570 | -0.002 (-0.007, 0.003) | 0.415 |
| HDL cholesterol | -0.003 (-0.008, -0.002) | 0.253 | 0.000 (-0.005, 0.006) | 0.886 | 0.001 (-0.005, 0.006) | 0.861 | 0.000 (-0.005, 0.006) | 0.933 |
| LDL cholesterol | -0.001 (-0.005, 0.002) | 0.461 | -0.002 (-0.006, 0.003) | 0.497 | -0.002 (-0.006, 0.003) | 0.483 | -0.002 (-0.007, 0.002) | 0.333 |
| Triglyceride | 0.002 (-0.002, 0.006) | 0.352 | 0.000 (-0.004, 0.005) | 0.972 | 0.001 (-0.004, 0.006) | 0.789 | 0.001 (-0.004, 0.006) | 0.814 |
| **Monocyte count** | | | | | | | | |
| Total cholesterol | -0.021 (-0.032, -0.010) | <0.001 | -0.022 (-0.035, -0.009) | <0.001 | -0.014 (-0.029, 0.002) | 0.090 | -0.017 (-0.033, -0.001) | 0.034 |
| HDL cholesterol | 0.003 (-0.010, 0.016) | 0.695 | 0.006 (-0.009, 0.021) | 0.433 | -0.008 (-0.024, 0.009) | 0.378 | -0.008 (-0.024, 0.009) | 0.371 |
| LDL cholesterol | -0.017 (-0.028, -0.006) | 0.002 | -0.017 (-0.030, -0.004) | 0.011 | -0.010 (-0.024, 0.003) | 0.129 | -0.014 (-0.028, 0.000) | 0.047 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Triglyceride | -0.020 (-0.031, -0.008) | <0.001 | -0.026 (-0.038, -0.014) | <0.001 | -0.026 (-0.040, -0.012) | <0.001 | -0.028 (-0.042, -0.013) | <0.001 |
| **Neutrophil count** | | | | | | | | |
| Total cholesterol | -0.002 (-0.009, 0.005) | 0.549 | -0.005 (-0.013, 0.003) | 0.224 | -0.002 (-0.011, 0.007) | 0.682 | 0.000 (-0.010, 0.010) | 0.958 |
| HDL cholesterol | 0.011 (0.004, 0.019) | 0.004 | 0.008 (-0.001, 0.017) | 0.082 | 0.003 (-0.007, 0.012) | 0.566 | 0.003 (-0.006, 0.013) | 0.527 |
| LDL cholesterol | -0.003 (-0.010, 0.003) | 0.276 | -0.005 (-0.012, 0.003) | 0.201 | -0.002 (-0.010, 0.006) | 0.689 | 0.000 (-0.001, 0.008) | 0.989 |
| Triglyceride | -0.012 (-0.021, -0.003) | 0.006 | -0.012 (-0.021, -0.003) | 0.011 | -0.010 (-0.021, 0.000) | 0.054 | -0.010 (-0.020, 0.001) | 0.069 |
| **Lymphocyte count** | | | | | | | | |
| Total cholesterol | 0.012 (0.001, 0.023) | 0.030 | 0.021 (0.008. 0.034) | 0.001 | 0.014 (-0.001, 0.029) | 0.060 | 0.012 (-0.003, 0.027) | 0.130 |
| HDL cholesterol | -0.027 (-0.039, -0.015) | <0.001 | -0.025 (-0.038, -0.011) | <0.001 | -0.009 (-0.024, 0.006) | 0.234 | -0.009 (-0.024, 0.006) | 0.239 |
| LDL cholesterol | 0.015 (0.004, 0.025) | 0.007 | 0.022 (0.010, 0.035) | <0.001 | 0.013 (0.000, 0.026) | 0.054 | 0.010 (-0.003, 0.024) | 0.125 |
| Triglyceride | 0.037 (0.025, 0.048) | <0.001 | 0.037 (0.025, 0.049) | <0.001 | 0.030 (0.016, 0.045) | <0.001 | 0.029 (0.015, 0.043) | <0.001 |

Regression coefficient B (95% confidence interval) were expressed as ln-transformed cell counts ($\times 10^3/\mu L$) per one SD unit increase in lipid levels.

Data on different white blood cell counts and triglycerides were ln-transformed in the analysis.

Model 1: Adjusted for ln-transformed total white blood cell counts (except for the analysis of total white blood cell counts), age, sex and ethnicity.

Model 2: Further adjusted for body mass index, family income, smoking, pack-years of smoking, current alcohol use, physical activity, hypertension, diabetes, use of any lipid-lowering medication, estimated glomerular filtration rate, *APOE* genotype, history of cardiovascular disease, and history of coronary revascularization.

Model 3: Further adjusted for ln-transformed triglycerides and HDL cholesterol for the analysis of total cholesterol and LDL cholesterol; LDL cholesterol and ln-transformed triglycerides for analysis of HDL cholesterol; and HDL cholesterol and LDL cholesterol for analysis of ln-transformed triglycerides.

Model 4: Further adjusted for red blood cell and platelet counts.

HDL, high-density lipoprotein; LDL, low-density lipoprotein.

**Table 3.** Association of lipid levels with different types of white blood cell counts after excluding participants taking lipid-lowering drugs (n=1715)

| Lipid measures | B (95% CI) | p-value |
|---|---|---|
| **White blood cell count** | | |
| Total cholesterol | -0.025 (-0.043, -0.008) | 0.004 |
| HDL cholesterol | -0.018 (-0.034, -0.001) | 0.033 |
| LDL cholesterol | -0.021 (-0.036, -0.006) | 0.006 |
| Triglyceride | 0.025 (0.010, 0.041) | 0.001 |
| **Basophil count** | | |
| Total cholesterol | 0.000 (-0.002, 0.003) | 0.804 |
| HDL cholesterol | 0.000 (-0.003, 0.003) | 0.986 |
| LDL cholesterol | 0.000 (-0.002, 0.002) | 0.943 |
| Triglyceride | 0.001 (-0.001, 0.003) | 0.425 |
| **Eosinophil count** | | |
| Total cholesterol | -0.003 (-0.009, 0.004) | 0.376 |
| HDL cholesterol | 0.001 (-0.007, 0.009) | 0.748 |
| LDL cholesterol | -0.003 (-0.009, 0.003) | 0.283 |
| Triglyceride | 0.001 (-0.005, 0.008) | 0.696 |
| **Monocyte count** | | |
| Total cholesterol | -0.014 (-0.034, 0.005) | 0.153 |
| HDL cholesterol | -0.014 (-0.037, 0.008) | 0.214 |
| LDL cholesterol | -0.012 (-0.029, 0.005) | 0.153 |
| Triglyceride | -0.025 (-0.044, -0.006) | 0.008 |
| **Neutrophil count** | | |
| Total cholesterol | 0.001 (-0.012, 0.011) | 0.931 |
| HDL cholesterol | 0.006 (-0.006, 0.018) | 0.353 |
| LDL cholesterol | 0.000 (-0.011, 0.010) | 0.944 |
| Triglyceride | -0.010 (-0.021, 0.002) | 0.098 |
| **Lymphocyte count** | | |
| Total cholesterol | 0.014 (-0.004, 0.033) | 0.126 |
| HDL cholesterol | -0.009 (-0.028, 0.010) | 0.352 |
| LDL cholesterol | 0.012 (-0.004, 0.028) | 0.130 |
| Triglyceride | 0.023 (0.006, 0.041) | 0.008 |

Regression coefficient B (95% confidence interval) were expressed as ln-transformed cell counts ($\times 10^3/\mu L$) per one SD unit increase in lipid levels. Data on different white blood cell counts and triglycerides were ln-transformed in the analysis.

All data were adjusted for ln-transformed total white blood cell counts (except for analysis of total white blood cell counts), age, sex, ethnicity, body mass index, family income, smoking, pack-years of smoking, current alcohol use, physical activity, hypertension, diabetes, estimated glomerular filtration rate, *APOE* genotype, history of cardiovascular disease, history of coronary revascularization, red blood cell counts and platelet counts. Data were also adjusted for ln-transformed triglycerides and HDL cholesterol for analysis of total cholesterol and LDL cholesterol;

LDL cholesterol and ln-transformed triglycerides for analysis of HDL cholesterol; and HDL cholesterol and LDL cholesterol for analysis of ln-transformed triglycerides.

HDL, high-density lipoprotein; LDL, low-density lipoprotein.

**Table 4.** Non-linear association of different lipid levels with total white blood cell counts

| Lipid measures | n | B (95% CI) | p-value |
|---|---|---|---|
| Total cholesterol | | | |
| <155 mg/dL | 708 | -0.053 (-0.120, 0.015) | 0.124 |
| ≥155 mg/dL | 2165 | -0.019 (-0.036, -0.002) | 0.031 |
| LDL cholesterol | | | |
| <125 mg/dL | 2137 | -0.038 (-0.059, -0.017) | <0.001 |
| ≥125 mg/dL | 736 | 0.029 (-0.004, -0.061) | 0.086 |

Regression coefficient B (95% confidence interval) were expressed as ln-transformed cell counts ($\times 10^3/\mu L$). Data on total white blood cell counts were ln-transformed in the analysis.

All data were adjusted for age, sex, ethnicity, body mass index, family income, smoking, pack-years of smoking, current alcohol use, physical activity, hypertension, diabetes, use of any lipid-lowering medication, estimated glomerular filtration rate, *APOE* genotype, history of cardiovascular disease, history of coronary revascularization, red blood cell counts and platelet counts. Data were also adjusted for ln-transformed triglycerides and HDL cholesterol for analysis of total cholesterol and LDL cholesterol; LDL cholesterol and ln-transformed triglycerides for analysis of HDL cholesterol; and HDL cholesterol and LDL cholesterol for analysis of ln-transformed triglycerides.

HDL, high-density lipoprotein; LDL, low-density lipoprotein.

**Table 5.** Summary of significant associations between different lipid measures and different white blood cell counts

| Lipid measures | Using ln-transformed cell counts | | Using un-transformed cell counts* | |
|---|---|---|---|---|
| | **All** | **Excluding participants taking lipid-lowering drugs** | **All** | **Excluding participants taking lipid-lowering drugs** |
| **White blood cell count** | | | | |
| Total cholesterol | - | - | | |
| HDL cholesterol | - | - | | |
| LDL cholesterol | - | - | | |
| Triglyceride | + | + | | |
| **Basophil count** | | | | |
| Total cholesterol | ns | ns | ns | ns |
| HDL cholesterol | ns | ns | ns | ns |
| LDL cholesterol | ns | ns | ns | ns |
| Triglyceride | ns | ns | ns | ns |
| **Eosinophil count** | | | | |
| Total cholesterol | ns | ns | ns | ns |
| HDL cholesterol | ns | ns | ns | ns |
| LDL cholesterol | ns | ns | ns | ns |
| Triglyceride | ns | ns | ns | ns |
| **Monocyte count** | | | | |
| Total cholesterol | - | ns | | |
| HDL cholesterol | ns | ns | | |
| LDL cholesterol | - | ns | | |
| Triglyceride | - | - | | |
| **Neutrophil count** | | | | |
| Total cholesterol | ns | ns | ns | - |
| HDL cholesterol | ns | ns | ns | ns |
| LDL cholesterol | ns | ns | ns | - |
| Triglyceride | ns | ns | - | ns |
| **Lymphocyte count** | | | | |
| Total cholesterol | ns | ns | | |
| HDL cholesterol | ns | ns | | |
| LDL cholesterol | ns | ns | | |
| Triglyceride | + | + | | |

"+" and "-" indicate significant positive and negative associations, respectively, in the final full adjustment model with $p \leq 0.05$. ns = not significant.

*Analysis was performed for basophil, eosinophil, and neutrophil counts only.

HDL, high-density lipoprotein; LDL, low-density lipoprotein.

**Supplementary Table 1.** Clinical characteristics of participants included and not included in this study.

| Characteristics | Not included | Included | p-value |
|---|---|---|---|
| n | 1843 | 2873 | |
| Age, years | 70.5 ± 9.7 | 69.5 ± 9.3 | <0.001 |
| Women | 995 (54.0%) | 1519 (52.9%) | 0.453 |
| Race/ethnicity | | | <0.001 |
| Non-Hispanic White | 695 (37.7%) | 1231 (42.8%) | |
| African American | 447 (24.3%) | 803 (27.9%) | |
| Hispanic American | 187 (10.1%) | 812 (28.3%) | |
| Chinese American | 514 (27.9%) | 27 (0.9%) | |
| Recruitment site | | | <0.001 |
| Forsyth County, North Carolina | 215 (11.7%) | 598 (20.8%) | |
| New York, New York | 148 (8.0%) | 662 (23.0%) | |
| Baltimore, Maryland | 154 (8.4%) | 504 (17.5%) | |
| St. Paul, Minnesota | 77 (4.2%) | 694 (24.2%) | |
| Chicago, Illinois | 833 (45.2%) | 43 (1.5%) | |
| Los Angeles County, California | 416 (22.6%) | 372 (12.9%) | |

Data are expressed as mean ± SD or n (%). Baseline characteristics at randomization were determined using a chi-square test for categorical variables, and an ANOVA test for continuous variables.

**Supplementary Table 2.** Association of lipid levels with un-transformed basophil, eosinophil and neutrophils counts using multivariable linear regression analysis (n=2873)

| **Lipid measures** | B (95% CI) | p-value |
|---|---|---|
| **Basophil count** | | |
| Total cholesterol | -0.001 (-0.003, 0.001) | 0.532 |
| HDL cholesterol | -0.001 (-0.003, 0.002) | 0.592 |
| LDL cholesterol | -0.001 (-0.003, 0.001) | 0.416 |
| Triglyceride | 0.002 (0.000, 0.004) | 0.055 |
| **Eosinophil count** | | |
| Total cholesterol | -0.003 (-0.010, 0.004) | 0.365 |
| HDL cholesterol | 0.002 (-0.006, 0.009) | 0.659 |
| LDL cholesterol | -0.003 (-0.009, 0.003) | 0.287 |
| Triglyceride | 0.001 (-0.006, 0.008) | 0.831 |
| **Neutrophil count** | | |
| Total cholesterol | -0.028 (-0.069, 0.013) | 0.175 |
| HDL cholesterol | 0.025 (-0.010, 0.060) | 0.156 |
| LDL cholesterol | -0.023 (-0.058, 0.012) | 0.193 |
| Triglyceride | -0.045 (-0.090, 0.000) | 0.050 |

Regression coefficient B (95% confidence interval) were expressed as cell counts ($\times 10^3/\mu L$) per one SD unit increase in lipid levels. Data on triglycerides were ln-transformed in the analysis.

All data were adjusted for ln-transformed total white blood cell counts, age, sex, ethnicity, body mass index, family income, smoking, pack-years of smoking, current alcohol use, physical activity, hypertension, diabetes, use of any lipid-lowering medication, estimated glomerular filtration rate, *APOE* genotype, history of cardiovascular disease, history of coronary revascularization, red blood cell and platelet counts. Data were also adjusted for ln-transformed triglycerides and HDL cholesterol for the analysis of total cholesterol and LDL cholesterol; LDL cholesterol and ln-transformed triglycerides for analysis of HDL cholesterol; and HDL cholesterol and LDL cholesterol for analysis of ln-transformed triglycerides.

HDL, high-density lipoprotein; LDL, low-density lipoprotein.

**Supplementary Table 3.** Association of lipid levels with un-transformed basophil, eosinophil and neutrophils counts using multivariable linear regression analysis after excluding participants taking lipid-lowering drugs (n=1715)

| Lipid measures | B (95% CI) | p-value |
|---|---|---|
| **Basophil count** | | |
| Total cholesterol | 0.000 (-0.002, 0.003) | 0.796 |
| HDL cholesterol | 0.000 (-0.003, 0.003) | 0.989 |
| LDL cholesterol | 0.000 (-0.002, 0.002) | 0.934 |
| Triglyceride | 0.001 (-0.002, 0.004) | 0.425 |
| **Eosinophil count** | | |
| Total cholesterol | -0.004 (-0.013, 0.004) | 0.322 |
| HDL cholesterol | 0.003 (-0.007, 0.014) | 0.526 |
| LDL cholesterol | -0.004 (-0.012, 0.003) | 0.239 |
| Triglyceride | 0.002 (-0.006, 0.011) | 0.580 |
| **Neutrophil count** | | |
| Total cholesterol | -0.046 (-0.091, -0.001) | 0.043 |
| HDL cholesterol | 0.011 (-0.033, 0.055) | 0.633 |
| LDL cholesterol | -0.039 (-0.078, 0.000) | 0.049 |
| Triglyceride | -0.029 (-0.074, 0.016) | 0.208 |

Regression coefficient B (95% confidence interval) were expressed as cell counts ($\times 10^3/\mu L$) per one SD unit increase in lipid levels. Data on triglycerides were ln-transformed in the analysis.

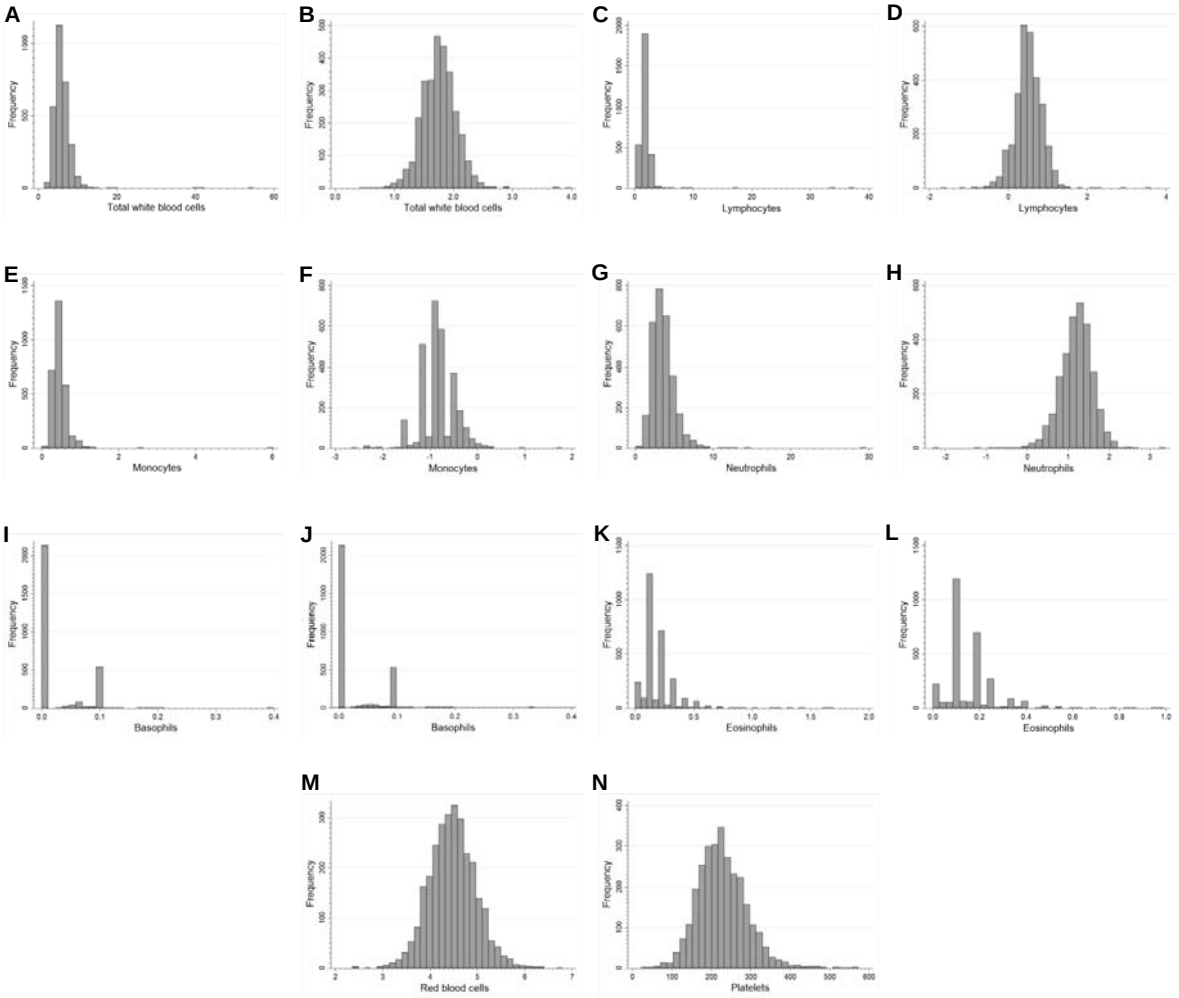
All data were adjusted for ln-transformed total white blood cell counts, age, sex, ethnicity, body mass index, family income, smoking, pack-years of smoking, current alcohol use, physical activity, hypertension, diabetes, estimated glomerular filtration rate, *APOE* genotype, history of cardiovascular disease, history of coronary revascularization, red blood cell counts and platelet counts. Data were also adjusted for ln-transformed triglycerides and HDL cholesterol for analysis of total cholesterol and LDL cholesterol; LDL cholesterol and ln-transformed triglycerides for analysis of HDL cholesterol; and HDL cholesterol and LDL cholesterol for analysis of ln-transformed triglycerides.

HDL, high-density lipoprotein; LDL, low-density lipoprotein.

**Supplementary Table 4.** Association of triglycerides levels with total white blood cell counts according to race/ethnicity using multivariable linear regression analysis (n=2873)

| Race/ethnicity | B (95% CI) | p-value |
|---|---|---|
| **Non-Hispanic White** | -0.015 (-0.003, 0.033) | 0.107 |
| **African American** | 0.054 (0.028, 0.080) | <0.001 |
| **Hispanic American** | 0.003 (-0.020, 0.027) | 0.779 |

Regression coefficient B (95% confidence interval) were expressed as ln-transformed cell counts ($\times 10^3/\mu L$) per one SD (0.451) unit increase in ln-transformed triglyceride level. All data were adjusted for age, sex, ethnicity, body mass index, family income, smoking, pack-years of smoking, current alcohol use, physical activity, hypertension, diabetes, use of any lipid-lowering medication, estimated glomerular filtration rate, *APOE* genotype, history of cardiovascular disease, history of coronary revascularization, HDL cholesterol, LDL cholesterol, red blood cell, and platelet counts. HDL, high-density lipoprotein; LDL, low-density lipoprotein.




**Supplementary Figure 1.** Distribution of total white blood cell (A, B), lymphocyte (C, D), monocyte (E, F), neutrophil (G, H), basophil (I, J) and eosinophil (K, L) counts ($\times 10^3/\mu L$), before (A, C, E, G, I and K) and after (B, D, F, H, J and L) ln-transformation. Distribution of untransformed red blood cell (M) ($\times 10^6/\mu L$) and platelet (N) ($\times 10^3/\mu L$) counts.