Prevalence of Apolipoprotein E Alleles in Healthy Subjects and Survivors of Ischemic Stroke

An Italian Case-Control Study

Maurizio Margaglione, MD; Davide Seripa, BS; Carolina Gravina, BS; Elvira Grandone, MD; Gennaro Vecchione, BS; Giuseppe Cappucci, BS; Giuseppe Merla, BS; Sara Papa, BS; Alfredo Postiglione, MD; Giovanni Di Minno, MD; Vito M. Fazio, MD

**Background and Purpose**—The e4 allele of the apolipoprotein E (apoE) has been related to the occurrence of myocardial infarction, but its association with ischemic stroke is controversial. We have evaluated the relation between apoE alleles and the occurrence of cerebrovascular ischemia.

**Methods**—The apoE e genotypes of 100 patients with a documented history of ischemic stroke without clinically apparent dementia (stroke+ and 108 subjects without such history (stroke−) were determined. The relative frequency of the apoE alleles and genotypes was estimated in 398 healthy subjects aged <40 years from the same ethnic background.

**Results**—The frequency of the apoE e4 allele in stroke+ (0.18 [95% CI, 0.12 to 0.25]) was higher than in stroke− (0.07 [95% CI, 0.03 to 0.12]; P<0.001) or in healthy subjects (0.09 [95% CI, 0.07 to 0.12]; P<0.001). Carriers of the e4 allele differed between stroke+ (0.30 [95% CI, 0.19 to 0.42]) and stroke− (0.12 [95% CI, 0.5 to 0.22]; P=.004) or healthy subjects (0.16 [95% CI; 0.12 to 0.22]; P=.015). Accordingly, e3/e3 homozygotes were less frequent in stroke+ (0.59 [95% CI, 0.45 to 0.71]) than in stroke− (0.72 [95% CI, 0.59 to 0.82]; P=.063) or in healthy subjects (0.73 [95% CI, 0.67 to 0.78]; P=.01). In a multiple logistic regression analysis, age (P=.05), positive family history (P<.04) and apoE (P<.002) independently contributed to a stroke history, with e4 carriers exhibiting a higher estimated risk (odds ratio, 5.05).

**Conclusions**—Our data show an association between apoE gene and a personal history of ischemic stroke and support the possibility that the apoE gene is a susceptibility locus for the risk of cerebrovascular ischemic disease. (Stroke. 1998;29:399-403.)

**Key Words:** apolipoprotein E | risk factors | stroke | thrombosis

**Subjects and Methods**

**Subjects**

After approval of the Ethics Committee, our studies were carried out according to the Principles of the Declaration of Helsinki; informed consent was obtained from all subjects. From February to December 1992, 210 subjects (108 men and 102 women; mean age, 63.6 years [range 31 to 86 years]) were enlisted for the study. They were chosen from among subjects who had been attending the metabolic ward of...
the outpatient Clinic of our Institution. From 8 to 12 months before being enlisted, 101 of them (51 males and 50 females) had survived an ischemic stroke. Demographic characteristics of the subjects, the manner in which they were enlisted (inclusion/exclusion criteria), and similarities and differences among cases (stroke +) and controls (stroke−) have been reported elsewhere. This population was free of mental impairment as assessed by the Mini-Mental State Exam. None of the 210 subjects had clinical evidence of cancer or acute or chronic inflammatory disease. All had been repeatedly instructed to stop smoking and drinking alcohol and to control food intake, and all were highly motivated to follow the advice. All had been on an isocaloric Mediterranean-style diet for at least 6 months. A complete clinical summary with emphasis on personal and family history for angina pectoris, myocardial infarction, ischemic stroke, peripheral arterial disease, and vascular risk factors was obtained from all subjects. Positive family history was defined as the occurrence of stroke or myocardial infarction before the age of 55 in male and 60 in female parents and siblings. The 109 stroke− subjects were comparable to stroke− individuals with respect to sex, height, occupation, social class, and risk factors for coronary artery disease. In particular, no difference between stroke− and stroke+ individuals was found with respect to mean plasma concentrations of total, HDL, and LDL cholesterol; triglycerides; and Lp(a). Neither were differences found with respect to the number of subjects with high blood pressure or cholesterol; triglycerides; and Lp(a). Neither were differences found with respect to the mean age of the subjects (mean, 66.2 ± 0.5) in the stroke− group and 67.2 ± 0.5 in stroke+ individuals. The ORs of having a stroke− setting than in stroke+ or in healthy subjects. The relative frequency of the apoE alleles and genotypes was estimated in 398 healthy subjects (168 men and 230 women) aged <40 years and from the same ethnic background. In particular, they were free of personal history of cardiovascular and neurovascular disease.

**Materials**
dNTP, KCl, MgCl2, gelatin, agarose, and mineral oil were from Perkin-Elmer Cetus. Proteinase K was obtained from USB Corp.; lymphoprep (d=1.077), from Nyegaard; and HEPES, Tris-HCl, EDTA, ethidium bromide, and SDS from Sigma Chemical Co. We collected 18 mL of blood from each subject at 9 to 9:30 AM (after 12 to 15 hours of overnight fasting) without venous stasis from the antecubital vein via a 19-gauge scalp vein needle. The blood was placed in a sterile tube containing 2 mL of sterile 3.8% trisodium citrate and processed immediately. Concentrations of total cholesterol, HDL cholesterol, triglycerides, and plasma glucose were detected enzymatically26,27 with use of commercially available reagents (Roche). The Friedwald equation (total cholesterol− HDL cholesterol− triglycerides÷5) was used to calculate concentrations of LDL cholesterol.

**Isolation of DNA and Genotype Analysis**
 Peripheral blood leukocytes were incubated overnight at 37°C in a digestion buffer (100 mmol/L NaCl, 10 mmol/L Tris-HCl, 25 mmol/L EDTA, 1% SDS, and 0.1 mg/mL proteinase K). DNA was isolated by phenol/chloroform extraction and ethanol precipitation.27 ApoE alleles were investigated as described by Wenham et al28 with some modifications. Briefly, the amplification was carried out on 50-μL volume samples in a Perkin-Elmer DNA model 480 thermal cycler. Each sample contained 250 ng genomic DNA, 20 pmol of each primer, 100 μM dNTPs, 10 mmol/L Tris HCl [pH 9.0], 50 mmol/L KCl, 1.5 mmol/L MgCl2, 0.1% (vol/vol) Triton X-100, 1 U Tag polymerase, 10% glycerc (J.T. Baker), and 5% formamide (BDH). The solution was overlaid with 50 μL mineral oil. The 40 cycles were at 94°C for 1 minute, at 65°C for 1 minute 30 seconds, and at 72°C for 1 minute 30 seconds. Ten μL of the amplification product was then digested for 2 hours at 37°C in a final volume of 20 μL with 1 U of HhaI restriction enzyme (Amersham), loaded on a 0.4-mm precasted gel containing 15% polyacrylamide gel, and allowed to run at 150 V for 2 hours. Finally, the gel was stained for 30 minutes with 0.5 μg/mL ethidium bromide and visualized under ultraviolet light.

**Statistical Analysis**
All the analyses were performed according to the SPSS/PC V2.0 statistical package, following the recommended procedures.27 The Kolmogorov-Smirnov test, a nonparametric method, was used to compare the distributions of the variables in stroke+ and stroke− subjects. Pearson’s χ2 statistic was used to evaluate the independent nature of the clinical condition with respect to categorical variables. ORs and 95% CIs were calculated. Appropriate models were set up to evaluate in a logistic analysis the independent contribution of each variable to the ischemic event. An enter method was used to set up the system; the log likelihood and Wald χ2 statistics are presented. For all the tests, significance was established at P<.05.

**Results**
In the stroke+ group, the frequency observed for the allele e4 was significantly higher than that observed in stroke− individuals (0.18 [95% CI, 0.12 to 0.25] versus 0.07 [95% CI, 0.03 to 0.12]; χ2 = 11.963; P<.001). Accordingly, the frequency of the e3 allele was lower in stroke+ (0.76 [95% CI, 0.68 to 0.83] versus 0.85 [95% CI, 0.78 to 0.90] in stroke−; χ2 = 5.065; P = .024). A similar figure was observed when stroke+ data were compared with those observed in a group of healthy subjects <40 years of age (Table 1). The distribution of the genotype frequencies differed significantly between stroke+ and the other two settings and slightly between the two control groups (Table 1). The frequency of the e3/e4 genotype was different in stroke+ and stroke− individuals. Likewise, the number of e3/e3 subjects varied significantly between stroke+ individuals and healthy subjects. Finally, the e4 carriers were more common in the stroke+ setting than in stroke− or in healthy subjects (χ2 = 8.30, P = .004, and χ2 = 5.93, P = .015, respectively). The genotype frequencies were not different from those predicted from the Hardy-Weinberg equilibrium in stroke+ (χ2 = 3.559; P = .724), in stroke− (χ2 = 1.432; P = 1.0), and in healthy subjects (χ2 = 6.444; P = .294). In addition to a positive family history for cardiovascular events and age >70 years, a carrier state of the e4 allele was more frequent in stroke+ than in stroke− individuals (Table 2). Accordingly, e3/e3 homozygotes were less common in stroke+ than in stroke− individuals. The ORs of having a history of stroke were 3.13 (95% CI, 1.52 to 6.44) and 0.55 (95% CI, 0.31 to 0.99) for the e4 allele and e3/e3 genotype, respectively. No differences were found between stroke+ and stroke− individuals in the frequency of hypertension (56% versus 55%), diabetes mellitus (27% versus 33%), and LDL cholesterol >3.4 mmol/L (24% versus 25%).

<table>
<thead>
<tr>
<th>Selected Abbreviations and Acronyms</th>
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<tbody>
<tr>
<td>apoE = apolipoprotein E</td>
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<tr>
<td>CI = confidence interval</td>
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<tr>
<td>OR = odds ratio</td>
</tr>
<tr>
<td>stroke− = study patients without documented history of ischemic stroke</td>
</tr>
<tr>
<td>stroke+ = study patients with documented history of ischemic stroke</td>
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**stroke−** = study patients without documented history of ischemic stroke  
**stroke+** = study patients with documented history of ischemic stroke
As many as 48 patients had an atherothrombotic infarction, 19 an embolic stroke, 10 a lacunar infarction, and 10 an ischemic episode involving a boundary region. The remaining 13 experienced an ischemic stroke of undetermined type. No association was found between apoE e4 alleles and type of ischemic stroke. No differences with respect to the apoE e4 alleles were found with respect to sex, age above or below 70 years, hypertension, diabetes mellitus, family history of ischemic events, t-PA >10 ng/dL, or PAI-1 levels. This was true in cases as well as in controls. When compared with e3/e3 subjects, the OR for having an ischemic stroke history was similar in e2 carriers (OR, 1.17; 95% CI, 0.51 to 2.68; P=NS). In contrast, the OR associated with e4 heterozygosity (OR; 2.64; 95% CI, 1.22 to 5.72; P=.02) was as high as that of the e4 carriers (OR, 3.05; 95% CI, 1.47 to 6.38; P=.004). The small numbers (2 and 7, respectively) hampered separate analyses for e2 and e4 homozygotes.

The independent nature of the contribution of the e4 allele to a stroke history was assessed in a multiple logistic regression model in which, in addition to the apoE polymorphism, a series of relevant covariates were included (Table 3). The analysis showed a significant excess (OR, 5.05; 95% CI, 1.82 to 14.01) of a personal history of cerebrovascular disease in apoE e4 carriers compared with e4 noncarriers, confirming the strength of the association observed in the univariate analysis (OR, 3.13).

### Table 2. Study Subject Characteristics

<table>
<thead>
<tr>
<th>Variable</th>
<th>Stroke+ (n=100)</th>
<th>Stroke− (n=108)</th>
<th>OR</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>51</td>
<td>57</td>
<td>0.93</td>
<td>0.54–1.60</td>
</tr>
<tr>
<td>Hypertension</td>
<td>56</td>
<td>59</td>
<td>1.05</td>
<td>0.61–1.82</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>27</td>
<td>36</td>
<td>0.74</td>
<td>0.41–1.34</td>
</tr>
<tr>
<td>LDL cholesterol &gt; 3.4 mmol/L</td>
<td>24</td>
<td>27</td>
<td>0.95</td>
<td>0.50–1.78</td>
</tr>
<tr>
<td>Positive family history</td>
<td>40</td>
<td>27</td>
<td>1.99</td>
<td>1.10–3.59</td>
</tr>
<tr>
<td>Age &gt; 70 y</td>
<td>52</td>
<td>35</td>
<td>2.26</td>
<td>1.29–3.97</td>
</tr>
<tr>
<td>ApoE e4 allele</td>
<td>30</td>
<td>13</td>
<td>3.13</td>
<td>1.52–6.44</td>
</tr>
</tbody>
</table>

### Table 3. Factors Associated With a History of Ischemic Stroke

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE</th>
<th>Wald</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive family history</td>
<td>1.0881</td>
<td>0.5060</td>
<td>4.6243</td>
<td>0.0315</td>
</tr>
<tr>
<td>ApoE e4 allele</td>
<td>1.6198</td>
<td>0.5205</td>
<td>9.6845</td>
<td>0.0019</td>
</tr>
<tr>
<td>Age, y</td>
<td>0.0515</td>
<td>0.0229</td>
<td>5.0781</td>
<td>0.0242</td>
</tr>
</tbody>
</table>

By logistic regression analysis. B indicates estimated coefficient; SE, standard error.

—2 log likelihood $\chi^2 = 274.466$; model $\chi^2 = 148.619$ (df=15, P<.0001).
portion of patients were diagnosed if the onset of dementia occurred within 3 months after stroke. Mean age of our stroke+ individuals (66.2 years) was slightly higher than that of our stroke− individuals (61.2 years) but lower than that of a French (72.3 years),10 a Spanish (71.2 years),32 and two Scandinavian series (68.9 and >80 years, respectively),23,24 and close to that (64.4 years) of a series in which a relation between apoE ε4 and ischemic stroke was suggested. Age distribution may be an important confounding factor; risk factor profiles of ischemic stroke vary in various age classes.33 Differences in the control subject selection among studies may account, at least in part, for some of these discrepancies, particularly in view of the low frequency of the ε4 allele.32 We selected control subjects (stroke−) among inpatients without ischemic cardiovascular and cerebrovascular diseases. However, the differences between stroke+ and stroke− individuals were comparable to those between stroke+ and healthy subjects aged <40 years. In addition, ε4 allele frequencies comparable to ours (<0.10) have been reported in other Italian series33,34 and also in elderly Italian controls.35 Population studies have demonstrated that the different ethnic and geographic distribution of apoE isoforms are associated with a different prevalence of dyslipidemia and coronary heart disease.36,37 Moreover, differences in stroke incidence among participating populations in the WHO MONICA project are quite similar to those observed in apoE gene frequencies showing a north-to-south gradient. In this respect, stroke incidence in Italian populations36–38 is consistently lower than those reported in other countries.39,40

In the present report, the distribution of the apoE genotypes slightly differs between stroke− and healthy subjects. However, allele frequencies were similar between the two groups. In our stroke− individuals, the frequency of the ε4 allele was 0.07; ie, it did not differ from that (0.09) observed in a setting of 398 healthy individuals of both sexes aged <40 years (χ² = 1.24; P = .265). Nor were ε2 and ε3 alleles different in the two settings. Thus, the different distribution of the apoE ε3/ε4 genotype between the two control settings may arise from variations by chance. Alternatively, the relative increase of ε2 carriers and the decrease of ε4 carriers among elderly stroke− subjects compared with the younger healthy group may suggest a role for the apoE polymorphism in the pathogenesis of ischemic stroke as age increases. Cross-sectional studies report a high association between the ε4 allele and the severity of atherosclerosis.13,14,41 Thus, different survival rates among apoE genotypes have to be taken into account, as suggested by a reduction of the ε4 allele among octogenarians and centenarians.15 In this respect, it has been suggested that apoE ε4 affects stroke survival.25 Since we did not enlist cases at the time disease to occur but makes it more likely that one will become ill. The extent to which this polymorphism confers an additional cerebrovascular risk has to be addressed in prospective studies.

References


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