Homocysteine and Risk of Recurrent Stroke

Gudrun Boysen, MD, DMSci; Thomas Brander, MD; Hanne Christensen, MD, PhD; Rolf Gideon, MD; Thomas Truelsen, MD, PhD

**Background and Purpose**—The goals of this work were to investigate whether elevated total homocysteine (tHcy) measured within 24 hours of acute stroke was an independent risk factor for recurrent stroke and to compare levels of tHcy in groups of patients with diagnoses of ischemic and hemorrhagic cerebrovascular events.

**Methods**—We performed a longitudinal study of 1039 stroke patients (mean age, 75 years). Fasting tHcy was measured the morning after primary admission. Patients were followed up for 15 months.

**Results**—Serum homocysteine was significantly higher in the 105 patients who experienced a recurrent stroke during the follow-up period than in patients without recurrence. The geometric mean ± SD was 13.4 ± 10.7 versus 11.8 ± 7.1 μmol/L (P=0.008), and the mean difference was 1.2 μmol/L [95% confidence interval (CI), 1.05 to 2.3]. In a multiple logistic regression model, tHcy was an independent explanatory variable of recurrent stroke within 15 months (odds ratio, 1.3; 95% CI, 1.1 to 1.5) for each increase in tHcy of 10 μmol/L. At the index event, serum homocysteine was significantly higher in 909 patients with ischemic cerebrovascular events than in 130 patients with intracerebral hemorrhage (geometric mean, 12.1±7.3 versus 10.4±5.2 μmol/L; P<0.001).

**Conclusions**—The data in this study indicate that elevated tHcy is an independent risk factor for recurrent stroke. (Stroke. 2003;34:1258-1261.)

**Key Words:** cerebral hemorrhage ■ cerebral infarction ■ cerebrovascular disorders ■ intracerebral hemorrhage ■ risk factors
hours and either a normal CT brain scan or evidence of a recent infarct in the relevant area of the brain. The criteria for TIA was similar, but with symptoms lasting <24 hours. The diagnosis of ICH was based in all cases on CT showing hemorrhage. Cerebrovascular events were also classified according to the Trial of Org 10172 in Acute Stroke Treatment (TOAST) criteria.8

Severity of neurological deficit was measured with the Scandinavian Stroke Scale (SSS)19 on admission. Baseline data on age, sex, diabetes, serum cholesterol, serum triglycerides, atrial fibrillation, and smoking were registered. History of stroke or TIA and history of hypertension were defined as either self-reported or based on information from previous medical records.

Total Hcy was determined as part of the patient’s workup. After an overnight fast, total plasma Hcy was measured on the first morning after admission within 24 hours after stroke onset. The blood sample was kept on ice until centrifugation. For the analysis, Abbott’s automated immunofluorescence Hcy test (Abbott ImX method, Abbott Laboratories) was used.

Patients were treated according to the department’s guidelines with antithrombotic and antihypertensive medication, and advice was given concerning lifestyle. Patients with tHcy >15 μmol/L were given advice regarding diet and supplementation with folic acid.

After 15 months, the electronic Hospital Information System was searched for admissions for cerebrovascular disease in each patient. This system covers the eastern part of Denmark, so the coverage was nearly complete. If patients had been admitted elsewhere for their recurrent stroke, they would later be transferred to their local hospital and thereby registered in the system. Nonhospitalized cases of stroke were not included in this analysis. Diagnoses of fatal and nonfatal stroke and TIA were based on discharge letters. The database on which this study was based has been presented to the regional Scientific Ethics Committee, who had no objections to its performance.

Results

Index Cerebrovascular Event

A total of 1039 patients with an acute cerebrovascular event had tHcy measured. In 702 patients with cerebral infarction and 207 patients with TIA, the geometric mean±SD tHcy was 12.1±7.3 μmol/L. In 130 patients with ICH, the geometric mean tHcy was 10.4±5.2 μmol/L. The difference in geometric mean tHcy between ischemic and hemorrhagic events was statistically significant (P<0.001). The mean difference was 1.2 μmol/L (95% CI, 0.2 to 2.2). The index stroke was classified as large-artery stroke in 13% of patients in whom the geometric mean tHcy was 12.2±7.3 μmol/L, as lacunar stroke in 25% with tHcy of 12.3±4.9 μmol/L, and as cardioembolic stroke in 16% with a mean tHcy of 12.6±7.6 μmol/L.

Not all 1039 index events were first-ever strokes. A prior stroke or TIA was reported by 34% of the 1039 patients and by 36% of the patients with ischemic stroke. Geometric mean tHcy was 12.2±7.8 μmol/L in patients who developed ischemic stroke and had a history of stroke or TIA before the index stroke; it was 11.9±6.6 μmol/L in patients without prior cerebrovascular events (P=0.433).

Recurrent Stroke

Recurrent stroke was registered in 105 patients: 97 had suffered an ischemic vascular insult as the index event, and 8 had suffered an ICH. Total Hcy was moderately but significantly higher in patients who developed recurrent stroke than in patients who did not (geometric mean, 13.4±10.7 versus 11.8±7.1 μmol/L; P=0.008; mean difference, 1.2 μmol/L; 95% CI, 1.05 to 2.3) (Table 1). The frequency of prior history of stroke or TIA was also significantly higher in patients who developed a new stroke event during follow-up. The new cerebrovascular events were classified as cerebral infarction in 57.1%, ICH in 9.5%, unspecified stroke in 10.2%, and TIA that required admission in 23.1%. When patients with TIA as the recurrent event were excluded, those who experienced a recurrent stroke had a geometric mean tHcy of 13.6±10.9 μmol/L, and those without recurrence had a mean tHcy of 11.9±7.1 μmol/L (P=0.005; mean difference, 1.2 μmol/L; 95% CI, 1.1 to 1.3) (Table 2).

In a multivariate logistic regression model adjusted for prior stroke or TIA, age, sex, SSS, diabetes mellitus, coronary heart disease, hypertension, and smoking, we found that tHcy was an independent risk factor of recurrent stroke (OR, 1.3; 95% CI, 1.1 to 1.5) for each 10-μmol/L increase in tHcy.
Prior stroke or TIA was also an independent risk factor (OR, 1.6; 95% CI, 1.1 to 2.5).

Discussion

In our study, elevated tHcy was independently associated with an increased risk of recurrent stroke within the first 15 months after the index cerebrovascular event. Our findings corroborate those of other investigators indicating hyperhomocysteinemia as a risk factor for ischemic stroke. Also, our results are in line with those of Del Ser et al,20 who found that tHcy exceeding the 75th percentile 3 months after an ischemic stroke was a predictor of vascular events, including stroke recurrence, acute myocardial infarction, deep venous thrombosis, and peripheral arterial disease. The incidence of vascular illness, however, was too low to be analyzed separately in that study. By focusing solely on cerebrovascular events, our study clearly identifies elevated tHcy as a risk factor for recurrent stroke.

To the best of our knowledge, this is the first study to demonstrate a significant difference in tHcy level between ischemic and hemorrhagic stroke. This difference indicates that the elevated level in ischemic stroke is not just a reaction to the acute illness but reflects the vascular difference between the 2 diseases. Brattström et al21 and Lindgren et al22 found no difference in tHcy between patients who had previously had cerebral infarcts and those with ICH. However, their series included only 14 and 12 hemorrhagic stroke patients, respectively.

A strength of our study is that tHcy was measured before the recurrent event. All samples were taken shortly after the index event, and even though they may have been influenced by the study, it could hardly affect the risk of a future event.

There are also limitations to our study. We did not have standardized conditions during venipuncture regarding the patient’s posture. This might have elevated tHcy in patients who had been out of bed compared with those who stayed in bed until sampling. However, all samples were obtained early in the morning while most of the patients were still in bed. Furthermore, the ascertainment of patients with recurrent stroke was limited to those who had been hospitalized. This means that we may have missed some cases and thus may have underestimated the effect of hyperhomocysteinemia. Furthermore, there was no systematic follow-up on tHcy concentrations during the observation period. We cannot reliably document the number of patients treated with folic acid after the index stroke because the advice about folate acid was given either to the patient or to the patient’s general physician. Intake of folate might have led to underestimation of the effect of hyperhomocysteinemia.

Some researchers have found an association between hyperhomocysteinemia and subtypes of ischemic stroke.21–24 Brattström et al21 looked at 142 survivors of stroke within 42 weeks after stroke onset; they found no significant differences in tHcy values between the stroke type subgroups. Lindgren et al22 found that tHcy was higher in the total anterior circulation infarct group than in other stroke types, which was partly explained by higher age in that group. Eikelboom et al23 studied 219 cases and 205 controls and found significantly higher plasma tHcy in cases with stroke caused by large-artery and small-artery disease compared with control subjects. Tan et al24 found higher tHcy levels in large-artery stroke compared with small-artery strokes in patients <50 years of age. In our study, we did not find any difference among the different ischemic stroke types, but ischemic stroke as a group had higher tHcy than hemorrhagic stroke.

It can be debated whether tHcy is a risk factor or only a risk marker for vascular disease, but the observation that hyperhomocysteinemia resulting from defects in 1 of 3 different enzymes (cystathionine synthase, MTHF homocysteine methyltransferase, or methyltetrahydrofolate reductase) in each case causes serious vascular disease supports the idea of a pathogenetic role for tHcy.25

In addition, a possible effect of tHcy on carotid artery stenosis has been examined by ultrasonography. Cross-sectional studies have shown that elevated levels of tHcy are associated with extracranial carotid artery stenosis,3,16,26,27 and treatment with tHcy-lowering agents such as folic acid, pyridoxine, and cyanocobalamin has been shown to slow the progression of carotid plaque in patients.28 A recent meta-analysis by the Homocysteine Studies Collaboration29 confirmed homocysteine as a risk factor for first events of stroke and coronary heart disease. A reduction in homocysteine level by ∼3 μmol/L was associated with 19% lower stroke risk (OR, 0.81; 95% CI, 0.69 to 0.95). A reduction in homocysteine level of ∼3 μmol/L is what can be achieved on average by folic acid supplementation.30 In our study, the OR of recurrent stroke was 1.3 per 10-μmol/L increase in tHcy, whereas in studies considering first stroke, an increase in tHcy of 5 μmol/L is associated with a similar OR. The magnitude of the effect thus seems greater in primary events than in recurrent events.

All the studies mentioned above support the hypothesis that tHcy plays a role in the pathogenesis of vascular disease.

In conclusion, the present data suggest that elevated tHcy is an independent risk factor for recurrent stroke. Measurement of tHcy may become an integrated part of the workup of stroke patients. Elevated tHcy values may easily be reduced by vitamin supplementation, which may be an important asset in future secondary stroke prevention. Ongoing intervention studies31,32 will clarify whether treating hyperhomocysteinemia can reduce the risk of stroke and recurrent stroke.

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References


