

HEMATOPOIESIS AND STEM CELLS

Association of clonal hematopoiesis with chronic obstructive pulmonary disease

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KEY POINTS

- Individuals with clonal hematopoiesis are more likely to have COPD and more severe disease.
- Mice lacking *Tet2* (often mutated in CHIP) in blood cells have accelerated development of emphysema in models of pulmonary inflammation.

Chronic obstructive pulmonary disease (COPD) is associated with age and smoking, but other determinants of the disease are incompletely understood. Clonal hematopoiesis of indeterminate potential (CHIP) is a common, age-related state in which somatic mutations in clonal blood populations induce aberrant inflammatory responses. Patients with CHIP have an elevated risk for cardiovascular disease, but the association of CHIP with COPD remains unclear. We analyzed whole-genome sequencing and whole-exome sequencing data to detect CHIP in 48 835 patients, of whom 8444 had moderate to very severe COPD, from four separate cohorts with COPD phenotyping and smoking history. We measured emphysema in murine models in which *Tet2* was deleted in hematopoietic cells. In the COPD Gene cohort, individuals with CHIP had risks of moderate-to-severe, severe, or very severe COPD that were 1.6 (adjusted 95% confidence interval [CI], 1.1-2.2) and 2.2 (adjusted 95% CI, 1.5-3.2) times greater than those for noncarriers. These findings were consistently observed in three additional cohorts and meta-analyses of all patients. CHIP was also associated with decreased FEV₁% predicted in the COPD Gene cohort (mean between-group differences, -5.7%; adjusted 95% CI, -8.8% to -2.6%), a finding replicated in additional cohorts. Smoke exposure was associated with a small but significant increased risk of having CHIP (odds ratio, 1.03 per 10 pack-years; 95% CI, 1.01-1.05 per 10 pack-years) in the meta-analysis of all patients. Inactivation of *Tet2* in mouse hematopoietic cells exacerbated the development of emphysema and inflammation in models of cigarette smoke exposure. Somatic mutations in blood cells are associated with the development and severity of COPD, independent of age and cumulative smoke exposure.

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Introduction

Chronic obstructive pulmonary disease (COPD) is a chronic lung disease that affects approximately 15 million adults and is the fourth leading cause of death in the United States.^{1,2} The pathophysiologic drivers of COPD are complex, including both innate and adaptive immune cells and increased levels of inflammatory cytokines.³⁻⁵ Cigarette smoking and age contribute to this aberrant inflammatory pathophysiology and are two of the strongest risk factors for the development and progression of COPD.^{1,6,7}

Clonal hematopoiesis of indeterminate potential (CHIP) is a common, age-related phenomenon in which somatic mutations in hematopoietic stem cells result in clonal outgrowth of a mutant population of blood cells in individuals without a hematologic malignancy.⁸ CHIP, which is associated with an increased risk of leukemia and ischemic cardiovascular diseases, is characterized by an aberrant inflammatory state.⁹⁻¹² We therefore hypothesized that CHIP may also be a causal risk factor for the development and/or progression of COPD.

Weak associations between CHIP and COPD have been observed in previous studies, but definitive conclusions were precluded by small sample size, quality of COPD phenotyping and smoking data, and a potential confounding association between CHIP and smoking.¹³⁻¹⁶ In this study, we sought to definitively assess the association between CHIP and COPD through analyses of whole-genome sequencing and whole-exome sequencing data from several large, extensively phenotyped cohorts of COPD patients and controls. We then used mouse models to determine whether there is a causal relationship between CHIP and emphysema, one of the most common manifestations of COPD.

Methods

Study samples

Spirometry data were available for all patients included in this study. The primary study cohort was COPDGene, the largest COPD study in the Trans-Omics for Precision Medicine (TOPMed) program.¹⁷ We also included the following three additional cohorts: (1) TOPMed studies that comprised population- and family-based cohorts and an additional COPD-enriched study¹⁸: Atherosclerosis Risk in Communities (ARIC), Cleveland Family Study (CFS), Framingham Heart Study (FHS), Jackson Heart Study (JHS), the Multi-Ethnic Study of Atherosclerosis (MESA) Lung Study, and the Evaluation of COPD Longitudinally to Identify Predictive Surrogate Endpoints (ECLIPSE); (2) two family-based cohorts: the International COPD Genetics Network (ICGN) study and the Boston Early-Onset COPD study (EOCOPD)¹⁹ (ICGN-EOCOPD); and (3) the subset of UK Biobank participants with whole-exome sequencing and spirometry data.²⁰

COPD and COPD severity were defined on the basis of spirometry grades from the Global Initiative for Chronic Obstructive Lung Disease (GOLD), in which GOLD 2 is classified as moderate, GOLD 3 as severe, and GOLD 4 as very severe.²¹ Age and cigarette smoking history (pack-years) were available for all

analyzed patients (Table 1; supplemental Tables 1 and 2; supplemental Figure 1 [available on the *Blood* Web site]). Further information about these cohorts is included in the supplemental Data.

Whole-genome sequencing and whole-exome sequencing

We obtained whole-genome sequencing or whole-exome sequencing data from DNA in peripheral blood samples. The raw sequencing data were processed, and somatic mutation calling was performed by using Mutect2 as previously described.^{11,22} We identified cases of CHIP by using a prespecified list of variants predicted or reported to be pathogenic and drivers of myeloid malignancies. Details regarding the sequencing procedures are provided in the supplemental Data.

Mouse models

We transplanted lethally irradiated mice with bone marrow from *Tet2* wild-type (WT) or *Tet2* knockout (KO) donors, exposed the recipient animals to air, cigarette smoke (CS), or CS and polyinosinic:polycytidylic acid (poly(I:C)), and quantified the development of emphysema by using morphometric methods.²³ Single-cell RNA-sequencing was performed on the 10x platform (10x Genomics). Details on the experimental approach, including quantification of occurrences of emphysema and single-cell analyses are provided in the supplemental Data.

Statistical analysis

We examined the associations of five COPD-related phenotypes with CHIP, including moderate-to-severe COPD (GOLD 2-4 vs GOLD 0), severe or very severe COPD (GOLD 3-4 vs GOLD 0), severe-to-very-severe COPD within the group of patients with moderate-to-severe COPD (GOLD 3-4 vs GOLD 2), and percent predicted forced expiratory volume in 1 second (FEV₁%p), and FEV₁%p within patients who had moderate-to-severe COPD (supplemental Tables 4, 7-9, and 11). We also examined the effect of smoking on CHIP.

For the COPDGene and UK Biobank data, we used multivariable logistic regression to examine the associations between COPD (GOLD 2-4 vs GOLD 0) and CHIP, adjusting for age at blood draw, age², sex, sequencing center, number of pack-years, smoking status, and the top 10 principal components of genetic ancestry. Linear regression tested the association between CHIP and FEV₁%p, a quantitative measure of airflow obstruction in patients with COPD, adjusted for the same set of covariates using all samples (including patients with GOLD 1). To examine the association between the presence of CHIP (as a binary outcome) and smoking, we used number of pack-years as the independent variable in the logistic regression, adjusting for age, sex, current smoking status, sequencing center, and top 10 principal components of genetic ancestry.

For the additional TOPMed, ICGN, and EOCOPD cohorts, we used a generalized linear mixed-effects model and linear mixed-effects models to account for family relatedness between patients in the GENESIS R package with the same covariates as described above.²⁴ Random effects meta-analyses were

Table 1. Cohort characteristics

| Characteristic | Cohort | | | | Total (N = 48 835) |
|--|---------------------|--|----------------------------|-------------------------|--------------------|
| | COPDGene (n = 8395) | Additional TOPMed studies (n = 11 269) | ICGN and EOCOPD (n = 1554) | UK Biobank (n = 27 617) | |
| Median age, y (IQR) | 58.7 (51.8-66.3) | 60.0 (53.0-67.0) | 56.0 (49.7-63.1) | 58 (51.0-63.0) | 58.6 (51.3-64.0) |
| Patients with CHIP | 478 (5.7) | 566 (5.0) | 92 (5.9) | 1,588 (5.8) | 2,724 (5.6) |
| COPD GOLD status | | | | | |
| 2-4 | 3421 | 2282 | 1282 | 1459 | 8444 |
| 3-4 | 1698 | 945 | 853 | 149 | 3645 |
| Mean predicted FEV ₁ % (SD) | 73 (25.6) | 87.7 (23) | 47.7 (26.8) | 100.8 (16.6) | 91.3 (24.2) |
| Smoking status | | | | | |
| Smokers | 8395 | 6515 | 1462 | 12 321 | 28 693 |
| Mean pack-years (SD) | 44.3 (25.0) | 16.1 (24.7) | 42.0 (26.7) | 6.2 (13.12) | 16.1 (24.1) |

Data represent no. (%) unless otherwise specified. IQR, interquartile range; SD, standard deviation.

conducted for the additional TOPMed cohorts for all the phenotypes by using the metafor package.²⁵

The 95% confidence intervals (CIs) reported for the primary cohort (COPDGene) were adjusted for the 6 phenotypes we examined (supplemental Table 4), and the significance level was defined as $0.05/6 = 0.0083$ for the primary cohort. Replication was defined as reaching a nominal significance level of 0.05 using a one-sided test with consistent direction of effect in at least one of the three replication cohorts. The reported 95% CIs for the additional cohorts (additional TOPMed, ICGN, EOCOPD, and UK Biobank cohorts) were not adjusted for multiple testing. Details regarding the statistical analyses are provided in the Extended Methods of the supplemental Data. Informed consent was obtained, per the Declaration of Helsinki.

Results

Association between CHIP and COPD in COPDGene

In our primary cohort (COPDGene), we identified CHIP mutations in 478 (5.7%) of the 8395 individuals (Table 1). The most common mutations were in *DNMT3A*, *TET2*, and *ASXL1*, genes that encode for epigenetic regulators and are the most commonly mutated genes in CHIP (Figure 1; supplemental Figure 2; supplemental Table 3).²² In a multivariable model that included age, smoking, and sex, CHIP was associated with odds ratios (ORs) of 1.6 (adjusted 95% CI, 1.1-2.2; $P = .0003$) for GOLD 2-4 and 2.2 (adjusted 95% CI, 1.5-3.2; $P < .0001$) for GOLD 3-4 COPD (Figure 2A-B; supplemental Table 4). Among the 3421 patients with GOLD 2-4 disease, CHIP was more common in those with GOLD 3-4 (OR, 1.6; adjusted 95% CI, 1.1-2.4; $P = .0009$) (Figure 2C; supplemental Table 4).

These associations remained significant in COPDGene after controlling for the COPD polygenic risk score, a metric that

integrates many germline risk alleles (OR for GOLD 2-4 COPD, 1.57; $P = .0006$; OR for GOLD 3-4 COPD, 2.15; $P < .0001$), and when adjusting for incident lung cancer, lung cancer mortality, other self-reported cancers, cardiovascular disease, and the highest degree of school completed as a measure of socioeconomic status (OR for GOLD 2-4 COPD, 1.53; $P = .001$) (supplemental Table 5).²⁶ Examining the individual genes, we found that patients in COPDGene with *DNMT3A* or *TET2* mutations had significantly higher odds of having GOLD 3-4 disease (OR, 1.8;

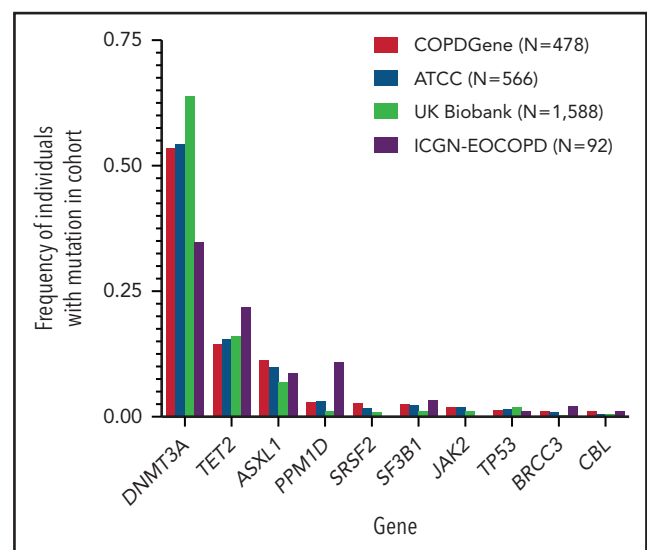


Figure 1. Distribution of clonal hematopoietic mutations in studied cohorts. Clonal hematopoietic mutations were identified from sequencing of whole genomes (COPDGene, additional TOPMed cohorts) or exomes (ICGN-EOCOPD, UK Biobank) found in samples of peripheral blood. Shown are the 10 most frequently mutated genes in COPDGene. N represents the number of CHIP carriers identified in each cohort. In patients with multiple mutations, the mutated gene with the largest variant allele frequency is shown.

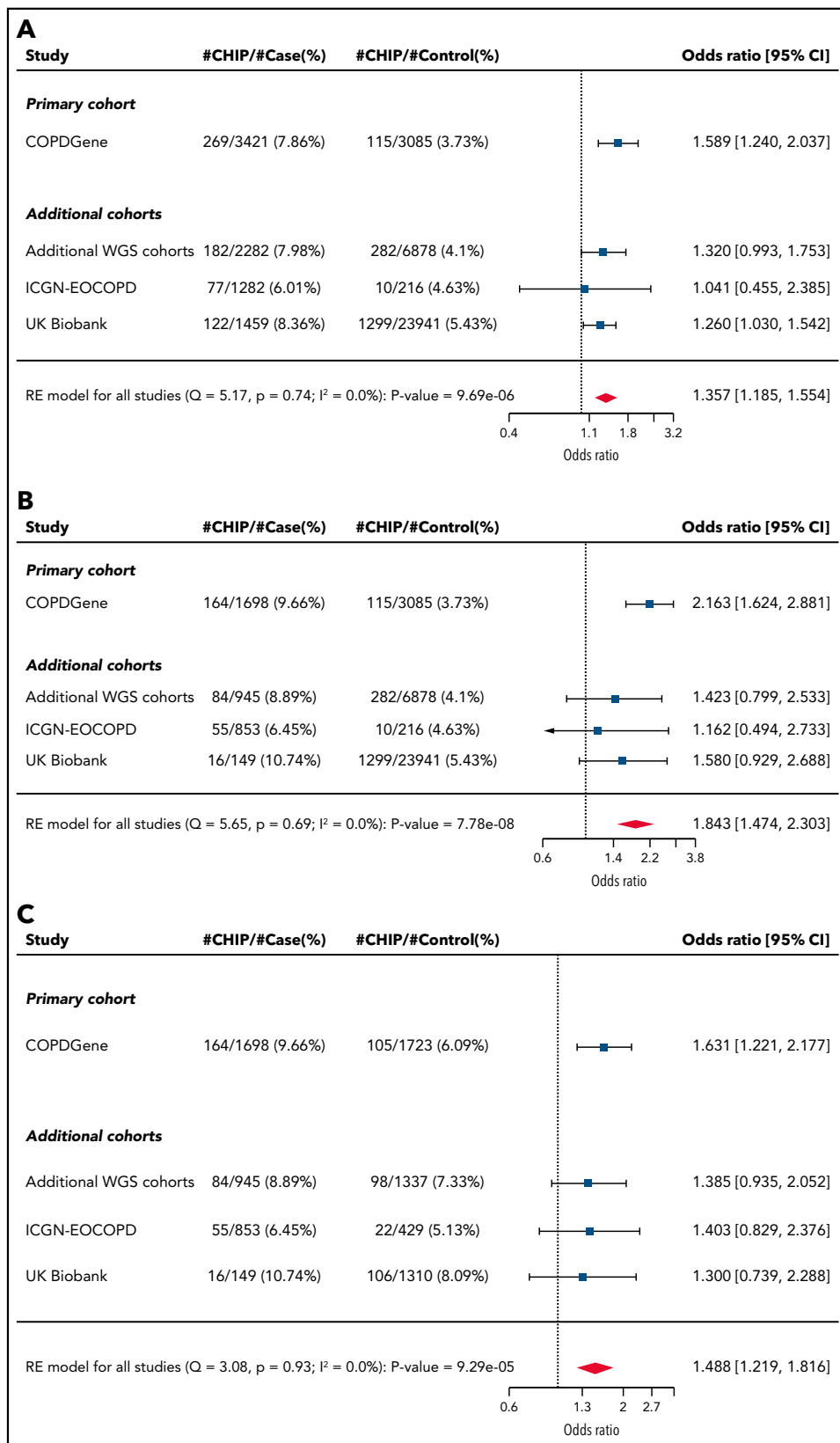


Figure 2. Association between CHIP status and COPD. Forest plots showing logistic regression results for association between CHIP status and (A) GOLD 2-4 and (B) GOLD 3-4 COPD among all patients. (C) Forest plot showing logistic regression results for association between CHIP status and severity (GOLD 3-4) among patients with GOLD 2-4 COPD. The arrowhead indicates that the limit of the CI is beyond the range annotated on the OR axis at the bottom. Note that the CIs listed for all cohorts are unadjusted. RE, random effects; WGS, whole-genome sequencing.

adjusted 95% CI, 1.03-3.06; $P = .004$ and OR, 3.7; adjusted 95% CI, 1.01-13.4; $P = .005$, respectively) (supplemental Table 6).

Association between CHIP and COPD in the ICGN, EOCOPD, and UK Biobank additional TOPMed cohorts

We next analyzed three additional cohorts, all of which included COPD phenotyping, smoking, and sequencing data. The additional TOPMed cohorts included six studies totaling 11 269 patients (2282 with COPD). ICGN-EOCOPD are family-based studies of younger patients and included 1554 patients (1282 with COPD). The UK Biobank has a population-based cohort and included 27 617 individuals (1459 with COPD). In the additional TOPMed cohorts, ICGN-EOCOPD, and the UK Biobank, CHIP was identified in 5.0%, 5.9%, and 5.8% of individuals, respectively.

Across all cohorts, CHIP was more common in the patients with COPD (supplemental Tables 7-9). In both UK Biobank and the additional TOPMed cohorts, CHIP was associated with an OR of 1.3 ($P = .025$ and one-sided $P = .028$, respectively) for GOLD 2-4 COPD, but was not significantly associated in ICGN-EOCOPD (Figure 2; supplemental Figure 3). The association in the UK Biobank remained after adjusting for lung cancer, lung cancer mortality, presence of other cancer, cardiovascular disease, and highest degree of school completed (OR, 1.3; $P = .03$) (supplemental Table 10). We also observed the association between *TET2* and GOLD 3-4 COPD in the UK Biobank cohort (OR, 2.67; 1-sided $P = .029$).

In an exploratory analysis of the UK Biobank using 14 International Classification of Diseases 10th Revision (ICD-10) codes (see the supplemental Data), we found that the presence of CHIP was significantly associated with an increased incidence of COPD with variant allele frequencies >0.1 , which is equivalent to $>10\%$ of DNA reads carrying a mutation (hazard ratio [HR], 1.69; 95% CI, 1.03-2.76; $P = .036$) but not with variant allele frequencies <0.1 (HR, 0.66; 95% CI, 0.33-1.24, $P = .18$) (supplemental Figure 4).

Association between CHIP and COPD in all patients

We combined all of the cohorts and performed random effects meta-analyses (Figure 2; supplemental Table 11). Across all 48 835 individuals, CHIP was associated with ORs of 1.4 (95% CI, 1.2-1.6; $P < .0001$) for GOLD 2-4 COPD and 1.8 (95% CI, 1.5-2.3; $P < .0001$) for GOLD 3-4 COPD (Figure 2A-B). Among the 8444 patients with GOLD 2-4 disease, CHIP was more common in those with GOLD 3-4 (OR, 1.5; 95% CI, 1.2-1.8; $P < .0001$) (Figure 2C). To quantify the effect of CHIP on COPD in terms of CS exposure, we compared the estimated OR for COPD with the presence of CHIP from the meta-analysis with the OR for COPD per 10 pack-years of smoking from the population-based BOLD study (estimated OR, between 1.16 and 1.28).^{27,28} The effect of CHIP on the odds of GOLD 2-4 disease was equivalent to 12 to 21 pack-years of smoking, and the effect on the odds of GOLD 3-4 disease was equivalent to 25 to 41 pack-years of smoking.

To further interrogate the relationship between COPD and the intensity of cigarette smoking, we generated six strata: never-

smokers, ever-smokers, current-smokers, former-smokers, heavy smokers (pack-years >30), and light smokers (pack-years <15) (supplemental Table 12; supplemental Figure 7). We observed a significant association between CHIP and GOLD 2-4 COPD in ever-smokers, former-smokers, and heavy-smokers and a nominal association in light-smokers. The OR in never-smokers and current-smokers was directionally consistent with the other strata but did not reach statistical significance, potentially because the former was underpowered with few cases of COPD in never-smokers and the latter was potentially confounded by the "healthy smoker phenomenon," in which patients with the worst COPD are more likely to quit smoking, causing a paradoxical finding that current-smoking status is protective for COPD and COPD exacerbations in COPDGene.

In the meta-analyses, GOLD 2-4 COPD was significantly associated with mutations in *DNMT3A* (OR, 1.30; adjusted 95% CI, 1.02-1.67, $P = .003$). GOLD 3-4 COPD was significantly associated with mutations in *DNMT3A* (OR, 1.7; adjusted 95% CI, 1.1-2.6, $P = .001$), *TET2* (OR, 2.4; adjusted 95% CI, 1.0-5.6, $P = .004$), and *TP53* (OR, 9.2; adjusted 95% CI, 1.5-57.7; $P = .001$) (supplemental Table 13).

Association between CHIP and quantitative impairment of lung function

We next analyzed the associations between CHIP and FEV₁%p (Figure 3). In COPDGene, CHIP was significantly associated with decreased FEV₁%p among all patients (mean between-group difference, -5.8% ; adjusted 95% CI, -8.7% to -2.8% ; $P < .0001$) and when restricted to those with GOLD 2-4 COPD (mean between-group difference, -2.6% ; adjusted 95% CI, -5.2% to -0.07% ; $P = .008$).

CHIP was significantly associated with decreased FEV₁%p in ICGN-EOCOPD (mean between-group difference, -6.4% ; 95% CI, -11.6% to -1.2% ; $P = .02$) and UK Biobank (mean between-group difference, -0.8% ; one-sided $P = .03$) but not in the additional TOPMed cohorts. When restricted to those with GOLD 2-4 COPD, CHIP was associated with decreased FEV₁%p in ICGN-EOCOPD (mean between-group difference, -5.0% ; 95% CI, -9.1% to -0.8% ; $P = .02$) but not in the additional TOPMed or UK Biobank cohorts.

Using a random effects meta-analysis, CHIP was associated with decreased FEV₁%p among all 48 835 patients (mean between-group difference, -1.9% ; 95% CI, -3.5% to -0.2% ; $P = .03$) and the 8444 patients with GOLD 2-4 COPD (mean between-group difference, -2.1% ; 95% CI, -3.2% to -0.9% ; $P = .0003$).

Association between CHIP and smoking

Smoking has been reported as a risk factor for CHIP, but these reports generally used discrete metrics of smoking (yes/no or former/current/never) and often have missing data.^{13,14} To address these issues, we examined the association between smoking status and CHIP by using the comprehensive smoking history available for all patients (supplemental Figure 5). After controlling for age, there was no significant association between CHIP status and number of pack-years of smoking in COPDGene, ICGN-EOCOPD, or UK Biobank cohorts. In contrast, CHIP was associated with smoking in the additional TOPMed cohorts

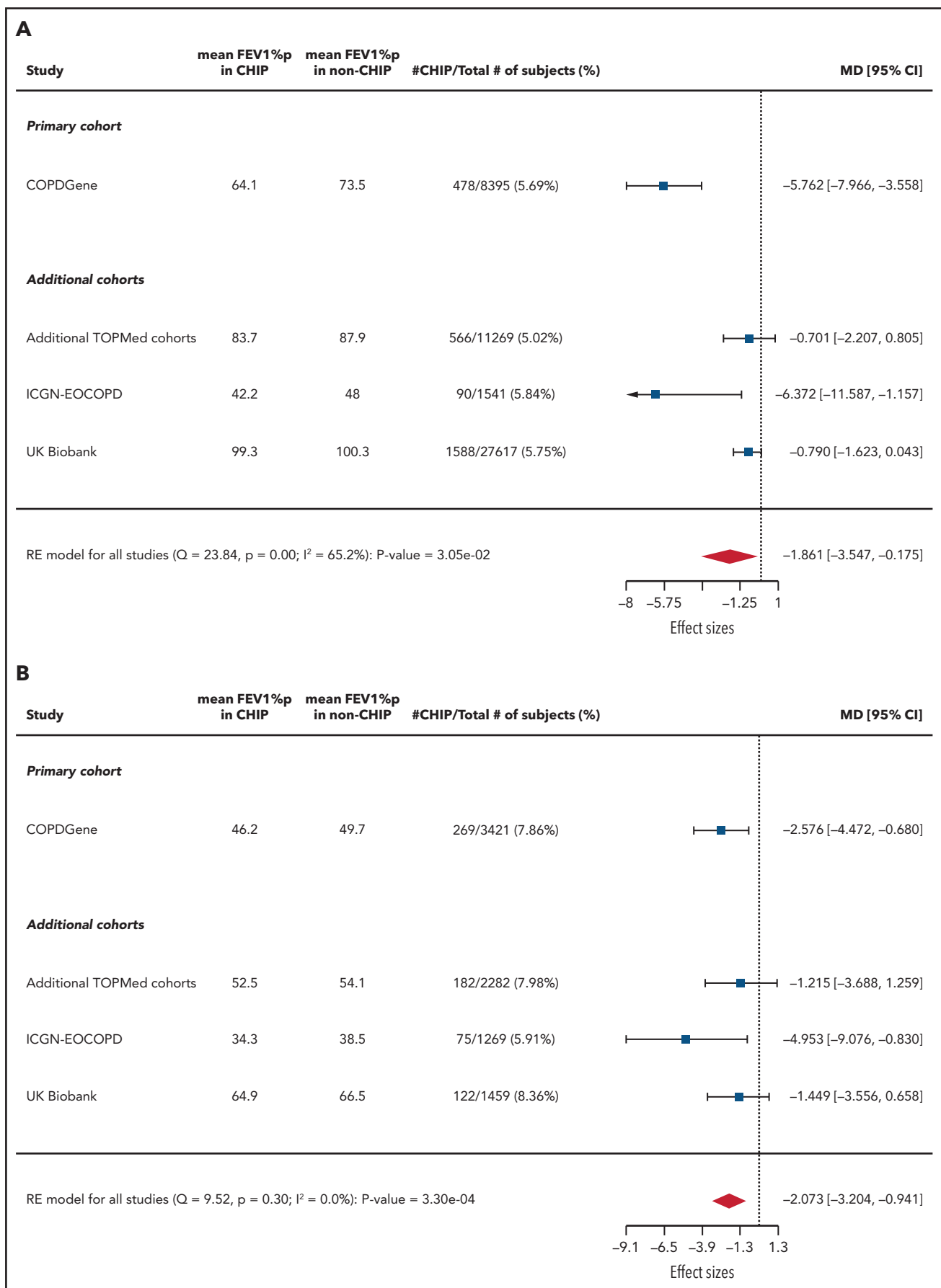


Figure 3. Association between CHIP status and FEV₁%p. Forest plots showing linear regression results of association between CHIP status and FEV₁%p (A) across all patients and (B) restricted to those with GOLD 2-4 COPD. Note that the CIs listed for all cohorts are unadjusted. MD, mean difference (%).

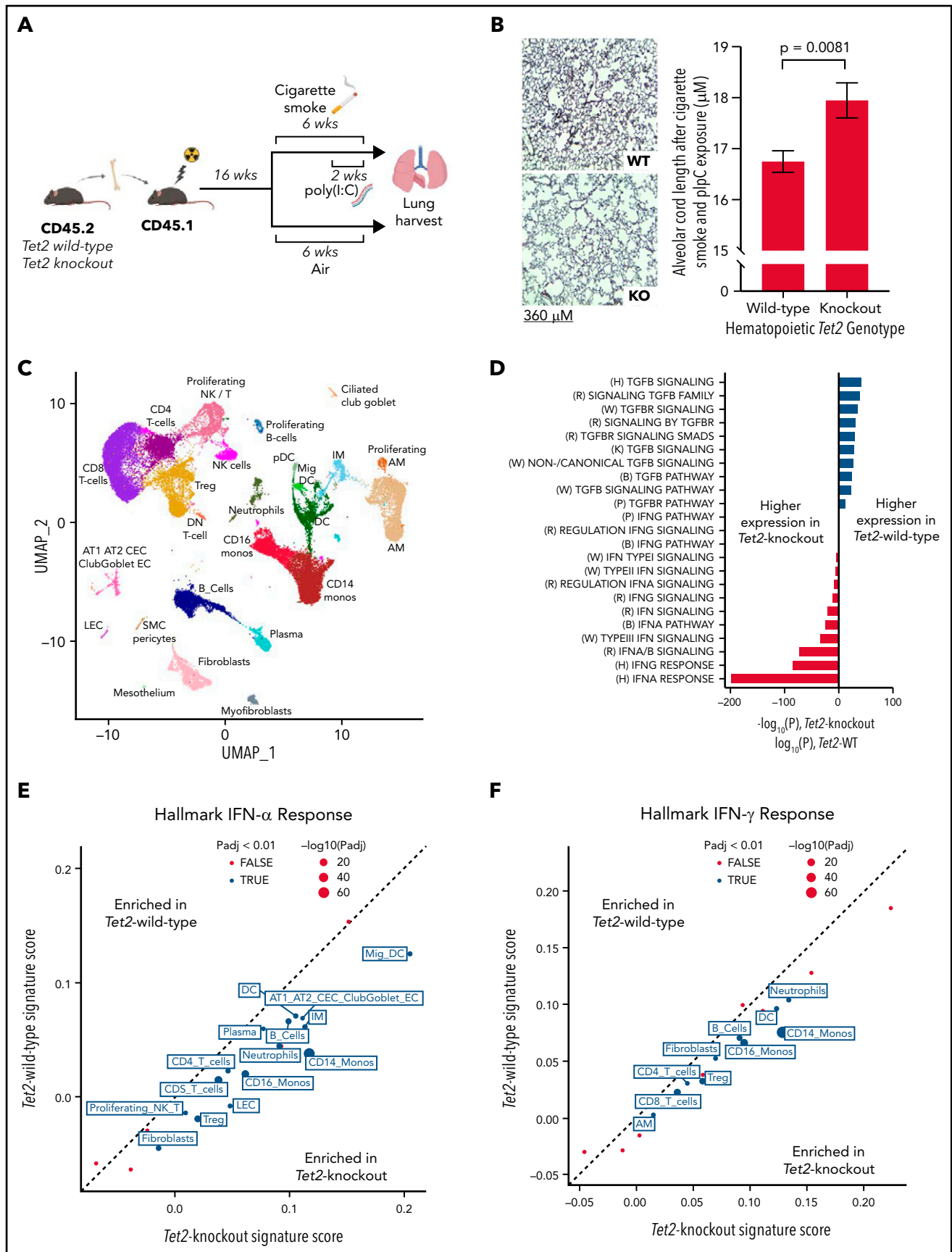


Figure 4. Effect of hematopoietic *Tet2* KO on emphysema development. (A) Schematic of experimental approach for mice treated with CS and poly(I:C). (B) Representative images of airspace destruction (Gill's stain imaged at $\times 10$ magnification) in *Tet2* WT and *Tet2* KO mice (left) and quantification of emphysema in *Tet2* WT

(OR, 1.007; 95% CI, 1.003-1.01; $P = .0005$). A random effects model of all patients revealed a small but significant association (OR, 1.003; 95% CI, 1.001-1.005; $P = .0037$) corresponding to an OR of 1.03 for every 10 pack-years of smoking (supplemental Figure 5; supplemental Table 14). Taken together, these data suggest that there is a small but significant relationship between cumulative CS exposure and CHIP.

Hematopoietic *Tet2* loss accelerates the development of emphysema in a mouse model via alteration in inflammation and cytokine signaling

On the basis of observed associations in humans, we hypothesized that mutated hematopoietic cells could promote an inflammatory phenotype to accelerate the pathogenesis of COPD. To test this hypothesis directly, we used *Tet2* KO mice to model CHIP because *TET2* was commonly mutated in and independently associated with COPD in the human cohorts (supplemental Table 13), and loss of *Tet2* in the blood cells of mice faithfully recapitulates inflammatory phenotypes observed in humans with CHIP.^{9,10,29,30} Mice carrying *Tet2* WT or *Tet2* KO hematopoietic cells were generated by bone marrow transplantation from 8-week-old donors that were aged for an additional 6 months and then exposed to CS for 6 weeks with poly(I:C) treatment during weeks 5 and 6 (Figure 4A).⁴ This model of smoking-induced COPD incorporates poly(I:C), a synthetic oligonucleotide that stimulates toll-like receptor 3 (TLR3) and is critical for the immune response to numerous viral infections, which are more common in patients with COPD.³¹ The mice were then euthanized and the lungs were analyzed.

Compared with the WT controls, mice carrying *Tet2* KO hematopoietic cells exhibited significantly increased development of emphysema (mean alveolar cord length [a measure of alveolar diameter], 16.0 vs 17.4 μM ; $P = .008$) (Figure 4B; supplemental Table 15). In a separate model that more closely resembles the clonal size of mutant hematopoietic cells found in human CHIP, mice with ~15% of hematopoietic cells lacking *Tet2* were exposed to 6 months of CS and also showed enhanced emphysema (18.0 vs 20.0 μM ; $P = .02$) (supplemental Figure 8A-B; supplemental Table 16).^{9,23} CS exposure did not lead to significant changes in the frequency of *Tet2* KO cells in the blood over 6 months, neither model showed a significant difference in alveolar cord length in the air controls, and there were no significant differences between genotypes upon exposure to CS for 6 weeks without poly(I:C) or to poly(I:C) without CS (supplemental Figure 8C-G).

We processed lungs from *Tet2* WT and *Tet2* KO mice exposed to either air or CS/poly(I:C) and performed single-cell RNA-sequencing, collecting 41 870 high-quality transcriptomes (supplemental Table 17). Clustering and annotation by canonical marker genes revealed 25 cell types. We did not find any significant differences in cell type frequencies between the groups (Figure 4C; supplemental Figure 9A-B; supplemental Table 18). We then scored all single-cell transcriptomes for the 50 well-established transcriptional signatures of different cellular programs to investigate gene expression changes between the groups.³² The most significant changes were upregulation of interferon type I (IFN-I) and IFN-II signaling in *Tet2* KO compared with *Tet2* WT mice, which we confirmed by using gene set enrichment analyses. We also identified natural killer and T cells as the predominant source of IFN- γ (Figure 4D-F; supplemental Figures 9C-D, and 10A).^{32,33} In contrast, transforming growth factor- β (TGF- β) signaling was significantly lower in the *Tet2* KO animals, with differing cellular sources of TGF- β depending on the isoform (supplemental Figure 10B).

To examine mediators of inflammation, we measured the levels of 44 secreted inflammatory cytokines and chemokines from *Tet2* WT or *Tet2* KO pulmonary macrophages cultured or after exposure to poly(I:C) for 24 hours. Seven proteins (Cxcl1, Cxcl2, Cxcl9, Ccl5, Ccl11, Ccl20, and Tnfa) were secreted at significantly higher levels from the *Tet2* KO macrophages (supplemental Figure 10C). Moreover, in the single-cell transcriptional data, RNA expression of these 7 proteins was enriched in *Tet2* KO alveolar macrophages and monocytes relative to *Tet2* WT controls (supplemental Figure 10D). Taken together, these data show that *Tet2* loss in hematopoietic cells enhances pulmonary inflammation, increases IFN signaling, decreases TGF- β signaling, and accelerates the development of emphysema in a mouse model.

Discussion

By using data from nearly 50 000 individuals in four large cohorts, we found that CHIP is independently associated with COPD, COPD severity, and quantitative impairment in pulmonary function. Moreover, we observed accelerated development of emphysema in mice with loss of *Tet2* in hematopoietic cells after two different stimuli. Taken together, our data suggest that the presence of somatic mutations in blood cells contributes to the development and severity of COPD. These findings also highlight that the inflammatory sequelae of CHIP extend beyond those established in cardiovascular disease and can influence pathophysiologic changes in other tissues.^{9,10}

Figure 4 (continued) (n = 10) and *Tet2* KO (n = 10) mice exposed to CS and poly(I:C). Error bars indicate standard error of the mean. (C) UMAP visualization of single-cell RNA sequencing data shows clustering of 25 cell types that were identified in the lungs of *Tet2* WT and *Tet2* KO mice. (D) Assessment of signature scores in the single-cell transcriptional data of mice exposed to CS and poly(I:C) across all cells for IFN and tumor growth factor β (TGFB) gene sets obtained from Hallmark (H), Reactome (R), Biocarta (B), KEGG (K), or Wikipathways (W). A positive value (blue) represents higher scores in *Tet2* WT (WT), and a negative value (orange) reflects higher scores in *Tet2* KO mice. The P values were calculated using a Wilcoxon test and adjusted (adj) using a Bonferroni correction. (E-F) For each cluster of cells, the mean of cell signature scores for (E) IFN- α and (F) IFN- γ was determined and plotted for *Tet2* WT (y-axis) and *Tet2* KO (x-axis) animals. Clusters above the line of identity are enriched for the signature in *Tet2* WT mice; clusters that fall below are enriched for the signature in *Tet2* KO mice. Clusters in red have significantly higher scores in *Tet2* KO mice with the size of each cluster representing the significance of difference between the *Tet2* KO and *Tet2* WT groups. AM, alveolar macrophage; AT1, alveolar type 1; AT2, alveolar type 2; CEC, circulating endothelial cell; DC, dendritic cell; DN, double negative; EC, endothelial cell; IM, interstitial macrophage; LEC, lymphatic endothelial cell; Mig DC, migratory dendritic cell; NK, natural killer [cell]; P, P value; pDC, plasmacytoid dendritic cell; SMC, smooth muscle cell; Treg, regulatory T cell. plpC, poly(I:C).

Risk factors for COPD include age, smoking, rare α 1-antitrypsin mutations, and inherited polygenic risk score.^{26,34,35} Our data indicate that CHIP increases the risk of COPD and disease severity independent of age, exposure to CS, or inherited polygenic risk score. CHIP confers a risk equivalent to ~20 to 40 pack-years of exposure to CS for the development of severe or very severe COPD. Given the high prevalence of and health implications of both COPD and CHIP, these findings could inform risk mitigation strategies, including smoking cessation, more intensive pulmonary observation, and therapeutic interventions targeting inflammatory pathways.

Although previous studies have reported smoking as a risk factor for developing CHIP, sample size and variable smoking data have complicated their interpretation.¹³ For example, a recent analysis of the UK Biobank cohort reported a significant association between CHIP and current smoking status but did not quantify the association per pack-year and did not find a significant association between past smoking status and CHIP.¹⁴ In a meta-analysis, we confirmed a significant association between pack-years of smoking and the risk of having CHIP. The per-pack-year risk is small, but it remains important, particularly in heavy smokers, because an individual with a 50 pack-year history has 16% higher odds of having CHIP. Given these findings, we included pack-year data as a covariate in all analyses of CHIP and COPD, and we found an effect of CHIP on COPD independent of smoking history. Furthermore, in contrast to other reported associations between COPD and CHIP, our study incorporates pack-year smoking data, includes thousands of patients and controls from four distinct cohorts, and uses detailed phenotyping, including severity of disease by both GOLD and quantitative spirometric measurements.

In mouse models of CHIP and COPD, *Tet2* KO in blood cells exacerbated the development of emphysema, enhanced inflammatory signaling via IFN-I and IFN-II, and attenuated TGF- β signaling. The changes we observed in these pathways are consistent with previous studies from mouse models of emphysema and from human genetics studies of COPD.^{36–40} Moreover, genome-wide association studies have identified variants near *TET2* associated with COPD and FEV₁.^{6,41} The causal gene and variant have not been identified, but this association raises the possibility that *TET2* is an effector gene at this locus. Additional murine experiments in which the ages of the animals are varied or other genes mutated in clonal hematopoiesis such as *Dnmt3a* are altered, may provide further insights into the timing and mechanism by which mutant hematopoietic cells influence pulmonary inflammation and emphysema development.

The strength of associations between CHIP and COPD was most significant in the COPDGene cohort compared with other cohorts. COPDGene patients undergo comprehensive phenotyping including chest computed tomography scans and exclusions for other lung diseases, and the study includes more than twice the number of moderate and severe or very severe cases of COPD than any other cohort. The remaining COPD cohorts are smaller, are unbalanced (ECLIPSE, few controls), or represent specific subsets (ICGN-EOCOPD, younger individuals with more severe disease). The remaining TOPMed cohorts and the population-based UK Biobank are not as well phenotyped, and each contain less than half the number of GOLD 2–4 and less than one-tenth the number of GOLD 3–4 COPD patients

compared with COPDGene. These factors may explain the stronger signal in COPDGene. Despite these limitations, we found consistent associations in the other cohorts.

One limitation of this study is the use of cross-sectional instead of incident COPD data, precluding calculations of HRs and the inference of causality from the observed human associations between CHIP and COPD. However, COPD is typically a disease that develops over decades, few cohorts have sufficient samples and follow-up using lung function, and incident case determination using self-reported or ICD-coded diagnoses are highly unreliable. Indeed, our ability to make COPD determinations using the standard definition requiring spirometry data and without using self-reported or ICD-coded diagnoses differentiates our study from many previous reports and further strengthens our confidence in the observed associations.

In summary, our data indicate that age-associated somatic mutations in blood cells are independently associated with the presence and severity of COPD. Identification of these mutations may provide important prognostic information for healthy individuals, those at high-risk for development of COPD, and those with COPD. Our results also highlight the potential therapeutic value of targeting CHIP in the treatment or prevention of COPD, including efforts to reduce the development or progression of clonal hematopoiesis, inhibition of the inflammatory response in mutant hematopoietic cells, and targeting elevated inflammatory cytokine levels present in patients with CHIP.

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Authorship

Contribution: P.G.M., D.Q., E.K.S., P.N., Y.T., M.H.C., and B.L.E. designed and conceived the study; D.Q., M.C.H., P.G.M., L.W., D.N., A.S.S., and M.H.C. performed the statistical analyses and analyzed and interpreted the data; A.G.B., A.N., C.J.G., M.L., and S.J. generated the somatic mutation calls; P.G.M., J.R.-Q., A.S.S., M.E.M., B.S., K.V., B.D.L., L.S., W.S., C.A.O., B.C.M., P.v.G., and Y.T. performed the mouse experiments and analyzed the data; M.M. generated the polygenic risk score information; B.E.C., R.G.B., A.C., L.A.C., S.A.G., L.A.L., S.J.L., A.M., G.T.O., E.C.O., D.J., S.M.G., S.R., S.S.R., J.I.R., V.R., and B.Y. provided the TOPMed cohort data; and D.Q., P.G.M., M.C.H., D.N., E.K.S., M.H.C., and B.L.E. drafted the manuscript.

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Appendix

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