Inherited Thrombophilic Disorders in Young Adults With Ischemic Stroke and Patent Foramen Ovale

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Background and Purpose—The pathogenic link between patent foramen ovale (PFO) and stroke remains unknown in most cases. We investigated the association between inherited thrombophilic disorders and PFO-related strokes in a series of young adults in the setting of a case-control study.

Methods—We investigated 125 consecutive subjects (age, 34.7±7.3 years) with ischemic stroke and 149 age- and sex-matched control subjects. PFO was assessed in all patients with transcranial Doppler sonography with intravenous injection of agitated saline according to a standardized protocol. Genetic analyses for the factor V (FV) G1691A mutation, the prothrombin (PT) G20210A variant, and the TT677 genotype of methylenetetrahydrofolate reductase (MTHFR) were performed in all subjects.

Results—A pathogenic role of PFO was presumed in 36 patients (PFO+). Interaltral right-to-left shunt either was not detected or was considered unrelated to stroke occurrence in the remaining 89 patients (PFO−). The PT G20210A variant was more frequent in the PFO+ group compared with control subjects and the PFO− group (PFO+ versus control subjects, 11% versus 2%; 95% CI, 0.04 to 0.94; PFO+ versus PFO−, 11% versus 1.1%; 95% CI, 1.09 to 109; P=0.047). A similar distribution was observed for subjects carrying either the PT G20210A variant or the FV G1691A mutation (PFO+ versus control subjects, 19.4% versus 5.3%; 95% CI, 0.08 to 0.75; PFO+ versus PFO−, 19.4% versus 3.3%; 95% CI, 1.45 to 26.1; P=0.021). Combined thrombophilic defects were observed in 3 subjects of the PFO+ group, in 2 control subjects (8.3% versus 1.3%; 95% CI, 0.01 to 0.66; P=0.015), and in 0 subjects in the PFO− group. A trend toward a difference in the frequency of the FV G1691A mutation between PFO+ and control subjects was found after bivariate analysis (11% versus 3.3%; P=0.068) but not after multinomial logistic regression analysis. No significant association was found in the distribution of the TT MTHFR genotype in the 3 groups.

Conclusions—In young adults, the PT G20210A variant and, to a lesser extent, the FV G1691A mutation may represent risk factors for PFO-related cerebral infarcts. A role of systemic thrombophilic disorders in the pathogenesis of this specific subtype of stroke may be hypothesized. (Stroke. 2003;34:28-33.)

Key Words: amine oxidoreductase ■ factor V ■ heart septal defects, atrial ■ prothrombin ■ stroke, ischemic

Over the last decade, patent foramen ovale (PFO) has been identified as an independent risk factor for cerebral infarct, particularly in young adults with cryptogenic stroke.1–4 However, the causal relationship is not established, and the pathophysiological process linking this abnormality to stroke remains elusive in most cases. Paradoxical embolism from the peripheral venous system,5 embolization from thrombi formed within the atrial septum,6,7 and the formation of thrombus as a result of transient atrial arrhythmias have been advocated.8 Furthermore, the detection of PFO in a stroke patient with an otherwise unexplained infarct does not necessarily identify the cause of stroke. Owing to the uncertainty about the mechanism of brain ischemia, secondary prevention for patients with PFO who have had a stroke is a subject of considerable debate.

Recently, sparse observations suggested that a disequilibrium of the hemostatic system toward a clotting diathesis may increase the propensity to form an unstable thrombus and affect the risk of cerebral embolism in the presence of interatrial septal abnormalities. The possibility that patients with PFO-related stroke have an underlying hypercoagulable state has potential implications for the understanding of the pathophysiological process and identification of the most appropriate therapeutic strategies. Most of the published data on this issue are either anecdotal9,10 or documented in case series11–14 and case-control studies not specifically designed

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to test this hypothesis.15–17 Thus, the association of PFO with inherited prothrombotic disorders in stroke patients remains to be determined.

The aim of the present study was to systematically explore such an association and to investigate the role of thrombophilic conditions in different pathogenic subtypes of ischemic stroke. To accomplish this purpose, we undertook a prospective case-control study including a series of young adults with first-ever ischemic stroke and a group of control subjects stratified by age and ethnic and geographic origin.

Subjects and Methods

Patients with first-ever ischemic stroke occurring at <45 years of age who were consecutively admitted to our department between January 1997 and December 2000 were invited to participate in a research program for the evaluation of gene-environment interactions in the development of ischemic cerebrovascular disease. From a series of 129 unrelated subjects, 125 were prospectively considered for participation. Unwillingness to undergo genetic analysis explains the exclusion of 4 subjects.

A detailed description of the diagnostic workup and the stroke subtype classification criteria have been presented previously.18 Briefly, the standard protocol included neurological examination, brain CT and/or MRI scan, extracranial Doppler ultrasonography with frequency analysis and B-mode imaging, transcranial Doppler (TCD), 12-lead ECG, transthoracic and/or transesophageal echocardiography, and standard blood tests. Coagulation testing, including prothrombin and activated partial thromboplastin times, antiphospholipid antibodies, fibrinogen, protein C, protein S, activated protein C resistance, and antithrombin III, was also carried out. MR angiography and/or conventional angiography of the neck and cerebral vessels were performed in selected cases. Assessment of right or left venous Doppler was performed whenever the clinical history and examination justified the suspicion of deep-vein thrombosis.

One hundred forty-nine subjects from the staff of our hospital with no known history of vascular disease, matched to the cases by sex and age in 3-year bands, were invited to participate in the study as control subjects. Both cases and controls were white and were from the same geographic area and social status.

Demographic data (age, sex) and history of conventional vascular risk factors such as hypertension, diabetes mellitus, cigarette smoking, and hypercholesterolemia were assessed in every subject according to predefined criteria.18 Genetic analyses for inherited prothrombotic conditions including the G1691A mutation in the factor V (FV) gene, the G20210A mutation in the PT gene were determined according to a standardized multiplex polymerase chain reaction method.20 The C677T MTHFR genotypes were determined according to the method of Froost and coworkers21 with polymerase chain reaction amplification and restriction digestion with HinfI to distinguish mutant from wild-type allele.

Statistical Analysis

Differences in the distribution of baseline categorical variables between cases and controls and among the PFO+ group, the PFO− group, and controls were compared with the use of Fisher’s exact test and Pearson’s χ² test computed by Monte Carlo procedure, respectively. A value of P=0.05 on the 2-sided likelihood ratio test was considered significant. A multinomial logistic regression model that included sex, age, hypertension, smoking status, hypercholesterolemia, and thrombophilic genotypes was used to examine the effect of these variables in the prediction of group status (PFO+, PFO−, control). Diabetes mellitus was not entered into the multiple regression equations because of the low frequency of this condition in the present series. Overall model fit for covariates and thrombophilic genotypes was tested by the likelihood ratio test between the model with the tested effect and the model without the effect. A value of P=0.05 on the 2-sided likelihood ratio test was considered significant. Results are given as odds ratios (ORs) with 95% CIs. The analyses were undertaken with the SPSS (version 11.1) software package.

Results

Table 1 shows the prevalence of baseline demographics and vascular risk factors among patients and controls. As expected, patients were more often smokers and more often had hypertension compared with controls, whereas the prevalence of diabetes mellitus and hypercholesterolemia was not significantly different between the 2 groups.

Distribution of the Prothrombotic Genotypes in the Patient Group

The observed distribution of the genotypes closely resembled those previously reported in other series from Northern Italy.22,23 The prevalence of subjects carrying at least 1 procoagulant genotype was significantly higher in the group of patients than in the group of controls (28% versus 18.7%; P<0.049). In contrast, no significant differences were ob-
served in the distribution of the FV G1691A mutation, PT G20210A variant, and TT MTHFR genotype, as well as the frequency of subjects carrying either the FV G1691A mutation or the PT G20210A Variant, the FV G1691A mutation or the TT MTHFR genotype, and the PT G20210A variant or the TT MTHFR genotype. Finally, the frequency of subjects with a combination of >1 prothrombotic defect did not differ significantly in the 2 groups. None of the study subjects was found to be homozygous for the FV G1691A mutation or the PT G20210A Variant. The overall distribution of the thrombo-

philic genotypes is shown in Table 2.

Distribution of the Prothrombotic Genotypes in the Group of PFO+ and PFO− Patients

A significant difference between the subgroup of PFO+ patients and the group of controls was observed in the distribution of the PT G20210A variant (χ² = 9.96; df = 2; P = 0.016), the prevalence of subjects carrying either the FV G1691A mutation or the PT G20210A variant (χ² = 11.6; df = 2; P = 0.003), and the frequency of subjects with a combination of >1 thrombophilic defect (χ² = 10.4; df = 2; P = 0.013). A trend toward a difference (χ² = 5.59; df = 2; P = 0.068) in the distribution of the FV G1691A mutation was also found. Findings from the bivariate analysis were further investigated in the multinomial logistic regression model adjusted for demographic variables (age and sex) and vascular risk factors. The results were substantially unaltered. However, as opposed to the PT G20210A variant, the FV G1691A mutation turned out to play a marginal role in the occurrence of stroke in PFO+ patients.

Both the PT G20210A variant and the carriership of either the FV G1691A mutation or the PT G20210A variant were also significantly associated in the subgroup of PFO+ patients compared with the subgroup of individuals whose cerebral infarct was unrelated to PFO (PFO−) (Table 3). In contrast, the distribution of the prothrombotic genotypes did not differ between PFO− patients and controls (data not shown).

Discussion

The literature on hypercoagulable states in stroke patients with PFO is scarce and mostly anecdotal. Ours is the first case-control study exploring the relationship between FV Leiden, the PTG20210A variant, and the TT MTHFR genotype and PFO-related cerebral infarcts. The present study provides evidence that the PT G20210A variant and, to a lesser extent, the FV G1691A mutation, are associated in the subgroup of PFO+ patients, suggesting a role of such disorders in the pathogenesis of stroke related to interatrial septal abnormalities. In contrast, despite the reported association between the homozygous deficient TT MTHFR genotype and venous thrombosis,24,25 the relationship of such a defect with cerebral ischemia in patients with PFO seems unlikely.

The role of prothrombotic states in patients with PFO-related stroke has seldom been satisfactorily investigated. Di

TABLE 2. Distribution of Prothrombotic Genotypes in Stroke Patients and Controls

<table>
<thead>
<tr>
<th>Prothrombotic Genotype</th>
<th>Stroke Patients (n=125)</th>
<th>Control Subjects (n=149)</th>
<th>Crude OR</th>
<th>95% CI</th>
<th>P Value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>FV G1691A</td>
<td>6 (4.8)</td>
<td>5 (3.3)</td>
<td>0.689</td>
<td>0.21–2.31</td>
<td>0.381</td>
</tr>
<tr>
<td>PT G20210A</td>
<td>5 (4.0)</td>
<td>3 (2.0)</td>
<td>0.493</td>
<td>0.12–1.26</td>
<td>0.269</td>
</tr>
<tr>
<td>TT MTHFR</td>
<td>27 (21.6)</td>
<td>23 (15.4)</td>
<td>0.663</td>
<td>0.36–1.23</td>
<td>0.123</td>
</tr>
<tr>
<td>FV G1691A or PT G20210A</td>
<td>10 (8)</td>
<td>8 (5.3)</td>
<td>0.652</td>
<td>0.25–1.71</td>
<td>0.263</td>
</tr>
<tr>
<td>FV G1691A or TT MTHFR</td>
<td>32 (25.6)</td>
<td>27 (18.1)</td>
<td>0.688</td>
<td>0.39–1.23</td>
<td>0.132</td>
</tr>
<tr>
<td>PT G20210A or TT MTHFR</td>
<td>31 (24.8)</td>
<td>26 (17.4)</td>
<td>0.674</td>
<td>0.37–1.21</td>
<td>0.121</td>
</tr>
<tr>
<td>FV G1691A or PT G20210A or TT MTHFR</td>
<td>35 (28)</td>
<td>28 (18.7)</td>
<td>0.595</td>
<td>0.34–0.99</td>
<td>0.049</td>
</tr>
<tr>
<td>Combined thrombophilic defects</td>
<td>3 (2.4)†</td>
<td>2 (1.3)‡</td>
<td>0.553</td>
<td>0.09–3.36</td>
<td>0.418</td>
</tr>
</tbody>
</table>

*P values obtained using 1-sided Fisher’s exact test.

†Heterozygosity for the FV G1691A mutation + heterozygosity for the PT G20210A variant, heterozygosity for the FV G1691A mutation + TT MTHFR genotype, and heterozygosity for the PT G20210A variant + TT MTHFR genotype, respectively.

‡Heterozygosity for the FV G1691A mutation + TT MTHFR genotype, and heterozygosity for the PT G20210A variant + TT MTHFR genotype, respectively.
Tullio et al.12 found a significantly higher prevalence of protein C deficiency among 25 stroke patients with PFO compared with 195 without PFO. However, the assessment of right-to-left shunt by transthoracic contrast echocardiography represents a substantial bias of that study. Barinagaramenteria et al.13 and Chaturvedi11 obtained similar findings in small case series, whereas Schwarze et al.26 found an increased prevalence of right-to-left shunts in patients with cerebrovascular accidents and activated protein C resistance compared with patients without this thrombophilic disorder. It is notable that a large group of control subjects with no history of stroke was lacking in all these studies. Furthermore, coagulation tests did not include specific genetic analyses. Nongenetic abnormalities and thrombophilic disorders in patients with PFO, no detailed information on the specific designed to explore the role of thrombophilic disorders in stroke patients exists, one would theoretically expect a better response to oral anticoagulants than to platelet inhibitors. However, because PICSS was not specifically designed to explore the role of thrombophilic disorders in patients with PFO, no detailed information on the patients’ coagulative status is available. A further explanation of this disagreement might be the age of the patients (59.0 and 34.7 years in PICSS and our series, respectively), which might exert an effect on the relation between cardiac abnormalities and thromboembolic disorders. Finally, contrary to PICSS, a recent meta-analysis found warfarin superior to antiplatelets in preventing recurrent ischemic events in patients with PFO.73

**Study Limitations**

Some limitations of our study should be noted. First, PFO is frequently associated with atrial septal aneurysm (ASA), and the presence of both abnormalities, as opposed to PFO alone, has been recently demonstrated to increase the risk of ischemic Stroke (PELVIS) study is ongoing to address these preliminary observations.32

Direct arterial embolism of thrombus from the atrial septum is another potential mechanism. In agreement with the concept of “vascular bed-specific hemostasis” proposed by Rosenberg and Aird.33 Kistler and coworkers hypothesized that the rate of cardioembolic stroke might be the result of a combination of anatomic and hemostatic defects.34 A systemic prothrombotic state affecting the coagulation process on the endocardial surface of the heart might be the first event in the pathophysiological mechanism leading to “local thrombus” formation.33 The likelihood of this process and the rate of subsequent embolism are expected to increase in subjects carrying anatomic abnormalities within the heart such as a PFO34,35 and might be even higher in the presence of additional predisposing conditions such as transient atrial arrhythmias.8

![Table 3](http://stroke.ahajournals.org/)

**Table 3. Distribution and Adjusted Odds Ratios of Prothrombotic Genotypes in PFO† and PFO‡ Patients**

<table>
<thead>
<tr>
<th>Genotype</th>
<th>PFO † Patients (n=36)</th>
<th>PFO‡ Patients (n=89)</th>
<th>PFO † vs Controls</th>
<th>PFO † vs PFO‡</th>
<th>OR</th>
<th>95% CI</th>
<th>P Value*</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>FVG1691A</em></td>
<td>1.0 (11)</td>
<td>2 (2.2)</td>
<td>NS</td>
<td>NS</td>
<td>0.09</td>
<td>0.01-0.66</td>
<td>0.015</td>
</tr>
<tr>
<td><em>PTG20210A</em></td>
<td>1.0 (11)</td>
<td>1 (1.1)</td>
<td>0.19</td>
<td>0.04−0.94</td>
<td>10.09</td>
<td>1.09−109</td>
<td>0.047</td>
</tr>
<tr>
<td><em>TT MTHFR</em></td>
<td>1.0 (19.4)</td>
<td>20 (22.4)</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>0.337</td>
</tr>
<tr>
<td><em>FVG1691A or PTG20210A</em></td>
<td>1.0 (19.4)</td>
<td>3 (3.3)</td>
<td>0.24</td>
<td>0.08−0.75</td>
<td>6.16</td>
<td>1.45−26.1</td>
<td>0.021</td>
</tr>
<tr>
<td><em>FVG1691A or TT MTHFR</em></td>
<td>1.0 (27.8)</td>
<td>22 (24.7)</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>0.294</td>
</tr>
<tr>
<td><em>PTG20210A or TT MTHFR</em></td>
<td>1.0 (27.8)</td>
<td>21 (23.6)</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>0.339</td>
</tr>
<tr>
<td><em>FVG1691A or PTG20210A or TT MTHFR</em></td>
<td>1.0 (33.3)</td>
<td>23 (25.8)</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>0.115</td>
</tr>
<tr>
<td>Combined thrombophilic defects</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>0.09</td>
<td>0.01−0.66</td>
<td>...</td>
<td>...</td>
<td>...</td>
</tr>
</tbody>
</table>

*P values obtained using the Likelihood Ratio Test of Multinomial Logistic Regression Models for testing overall prothrombotic genotypes effect. NS indicates not significant.
recurring stroke.38 The TCD technique prevents the assessment of ASA, which represents the major drawback of the present study. Any further analyses comparing the prevalence of inherited thrombophilias in stroke patients with PFO, ASA, or both are hindered by the lack of precise data on the frequency of ASA in our series. Second, our protocol did not include any measurement, albeit semiquantitative, of PFO diameter, an anatomic marker that may allow the identification of patients at high risk of embolism.39 However, because of the anatomic characteristics of the foramen ovale, it is not simple to obtain measures of the maximum size of the opening with contrast TCD, and it might be that the microbubble count does not reflect the exact amount of shunting.40 Finally, the lack of a systematic search for right-to-left shunt in the group of controls hampers any comparisons between the PFO subjects with stroke and those without stroke. The clinical implications of these missing data are noteworthy, but it seems unlikely that they have significantly altered the results of our study.

**Clinical Implications**

Besides the potential impact on the understanding of the pathophysiology of PFO-related infarcts, an additional implication of our findings concerns the evaluation of the appropriateness of coagulation testing in patients with ischemic stroke and the selection of patients eligible for detailed coagulation studies.41 Coagulation tests seem to be of little cost-effective.

**Acknowledgments**

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**References**


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