Coagulation Factors and the Increased Risk of Stroke in Nonvalvular Atrial Fibrillation

Claes Gustafsson, MD, Margareta Blomback, MD, Mona Britton, MD, Anders Hamsten, MD, and Jan Svensson, MD

We studied whether hemostatic abnormalities contribute to the increased risk of stroke in patients with nonvalvular atrial fibrillation. Hemostatic function was studied in four age-matched groups: 20 patients with nonvalvular atrial fibrillation and a previous ischemic stroke, 20 patients with nonvalvular atrial fibrillation without a previous stroke, 20 stroke patients with sinus rhythm, and 40 healthy controls. Both groups with nonvalvular atrial fibrillation had significantly higher concentrations of von Willebrand factor, factor VIII:C, fibrinogen, D-dimer (a fibrinolytic product), β-thromboglobulin, and platelet factor 4; a significantly higher fibrinogen/antithrombin ratio; and significantly higher spontaneous amidolytic activity than the healthy controls. Prekallikrein levels were significantly lower in both groups with nonvalvular atrial fibrillation. Stroke patients with sinus rhythm had normal hemostatic function, normal concentrations of platelet-related factors, and a slightly increased concentration of fibrinopeptide A compared with the healthy controls. Both groups with nonvalvular atrial fibrillation differed from the stroke patients with sinus rhythm as they did from the healthy controls. No difference in hemostatic function was seen between the nonvalvular atrial fibrillation patients with and without a previous ischemic stroke. Thus, alterations in hemostatic function may contribute to the increased risk of stroke in patients with nonvalvular atrial fibrillation. (Stroke 1990;21:47-51)

Nonvalvular atrial fibrillation (NVAF) afflicts 2–4% of 70-year-old people, and its prevalence increases with age. NVAF is an important risk factor for stroke. In the Framingham Study, NVAF was associated with a 5–6 times higher incidence of stroke compared with an age-, sex-, and blood pressure-matched control group without NVAF.

Left atrial thrombosis causing stroke by arterial embolism has been thought to be the main pathogenetic mechanism in the association between NVAF and stroke. However, the precise mechanism is difficult to determine in individuals with NVAF. As pointed out in recent studies, a considerable proportion of strokes are probably due to atherothrombosis. Generalized atherosclerosis might be the common cause of both NVAF and stroke, thereby explaining the association. If this is true, it can be assumed that there are higher concentrations of fibrinogen, factor VIII:C, and von Willebrand factor (vWF:Ag) due to more pronounced atherosclerosis or as a sign of hypercoagulation in NVAF patients.

Prophylactic measures to diminish the risk of stroke in patients with NVAF are much needed. Anticoagulant treatment with coumarin derivatives might be the best choice if embolism were the predominant cause. However, many NVAF patients are too old for such treatment or have other contraindications to this medication. Since atherothrombosis involving platelet aggregation is a plausible mechanism of stroke in many patients with NVAF, treatment with acetylsalicylic acid might be an alternative to anticoagulant therapy. We studied several aspects of hemostatic function in NVAF patients, in stroke patients with sinus rhythm, and in healthy controls to investigate possible disturbances in the blood coagulation and fibrinolytic systems that might increase the risk of stroke among NVAF patients. The second aim of our study was to investigate whether NVAF patients with stroke differed in their hemostatic function from NVAF patients without a previous stroke and if factors could be found that identify high-risk NVAF patients who might benefit from prophylactic treatment.
The concentration of the acute-phase reactant orosomucoid was determined by quantitative electroimmunoassay.9 The concentration of β-thromboglobulin was determined according to the method of Ludlam et al10 using reagents from Amersham International, Ame-

sham, England. The concentration of platelet factor 4 was measured according to the manufacturer, Abbott Laboratories, North Chicago, Illinois.

The concentration of factor VIII:C was analyzed with both one-stage and two-stage clotting assays.11,12 The concentration of vWF:Ag (formerly factor VIII R:Ag) was determined by quantitative electromunoassay.9 The vWF:Ag/factor VIII:C ratio was calculated, with a value of >1.0 indicating hypercoagulability.13 Antithrombin concentration was measured with a heparin cofactor assay using a synthetic chromogenic peptide substrate (S-2238) method.14 Fibrinogen concentration was analyzed by a polymerization test.15 The fibrinogen/antithrombin ratio was calculated as an index of hypercoagulability.16 Protein C concentration was determined using an enzyme-linked immunosorbent assay (ELISA) method using reagents from Boehringer Mannheim, Mannheim, Germany.17

Platelet function analyzer (PFA) activity was determined by a fibrin plate method,18 and PFA capacity was measured as the difference in tPA activity before and after 10 minutes of venous stasis at 100 mm Hg (between the systolic and diastolic blood pressures). Plasminogen activator inhibitor (PAI) and α2-antiplasmin concentrations were analyzed with synthetic chromogenic substrate (S-2251) methods.19,20 Prekallikrein concentration and kallikrein inhibiting activity were measured using synthetic chromogenic peptide substrate (S-2302) methods,21 as was spontaneous amidolytic activity (SPA) using substrate S-2288.22 The concentration of fibrinopeptide A (FPA) was determined using a radioimmunoassay23 as mod-

ified by Kockum and Frebelius.24 The concentrations of D-dimer and related cross-linked fibrin derivatives were measured using an ELISA method25 and reagents from Mabco, Brisbane, Australia; this analysis was possible in only 13 NVAF stroke and 11 NVAF control patients.

Informed consent was obtained from all partici-

pants, and the study protocol was approved by the regional ethical committee.

The significance of differences in hemostatic vari-

ables among and between groups was tested using

one-way analysis of variance and two-tailed t tests. Individual values for PA inhibitor activity were subjected to logarithmic transformation due to skew-

ness before statistical analysis and significance testing. Correlation between variables was evalu-

ated using the Pearson correlation coefficient. The levels of significance considered were 0.1%, 1%, 5%, and not significant (NS).

Results

Platelet counts were significantly lower and β-

thromboglobulin concentrations were significantly higher in both NVAF groups than in the healthy controls.
Platelet factor 4 concentrations were significantly higher in the NVAF group with stroke than in the healthy controls (Table 2). Platelets were thus activated in the patients with NVAF, possibly more so in those with stroke. Furthermore, β-thromboglobulin levels were higher in both NVAF groups than in the stroke patients with sinus rhythm.

The concentrations of several coagulation factors (factor VIII:C, vWF:Ag, and fibrinogen and the fibrinogen/antithrombin ratio) were significantly elevated, indicating an increased risk of thrombosis in the two NVAF groups compared with the healthy controls (Table 3). The same differences were seen relative to the stroke patients with sinus rhythm.

Factor VIII:C, vWF:Ag, fibrinogen, and antiplasmin are considered to reflect an acute-phase reaction, but no correlation with stroke was seen for the other acute-phase reactant, orosomucoid (data not shown). In the NVAF group without stroke, α2-antiplasmin concentration was increased (Table 4).

The concentration of prekallikrein was significantly decreased in both NVAF groups, indicating an activation of the kallikrein system compared with the healthy controls (Table 4). Concentrations of D-dimer, the cross-linked fibrin derivative, were significantly increased in both NVAF groups, indicating fibrin formation and secondary fibrinolysis relative to the healthy controls. SPA, indicating increased proteolytic activity, was also significantly higher in the NVAF groups than in the healthy controls. These latter findings are consistent with activation of both the coagulation and the fibrinolytic systems. Compared with the stroke patients with sinus rhythm, both NVAF groups had significantly increased SPA concentrations. Furthermore, the two NVAF groups had significantly lower prekallikrein concentrations.

The results of the coagulation (Table 3) and fibrinolytic (Table 4) analyses as well as analysis of the platelet-related factors (Table 2) in the stroke patients with sinus rhythm were similar to those in the healthy controls. The only significant difference was a slightly increased FPA concentration (Table 3).

No significant difference in platelet activation was seen between the NVAF patients with stroke and the

### TABLE 2. Platelet Counts and Concentrations of Related Factors in Patients With Nonvalvular Atrial Fibrillation, Stroke Patients With Sinus Rhythm, and Healthy Controls

<table>
<thead>
<tr>
<th></th>
<th>Without stroke (n=20)</th>
<th>Sinus rhythm (n=20)</th>
<th>Healthy controls (n=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Platelet count (10^9/l)</strong></td>
<td>188*</td>
<td>174§§</td>
<td>241</td>
</tr>
<tr>
<td><strong>Platelet factor 4 (ng/ml)</strong></td>
<td>6.6f</td>
<td>3.9</td>
<td>2.6</td>
</tr>
<tr>
<td><strong>β-Thromboglobulin (ng/ml)</strong></td>
<td>42.8§§</td>
<td>36.0§§</td>
<td>25.9</td>
</tr>
<tr>
<td><strong>Mean</strong></td>
<td>First-third quartiles</td>
<td>First-third quartiles</td>
<td>First-third quartiles</td>
</tr>
</tbody>
</table>

*##p<0.05, 0.01, 0.001, respectively, different from healthy controls by two-tailed t test.
§§p<0.05, 0.001, respectively, different from sinus rhythm by two-tailed t test.

### TABLE 3. Concentrations and Activities of Blood Coagulation Factors and Their Inhibitors in Patients With Nonvalvular Atrial Fibrillation, Stroke Patients With Sinus Rhythm, and Healthy Controls

<table>
<thead>
<tr>
<th></th>
<th>With previous stroke (n=20)</th>
<th>Without stroke (n=20)</th>
<th>Sinus rhythm (n=20)</th>
<th>Healthy controls (n=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Factor VIII:C</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One-stage clotting (IU/ml)</td>
<td>1.92*†</td>
<td>1.80–2.14</td>
<td>1.86*†</td>
<td>1.48–2.29</td>
</tr>
<tr>
<td>Two-stage clotting (IU/ml)</td>
<td>1.88‡‡</td>
<td>1.54–2.19</td>
<td>1.81‡‡</td>
<td>1.57–2.10</td>
</tr>
<tr>
<td>von Willebrand factor (IU/ml)</td>
<td>1.81§§</td>
<td>1.29–2.19</td>
<td>1.83§§</td>
<td>1.22–2.27</td>
</tr>
<tr>
<td>von Willebrand factor/factor VIII:C ratio**</td>
<td>0.95 0.72–1.28</td>
<td>0.98 0.74–1.14</td>
<td>0.97 0.72–1.24</td>
<td>1.08 0.88–1.17</td>
</tr>
<tr>
<td><strong>One-stage clotting</strong></td>
<td>0.93 0.78–1.07</td>
<td>0.98 0.72–1.23</td>
<td>0.97 0.82–1.17</td>
<td>0.99 0.78–1.20</td>
</tr>
<tr>
<td><strong>Antithrombin (units/ml)</strong></td>
<td>0.91 0.84–1.02</td>
<td>0.92 0.88–0.95</td>
<td>0.97 0.91–1.02</td>
<td>0.93 0.87–1.02</td>
</tr>
<tr>
<td><strong>Fibrinogen (g/l)</strong></td>
<td>4.4††</td>
<td>4.0–4.8</td>
<td>4.6††</td>
<td>3.7–5.1</td>
</tr>
<tr>
<td><strong>Fibrinogen/antithrombin ratio</strong></td>
<td>4.9§§</td>
<td>3.9–5.7</td>
<td>5.0§§</td>
<td>4.2–5.5</td>
</tr>
<tr>
<td><strong>Fibrinopeptide A (nmol/l)</strong></td>
<td>6.3</td>
<td>2.7–7.7</td>
<td>5.2</td>
<td>3.0–5.3</td>
</tr>
<tr>
<td><strong>Protein-C antigen (units/ml)</strong></td>
<td>0.85 0.70–0.94</td>
<td>0.89 0.81–0.95</td>
<td>0.96 0.87–1.08</td>
<td>0.93 0.79–1.04</td>
</tr>
</tbody>
</table>

*##p<0.001, 0.01, 0.05, respectively, different from healthy controls by two-tailed t test.
††p<0.001, 0.01, 0.05, respectively, different from sinus rhythm by two-tailed t test.
NVAF patients without stroke, although there was a tendency toward more pronounced changes in the former relative to the healthy controls (Table 2). Neither were there any significant differences between the two NVAF groups in the mean values of the coagulation (Table 3) or fibrinolytic (Table 4) variables.

In the NVAF stroke group, men had lower concentrations than women of antithrombin and protein C ($p<0.05$, data not shown). No association was seen between low concentrations of antithrombin and high factor VIII:C. The discrepancy might be explained by a very slow, continuous activation of the coagulation system, which leads to an unaltered vWF:Ag/factor VIII:C ratio in the NVAF patients, confirmed by their almost-normal FPA concentrations. The significantly lower prekallikrein concentration is consistent with an activation of the kallikrein system.

Regarding the vWF:Ag/factor VIII:C ratio, we found values just below 1.0 in both NVAF groups, which does not support the hypothesis of a prothrombotic state in these patients since values of $>1.0$ indicate hypercoagulation due to consumption of factor VIII:C. The discrepancy might be explained by the findings of the previous studies discussed above, which, however, did not separate NVAF patients and those with sinus rhythm. It seems that, at least in the elderly, altered hemo-

### Table 4. Concentrations and Activities of Fibrinolytic and Kallikrein Factors and Their Inhibitors in Patients With Nonvalvular Atrial Fibrillation, Stroke Patients With Sinus Rhythm, and Healthy Controls

<table>
<thead>
<tr>
<th></th>
<th>Nonvalular atrial fibrillation</th>
<th>Sinus rhythm (n=20)</th>
<th>Healthy controls (n=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With previous stroke (n=20)</td>
<td>Without stroke (n=20)</td>
<td></td>
</tr>
<tr>
<td>Tissue plasminogen activator capacity (FU)</td>
<td>0.47 (0.03-0.42)</td>
<td>0.47 (0.04-0.83)</td>
<td>0.50 (0.10-1.00)</td>
</tr>
<tr>
<td>Plasminogen activator inhibitor (units/ml)*</td>
<td>2.2 (1.2-2.0)</td>
<td>2.2 (1.2-3.0)</td>
<td>-</td>
</tr>
<tr>
<td>α2-Antiplasmin (units/ml)</td>
<td>0.89 (0.82-0.96)</td>
<td>0.92 (0.85-0.96)</td>
<td>0.91 (0.83-0.98)</td>
</tr>
<tr>
<td>Prekallikrein (units/ml)</td>
<td>0.91 (0.95)</td>
<td>0.88 (1.07)</td>
<td>1.12</td>
</tr>
<tr>
<td>Kallikrein inhibiting activity (units/ml)</td>
<td>1.03 (0.94-1.13)</td>
<td>0.99 (0.90-1.05)</td>
<td>1.02 (0.89-1.13)</td>
</tr>
<tr>
<td>Spontaneous amidolytic activity</td>
<td>0.10 (0.04-0.14)</td>
<td>0.08 (0.04-0.12)</td>
<td>0.04</td>
</tr>
<tr>
<td>D-dimer (ng/ml)†</td>
<td>295.1 (107.4-420.0)</td>
<td>275.5 (107.0-375.0)</td>
<td>184.8</td>
</tr>
</tbody>
</table>

*Measured in only healthy controls mean age 40 years.
†Measured in only healthy controls mean age 40 years.
‡‡$p<0.05$, 0.01, 0.001, respectively, different from healthy controls by two-tailed t test.
static function is mainly confined to patients with NVAF.

Our second aim was to look for hemostatic risk factors for stroke among the patients with NVAF. However, no clear differences were found between NVAF patients with and without stroke. Thus, it does not seem possible to use these hemostatic variables to select high-risk patients for prophylactic treatment.

These NVAF patients were elderly but nevertheless are comparable with our earlier reported stroke patients with NVAF. Inherited coagulation disorders in these patients seem less probable as an explanation of their prothrombotic state. The findings may contribute to left atrial thrombus formation with secondary embolism as well as to atherothrombotic stroke. Clearly, however, prospective studies of hemostatic function in relation to the risk of stroke in NVAF patients would be desirable.

References
32. Marra R, De Stefano V, Pagano L, Giovanni G, Bizzzi B: Evaluation of some coagulation parameters in cerebral isch-
Coagulation factors and the increased risk of stroke in nonvalvular atrial fibrillation.
C Gustafsson, M Blombäck, M Britton, A Hamsten and J Svensson

Stroke. 1990;21:47-51
doi: 10.1161/01.STR.21.1.47

Stroke is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 1990 American Heart Association, Inc. All rights reserved.
Print ISSN: 0039-2499. Online ISSN: 1524-4628

The online version of this article, along with updated information and services, is located on the
World Wide Web at:
http://stroke.ahajournals.org/content/21/1/47

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Stroke can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Stroke is online at:
http://stroke.ahajournals.org//subscriptions/