Antibodies to Periodontal Pathogens and Stroke Risk

Pirkko J. Pussinen, PhD; Georg Alfthan, PhD; Harri Rissanen, MSc; Antti Reunanen, MD; Sirkka Asikainen, DDS; Paul Knekt, PhD

Background and Purpose—The association between cerebrovascular events and periodontitis has been found in few studies based on clinical periodontal examinations. However, evidence on the association between periodontal pathogens and stroke is lacking. Therefore, the aim of the study was to investigate whether elevated levels of serum antibodies to major periodontal pathogens predict stroke in a case–control study.

Methods—The study population comprised 6950 subjects (aged 45 to 64 years) who participated in the Mobile Clinic Health Survey in 1973 to 1976 in Finland. During a follow-up of 13 years, a total of 173 subjects had a stroke. From these, 64 subjects had already experienced a stroke or had signs of coronary heart disease (CHD) at baseline, whereas 109 subjects were apparently healthy. Two controls per case were matched for age, gender, municipality, and disease status. Serum IgG and IgA class antibody levels to the periodontal pathogens, Actinobacillus actinomycetemcomitans and Porphyromonas gingivalis, were determined by multisertype enzyme-linked immunosorbent assay.

Results—The cases identified during the follow-up that were free of stroke or CHD at baseline were more often IgA-seropositive for A. actinomycetemcomitans than were their controls, 41.3% versus 29.3%. Compared with the seronegative, the seropositive subjects had a multivariate odds ratio of 1.6 (95% CI, 1.0 to 2.6) for stroke. The patients with a history of stroke or CHD at baseline were more often IgA-seropositive for P. gingivalis than were their controls, 79.7% versus 70.2%. When compared with the seronegative, the seropositive subjects had an odds ratio of 2.6 (1.0 to 7.0) for secondary stroke.

Conclusions—The present prospective study provides serological evidence that an infection caused by major periodontal pathogens is associated with future stroke. (Stroke. 2004;35:2020-2023.)

Key Words: cerebrovascular disorders ■ epidemiology ■ risk factors ■ stroke
of the National Public Health Institute, Helsinki, Finland were followed in the conduct of this study.

Serum cholesterol concentration was determined by an auto-analyzer modification of the Liebermann–Burchard reaction at baseline. Serum IgG and IgA class antibodies to A. actinomycetemcomitans and P. gingivalis were determined by multisertype enzyme-linked immunosorbent assay. Two dilutions of each serum (stored at −20°C) in duplicate were used and the results (ELISA units [EU]) consisting of mean absorbances were calculated as continuous variables. We included on each plate a high and a low control serum in duplicates to monitor the interassay variations. The interassay coefficients for variation were 5.2% and 4.6% for A. actinomycetemcomitans and 4.0% and 3.7% for P. gingivalis IgG and IgA, respectively. The ELISA results of each plate were corrected according to the mean of the high control values after the whole material was analyzed. The subjects were considered seropositive for A. actinomycetemcomitans and P. gingivalis, when the corresponding IgG value was ≥5.0 EU or the IgA value ≥2.0 EU, which represent the mean antibody levels plus 1.5×SD of periodontally healthy subjects.

The mean levels of antibodies and the proportions of seropositive subjects were compared and the significance of differences between cases and controls were tested using t test or χ² test. The odds ratios and their 95% CIs of stroke between subjects seropositive and seronegative for A. actinomycetemcomitans and P. gingivalis were estimated using the conditional logistic model. Potential confounding factors were included in the model. The statistical analyses were performed using SAS program version 6.12.

**Results**

The characteristics of the cases and controls are summarized in Table 1. Among subjects without and with a history of stroke or CHD at baseline, the cases were more often hypertensive and more likely to have diabetes than did the controls, and the cases with a history of stroke or CHD were more frequently current smokers than their controls. At baseline, there were no statistically significant differences in the mean antibody levels against A. actinomycetemcomitans or P. gingivalis between the groups of subjects with or without a history of stroke or CHD (data not shown). Furthermore, the proportion of seropositive subjects for either pathogen did not differ statistically significantly between these groups at baseline (data not shown).

In the study populations with or without a history of stroke or CHD at baseline, there were no statistically significant differences in the mean IgG or IgA class antibody levels to A. actinomycetemcomitans or P. gingivalis between the cases and the controls (Table 2). The cases identified during the follow-up but free of stroke and CHD at baseline were more often seropositive for A. actinomycetemcomitans in IgG and IgA classes than those remaining free of stroke, 35.2% versus 27.2%, and 41.3% versus 39.1%, respectively (Figure). Compared with the seronegative subjects, the univariate odds ratio for stroke among individuals IgA-seropositive for A. actinomycetemcomitans was 1.6 (95% CI, 1.0 to 2.6) (Table 3). The corresponding multivariate odds ratio adjusted for age, gender, place of residence, diabetes, smoking, alcohol consumption, body mass index, and serum cholesterol concentration was 1.7 (1.0 to 2.9). The proportion of P. gingivalis-

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### Table 1. Mean Baseline Levels (SD) of Potential Confounding Factors of Stroke Cases and Controls

<table>
<thead>
<tr>
<th>Baseline Variable</th>
<th>No History of Stroke or CHD at Baseline</th>
<th>History of Stroke or CHD at Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cases (n=109)</td>
<td>Controls (n=206)</td>
</tr>
<tr>
<td>Age, y</td>
<td>55.7 (5.7)</td>
<td>55.7 (5.6)</td>
</tr>
<tr>
<td>Gender, % male</td>
<td>49.5</td>
<td>49.5</td>
</tr>
<tr>
<td>Current smoker, %</td>
<td>27.8</td>
<td>26.9</td>
</tr>
<tr>
<td>Diabetic subjects, %</td>
<td>8.3</td>
<td>3.7</td>
</tr>
<tr>
<td>Hypertensive subjects, %</td>
<td>42.2</td>
<td>24.8</td>
</tr>
<tr>
<td>Body mass index, kg/m²</td>
<td>27.0 (4.7)</td>
<td>26.6 (2.8)</td>
</tr>
<tr>
<td>Alcohol consumption, g/wk</td>
<td>62.4</td>
<td>56.9</td>
</tr>
<tr>
<td>Cholesterol concentration, mmol/L</td>
<td>7.35 (1.3)</td>
<td>7.35 (1.0)</td>
</tr>
</tbody>
</table>

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### Table 2. Mean Serum Antibody Levels to Periodontal Pathogens

<table>
<thead>
<tr>
<th>Pathogen</th>
<th>No History of Stroke or CHD at Baseline</th>
<th>History of Stroke or CHD at Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cases (n=109)</td>
<td>Controls (n=206)</td>
</tr>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>A. actinomycetemcomitans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IgG (EU)</td>
<td>4.86 (2.79)</td>
<td>4.79 (2.65)</td>
</tr>
<tr>
<td>IgA (EU)</td>
<td>1.88 (1.14)</td>
<td>1.84 (0.96)</td>
</tr>
<tr>
<td>P. gingivalis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IgG (EU)</td>
<td>8.05 (2.84)</td>
<td>8.21 (2.22)</td>
</tr>
<tr>
<td>IgA (EU)</td>
<td>3.43 (1.89)</td>
<td>3.22 (1.16)</td>
</tr>
</tbody>
</table>

* t test.
seropositive subjects did not differ significantly between these cases and controls: 81.5% versus 80.6% for IgG, and 74.1% versus 78.6% for IgA class antibodies, respectively (Figure).

The cases with a history of stroke or CHD at baseline were more frequently IgA-seropositive when their serum IgG class antibody level was \( \geq 5.0 \) EU and IgA class antibody level \( \geq 2.0 \) EU to \( A. \) actinomyctetemcomitans and \( P. \) gingivalis.

The subjects with a history of stroke or CHD at baseline were more frequently IgA-seropositive, but not IgG-seropositive for \( P. \) gingivalis than their controls: 79.7% versus 70.2%, and 68.8% versus 75.2%, respectively (Figure). The subjects IgA-seropositive for \( P. \) gingivalis had a univariate odds ratio of 1.7 (0.8 to 3.7) and a multivariate odds ratio of 2.6 (1.0 to 7.0) for stroke when compared with the seronegative subjects (Table 3). No statistically significant differences in the proportions of \( A. \) actinomyctetemcomitans-seropositive subjects were found between these cases and controls (Figure).

**Discussion**

We found that an elevated serum IgA-class antibody level to \( A. \) actinomyctetemcomitans predicted stroke in a prospective case–control study. In addition, an elevated IgA-antibody level to \( P. \) gingivalis predicted a recurrent stroke in subjects with a history of stroke or CHD at baseline. Elevated IgA class antibody levels to periodontal pathogens in saliva are believed to indicate persistent periodontitis with active tissue destruction.\(^{15}\) The significance of elevated serum IgA levels against periodontal pathogens, however, is not fully understood. Nevertheless, when determined from dentate patients with periodontitis, serum and salivary IgA antibody levels to periodontal pathogens have a strong positive correlation with each other.\(^{15}\) Therefore, our results suggest that aggressive forms of periodontitis addressed to \( A. \) actinomyctetemcomitans, usually occurring particularly at young age (younger than 35 years), and to \( P. \) gingivalis, developing often at adult age, are associated with incidence of stroke.

Based on serum IgG antibody levels, 27.2% and 80.6% of the controls free of stroke at baseline were seropositive for \( A. \) actinomyctetemcomitans and \( P. \) gingivalis, respectively. The proportion of \( A. \) actinomyctetemcomitans-seropositive subjects was in the same range as in our previous study (32%) comprising middle-aged men in 1997.\(^{4}\) In the present study, the proportion of \( P. \) gingivalis-seropositive subjects was much higher than in the earlier one (53%),\(^{4}\) although here we also included women, who are known to suffer from periodontitis less frequently than men.\(^{15}\) This suggests that the dental care services and/or dental hygiene have improved in Finland since the 1970s.

In our previous study, 17% of the subjects free of CHD were edentulous, which proved to be the most important confounding factor for the serum IgG class antibody levels to...
these periodontal pathogens. Furthermore, the antibody levels correlated strongly, but not linearly, with the number of natural teeth. In the present study, we did not have any information on the dental status of the subjects. The present population is likely to comprise a significant proportion of edentulous subjects or subjects with only a few natural teeth, which may cause a bias toward low serum antibody levels and overemphasize their significance. The reliability of the results would have benefited if the edentulous and dentate subjects had been analyzed separately. However, the significant odds ratios in our study were of the same magnitude as reported in earlier prospective studies, indicating a moderate association between periodontitis and stroke. Seropositivity for \textit{P. gingivalis} IgA class antibodies predicted stroke only in subjects with evidence of known CVD at baseline, but not in subjects free from CVD. The results therefore do not suggest a causal role for \textit{P. gingivalis} infection in the pathogenesis of stroke in a healthy population—contradictory to CHD. However, the association of \textit{A. actinomycetemcomitans} IgA seropositivity and stroke in initially healthy subjects is, to our knowledge, the first finding connecting infection by this pathogen to an increased risk for CVD in humans. There are several aspects that may contribute to the difference in the results between the subjects with and without a history of CVD at baseline. For example, efficacy of the immune response or epitope distribution of serum antibodies exhibits strain-to-strain variation depending on genotypes and serotypes of the pathogens.

The mechanisms by which chronic infections increase the likelihood of atherosclerosis or thrombosis are not clear, but the prerequisite is believed to be the long-term systemic exposure to the pathogens. In periodontitis, gingival inflammation accompanied by microlature of the periodontal pocket epithelium and increasing subgingival space for bacterial deposits provide bacteria and their components access to the bloodstream. Local infection in the periodontal pockets triggers a systemic inflammatory response releasing inflammatory mediators, e.g., C-reactive protein, whose elevation has been shown to be directly associated with atherogenesis. Furthermore, periodontitis is accompanied by proatherogenic lipid profiles. In an earlier study, the relative risk for cerebrovascular disease tended to be higher for periodontitis than for edentulism, which supports the hypothesis of periodontal pathogens/periodontal inflammation being the cause for the association. The direct role of periodontal pathogens in atherogenesis was recently supported by 2 studies using mouse models. In these studies, intravenous and oral application of \textit{P. gingivalis} exacerbated early atherosclerotic lesions, which were more advanced and occurred earlier in pathogen-challenged animals than in the vehicle control animals. One of the bacterial virulence factors behind the atherogenic properties of \textit{A. actinomycetemcomitans} and \textit{P. gingivalis} may be lipopolysaccharide, which activates macrophages and induces their conversion into foam cells.

In conclusion, the present prospective study provides first serological evidence that a chronic infection caused by the periodontal pathogens \textit{A. actinomycetemcomitans} and \textit{P. gingivalis} is associated with incident stroke.

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References

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