Chronic Chlamydia pneumoniae Infection and Stroke in Cameroon
A Case-Control Study

Alfred K. Njamnshi, Kathleen Ngu Blackett, Josephine N. Mbuagbaw, Freedom Gumedeze, Sandeep Gupta, Charles S. Wiysonge

Background and Purpose—To determine the relationship between chronic Chlamydia pneumoniae infection and stroke in Cameroon.

Methods—Sixty-four consecutive stroke patients 26 to 80 years of age were enrolled at 2 tertiary hospitals in Yaoundé, Cameroon, between March 2000 and December 2001 and matched for age and sex to 64 controls. We measured IgG (1/64) and IgA (1/16) titers against C pneumoniae in both patients and controls using a validated microimmunofluorescence technique.

Results—There was no significant difference between cases and controls with respect to hypertension (P=0.2), smoking (P=0.53), alcohol intake (P=0.8), body mass index (P=0.49), waist-to-hip ratio (P=0.14), and diabetes (P=0.76). IgA antibodies were detected in 50 (78.1%) patients and 27 (42.2%) controls (odds ratio [OR] 4.29; 95% CI, 1.84 to 11.56; P=0.0002), and IgG antibodies in 41 (64.1%) patients and 35 (54.7%) controls (OR, 1.46; 95% CI, 0.68 to 3.22; P=0.29). For confirmed thrombotic stroke, the association with IgA antibodies became stronger (OR, 21.0; 95% CI, 3.38 to 868.45; P<0.0001), but there was still no association with IgG antibodies (OR, 1.86; 95% CI, 0.69 to 5.50; P=0.18).

Conclusions—Our study shows a strong statistical association between (IgA, and not IgG, as a serological marker of) chronic C pneumoniae infection and stroke for the first time in a resident indigenous African population. These findings, if confirmed, may have important policy implications (in terms of antibiotic use in stroke prevention) in sub-Saharan Africa. (Stroke. 2006;37:796-799.)

Key Words: atherosclerosis ■ infection ■ stroke

Atherosclerosis is a leading cause of mortality and morbidity worldwide. Conventional stroke risk factors including hypertension, cigarette smoking, diabetes mellitus, and hyperlipidemia do not fully explain the incidence of atherosclerotic vascular disease. Inflammation has been postulated to play an important role in the initiation and development of atherosclerosis. Recently, increasing interest has focused on the putative causal role of chronic infections such as Helicobacter pylori and Chlamydia pneumoniae. C pneumoniae is a Gram-negative intracellular bacterium that commonly causes upper respiratory tract infection, bronchitis, pharyngitis, sinusitis, and pneumonia. The link between C pneumoniae and cerebrovascular disease has been investigated in a number of seroepidemiological and antibiotic intervention studies. However, the causal role of C pneumoniae infection is still controversial. In addition, to the best of our knowledge, no such study has been performed in any resident indigenous African population. The present study was designed to investigate whether serological markers of C pneumoniae infection were associated with acute stroke or transient ischemic attack (TIA) in an indigenous population of Cameroon in sub-Saharan Africa. The prevalence of stroke in patients attending the university teaching hospital in Yaoundé, Cameroon varies from 2% in the internal medicine unit to 9% in the medical intensive care unit. In the Yaoundé Central Hospital, stroke prevalence is 3% in the internal medicine unit, with 52% hemorrhagic and 48% ischemic in patients with brain scan confirmation.

Patients and Methods
This case-control study was undertaken in the university teaching hospital and central hospital in Yaoundé, Cameroon. Consecutive patients presenting with stroke or TIA in these hospitals were recruited into the study from March 2000 to December 2001. Patients were eligible for inclusion if they were natives of Cameroon,
TABLE 1. Characteristics of Study Population

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Cases</th>
<th>Controls</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension*</td>
<td>53/64 (82.8%)</td>
<td>48/64 (75.0%)</td>
<td>0.20</td>
</tr>
<tr>
<td>Current smokers</td>
<td>12/62 (19.7%)</td>
<td>8/31 (25.8%)</td>
<td>0.53</td>
</tr>
<tr>
<td>Current alcohol consumers</td>
<td>34/63 (54.8%)</td>
<td>20/31 (64.5%)</td>
<td>0.80</td>
</tr>
<tr>
<td>Diabetes</td>
<td>8/59 (13.6%)</td>
<td>7/44 (15.9%)</td>
<td>0.76</td>
</tr>
<tr>
<td>Height, meters (m)</td>
<td>1.64 (0.08)</td>
<td>1.67 (0.08)</td>
<td>0.16</td>
</tr>
<tr>
<td>Weight, kilograms (kg)</td>
<td>74 (14)</td>
<td>72 (13)</td>
<td>0.54</td>
</tr>
<tr>
<td>Body mass index, kg/m²</td>
<td>27.4 (4.5)</td>
<td>26.6 (4.5)</td>
<td>0.49</td>
</tr>
<tr>
<td>Waist circumference, centimeters (cm)</td>
<td>89 (14)</td>
<td>97 (11)</td>
<td>0.06</td>
</tr>
<tr>
<td>Hip circumference, cm</td>
<td>95 (16)</td>
<td>99 (11)</td>
<td>0.40</td>
</tr>
<tr>
<td>Waist-to-hip ratio</td>
<td>0.94 (0.09)</td>
<td>0.98 (0.08)</td>
<td>0.14</td>
</tr>
</tbody>
</table>

Values are count/total (proportion) for categorical and mean (SD) for continuous variables. Denominators differ because of missing values; this information was not completed on the data collection forms. *Hypertension indicates blood pressure ≥140/90 mm Hg or current use of blood pressure-lowering drugs.

admitted to either hospital with stroke or TIA, and had no signs of acute infection. Stroke was defined according to the recommended standard World Health Organization definition as a focal (or at times global) neurological impairment of sudden onset, lasting >24 hours or leading to death, and of presumed vascular origin. An abrupt-onset neurological deficit lasting <24 hours was considered a TIA. Sixty-four consecutive patients were recruited prospectively. Controls, matched for age, sex, and (as much as possible) hypertensive status (blood pressure ≥140/90 mm Hg or use of blood pressure-lowering agents), were recruited consecutively from the university teaching hospital during the same study period, from patient visitors, hospital staff, and noncardiac outpatient attendees. The exclusion criteria for the controls were a history of stroke or TIA or coronary heart disease and acute or active cardiopulmonary or infective conditions.

Age and sex were recorded, as well as a medical history of hypertension, smoking, diabetes mellitus, hypercholesterolemia, ischemic heart disease, stroke, or TIA. Weight and height were measured using standard procedures. Hip and waist circumferences were measured in a standardized way using a plastic inelastic tape measure. Hip circumference was measured at the widest part (lower buttock level). Waist circumference was measured at expiration (where possible), with the tape passing midway between the costal margin and the iliac crest. The body mass index was computed as the weight in kilograms divided by the height in meters squared. The waist-to-hip ratio was calculated as the waist divided by hips.

At least 2 mL of serum obtained from each patient was stored at −20°C before laboratory analyses. Detection of IgA and IgG antibodies to C pneumoniae was done with a validated microimmunofluorescence technique (MRL Diagnostics). The cutoff point for seropositivity was 1/16 for IgA and 1/64 for IgG. Testing procedures followed the recommendations of the manufacturer. Control tests were performed using positive serum preparations as well as negative patient serum. For every batch of slides tested, 2 control preparations were applied to 2 slides. The laboratory technician who performed all the analyses was unaware of the study hypothesis.

TABLE 2. Seroprevalence of C pneumoniae Antibodies in Cases and Controls

<table>
<thead>
<tr>
<th>Antibody Type</th>
<th>Stroke Cases</th>
<th>Controls</th>
<th>OR, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>All cases of stroke (64 case-control pairs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IgA</td>
<td>50 (78.1%)</td>
<td>27 (42.2%)</td>
<td>4.29, 1.84 to 11.56; P=0.0002</td>
</tr>
<tr>
<td>IgG</td>
<td>41 (64.1%)</td>
<td>35 (54.7%)</td>
<td>1.46, 0.68 to 3.22; P=0.29</td>
</tr>
<tr>
<td>Thrombotic stroke cases (35 case-control pairs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IgA</td>
<td>33 (94.3%)</td>
<td>13 (37.1%)</td>
<td>21.00, 3.38 to 868.45; P&lt;0.0001</td>
</tr>
<tr>
<td>IgG</td>
<td>22 (62.9%)</td>
<td>16 (45.7%)</td>
<td>1.86, 0.69 to 5.50; P=0.18</td>
</tr>
</tbody>
</table>

Values are absolute count (percentage).
TABLE 3. Frequency of Each Stroke Subtype in the Sample Population

<table>
<thead>
<tr>
<th>Subtype</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardioembolic</td>
<td>2 (3.1)</td>
</tr>
<tr>
<td>Thrombotic</td>
<td>35 (54.7)</td>
</tr>
<tr>
<td>Hemorrhagic</td>
<td>10 (15.6)</td>
</tr>
<tr>
<td>Unknown*</td>
<td>17 (26.6)</td>
</tr>
<tr>
<td>Total</td>
<td>64 (100)</td>
</tr>
</tbody>
</table>

*Seventeen patients did not do the computerized tomographic scan, and we do not know the nature of their lesions.

Discussion

This case-control study was performed in 2 tertiary hospitals in Yaoundé, Cameroon, aimed at examining the relationship between chronic C pneumoniae infection and stroke or TIA. To the best of our knowledge, this is the first study of its kind on indigenous patients of an African country. Using microimmunofluorescence assay, we found that 94.3% of thrombotic stroke patients tested positive for IgA antibodies against C pneumoniae and 62.9% for IgG, similar to the high prevalence reported in studies from Japan,20 Taiwan,21 Israel,22 United Kingdom,23 and Turkey.24 The seroprevalence of chronic C pneumoniae infection (IgA) was significantly higher in stroke patients than in the controls (OR, 4.29; 95% CI, 1.23; 95% CI, 0.31 to 4.90; P=0.52 for IgG).

Table 3 shows that 47 patients had computerized tomographic brain scans done: 35 (74.5%) had ischemic strokes presumed to be thrombotic, and 2 ischemic strokes (4.2%) were considered cardioembolic given that ECG findings in these patients showed atrial fibrillation and 10 (21.3%) strokes were hemorrhagic.

Admitted with acute noncardiopulmonary and noninfective disorders, Ngeh et al, using an ELISA method for detecting C pneumoniae infection, did not find a difference in prevalence between patients and controls.23 In a subgroup analysis of 43 cases and 44 controls without a known history of ischemic heart disease, there was a trend toward a significant association between C pneumoniae IgG seropositivity and stroke. However, other studies assessing only IgG antibodies31,32 have not reported an association.

Most reports on the relationship between C pneumoniae infection and stroke have been from case-control studies. As such, the temporal sequence of the events, infection-atherosclerosis-stroke, needs to be ascertained through cohort studies or randomized controlled trials. C pneumoniae infection may increase systemic inflammation and immune-mediated vascular damage and cause altered lipid metabolism.15,34–36 These changes may adversely modify conventional risk factors of atherosclerosis and consequently lead to stroke.

Some prospective studies have shown that C pneumoniae seropositivity predicted the risk of future stroke,10,32,33 but a study in women only failed to show this risk.31 In our study, 50% of both cases and controls were women. Preliminary evidence is becoming available from intervention studies to support the link between chronic C pneumoniae infection and stroke. Thirty-day antibiotic treatment of C pneumoniae–infected patients was shown in a randomized controlled trial to sustain a significant reduction of atherosclerosis progression in the common carotid artery for up to 2 years.14 However, 2 recent large randomized controlled trials did not observe a beneficial effect of antichlamydial antibiotic therapy on the secondary prevention of cardiovascular heart disease.37,38 Neither trial used the serological marker of chronic C pneumoniae infection during patient selection. C pneumoniae IgA antibody was assessed in only 32.4% of the participants of one trial and no participant of the other trial. In the absence of chronic C pneumoniae infection among the trial participants, there is little reason to expect a clinical benefit with antichlamydial antibiotic treatment. In light of the foregoing evidence, the association between C pneumoniae and stroke is emerging. However, because of paucity of data from prospective cohort studies and randomized controlled trials, causality10 cannot be firmly established at present.

Conclusion

Our data confirm a strong association between (IgA, and not IgG, as a serological marker of) chronic C pneumoniae infection and stroke for the first time in an indigenous population of the African continent. These findings, if confirmed by larger studies, may have important policy implications in sub-Saharan Africa, where stroke is a major public health problem, because antibiotic treatment of chronic C pneumoniae infection would be a simple and easily available intervention for primary prevention of thrombotic stroke. Given the inherent difficulty of defining the direction of causality in case-control studies, there is need for large prospective cohort studies and randomized controlled interventional trials to examine this association.
References


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