Reduction in the Recurrence of Stroke by Eicosapentaenoic Acid for Hypercholesterolemic Patients
Subanalysis of the JELIS Trial

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Background and Purpose—The JELIS trial examined the preventive effect of eicosapentaenoic acid (EPA) against coronary artery diseases. Hypercholesterolemic patients received statin only (no EPA group: n=9319) or statin with EPA (EPA group: n=9326) for around 5 years. EPA significantly suppressed the incidence of coronary events in previous analysis. Herein, we investigated the effects of EPA on the primary and secondary prevention of stroke.

Methods—We conducted a subanalysis of JELIS with respect to stroke incidence in the primary and secondary prevention subgroups defined as those without and with a prior history of stroke using Cox proportional hazard ratios, adjusted for baseline risk factor levels.

Results—as for primary prevention of stroke, this occurred in 114 (1.3%) of 8862 no EPA group and in 133 (1.5%) of 8841 EPA group. No statistically significant difference in total stroke incidence (Hazard Ratio, 1.08; 95% confidence interval, 0.95 to 1.22) was observed between the no EPA and the EPA groups. In the secondary prevention subgroup, stroke occurred in 48 (10.5%) of 457 no EPA group and in 33 (6.8%) of 485 EPA group, showing a 20% relative reduction in recurrent stroke in the EPA group (Hazard Ratio, 0.80; 95% confidence interval, 0.64 to 0.997).

Conclusions—Administration of highly purified EPA appeared to reduce the risk of recurrent stroke in a Japanese population of hypercholesterolemic patients receiving low-dose statin therapy. Further research is needed to determine whether similar benefits are found in other populations with lower levels of fish intake. The trial is registered at ClinicalTrials.gov (number NCT00231738).

Key Words: JELIS ■ EPA ■ stroke ■ clinical trial ■ prevention

Prevention of stroke is a major issue in modern medicine. In the United States, stroke affects more than 700 000 new patients and claims more than 160 000 lives each year, whereas 4.8 million patients suffer from sequelae. In addition, the cost of treatment for stroke reached $53.6 billion in 2004. In Japan, the rate of mortality attributable to stroke is more than twice for men and 1.5-fold for women than those in the United States. Thus, the problem of stroke prevention is also recognized as a national issue in Japan. In comparison to cardiac events, stroke has a higher tendency to leave sequelae and requires long-term rehabilitation and care, and is thus associated with key problems such as increased family burden and medical costs. Although the predominant risk factor for stroke is hypertension, other risk factors exist such as diabetes, hypercholesterolemia, smoking, nonvalvular atrial fibrillation, and heavy drinking.
Medical therapies for preventing stroke, which include antihypertensive, antiplatelet, anticoagulant, and antihyperlipidemic therapies, have been supported by increasing evidence. In particular, in antihyperlipidemic therapy, statins have been found useful to prevent stroke in hyperlipidemic patients with coronary artery disease, besides, high dose atorvastatin reduced the risk of stroke in patients with cerebrovascular disease.

In addition, various cohort studies have found that increased fish intake was associated with a lower risk of stroke. In a meta-analysis by He et al, those who ate fish at least once a week had a significantly lower risk of stroke than subjects who ate fish less than once a month. However, the effects of fish or fish oil have not been conclusively determined in randomized controlled trials; whereas Schacky et al showed a lower incidence of stroke, Marchioli et al (the GISSI-Prevenzione trial) showed a 22% increase in risk of stroke in the ω3 polyunsaturated fatty acids group, although neither finding was statistically significant.

We have previously reported that in a large prospective clinical controlled trial (JELIS) in which highly purified EPA was given to Japanese hypercholesterolemic patients, EPA significantly reduced coronary events (the primary end point), during the 4.6-year mean observation period in subjects receiving low-dose statin therapy and at the start of the study presumably having higher intake of fish compared to those having a Western style diet judging from their plasma EPA concentration. Herein, we investigated the effects of EPA on the risk of stroke separately for those without a history of stroke (primary prevention) and those with a history of stroke (secondary prevention) at baseline.

Materials and Methods

Study Design and Patients

JELIS was a prospective randomized open-label, blinded end point trial. Stroke was a secondary outcome in the study design of JELIS. The inclusion criteria were hypercholesterolemic patients with serum total cholesterol of 6.5 mmol/L or higher (men aged over 40 to 75 years, women after menopause to 75 years). The exclusion criteria were acute myocardial infarction within the last 6 months, unstable angina pectoris, a history of or complication by serious heart disease (severe arrhythmia, heart failure, primary or secondary cardiac myopathy, valvular heart diseases, congenital heart diseases, etc), cardiovascular reconstruction within the last 6 months, cerebrovascular disorder occurring within the last 6 months, serious hepatic or renal disease, malignant tumor, uncontrollable diabetes mellitus, hyperlipidaemia associated with effect of drug such as steroid hormone, hemorrhage (hemophilia, capillary fragility, gastrointestinal ulcer, urinary tract hemorrhage, hemoptysis, vitreous hemorrhage, etc), hemorrhagic diathesis, hypersensitivity to the study drug formulation, planned surgery, or other condition judged inappropriate for inclusion in the study by the physician in charge. The study design as well as the inclusion and exclusion criteria were described in detail elsewhere.

Hypercholesterolemic patients (total cholesterol 6.5 mmol/L or higher) who gave informed consent were randomly assigned to receive EPA (300-mg capsules of highly purified (98%) EPA ethyl ester). Herein, we investigated the effects of EPA on the risk of stroke separately for those without a history of stroke (primary prevention) and those with a history of stroke (secondary prevention) at baseline.

Results

Patient Population

Table 1 shows background data for enrolled patients after randomization, specifically blood pressure, serum lipid level, and plasma fatty acid level. Among all patients randomized to the no EPA (n=9319) and EPA (n=9326) groups, a total of 457 patients in the no EPA group and 485 patients in the EPA group had a history of stroke, whereas 8862 patients in the no EPA group and 8841 patients in the EPA group did not (Table 1). At baseline in the primary prevention subgroup, the rate of smokers, mean of high density lipoprotein cholesterol, EPA concentration, and EPA/AA ratio were significantly higher in the EPA group than in the no EPA group. The rate of coronary heart disease was significantly lower in the EPA group than in the no EPA group at baseline in the secondary prevention subgroup. In the secondary prevention subgroup, ischemic stroke accounted for >60% of stroke cases. Table 2 shows serum lipid level, plasma fatty acid level, and blood pressure at the baseline and during the observation period. Low density lipoprotein cholesterol decreased to 3.54 mmol/L.
Discussion

In the present study, in which occurrence and recurrence of stroke among hypercholesterolemic patients in the JELIS...
were analyzed by classifying patients into groups with and without a history of stroke, the preventive effect of EPA on recurrence of stroke was observed. No prospective studies on the preventive effects of fish and fish oil on recurrence of stroke in patients have been reported to date. Incidence of stroke events during the 4.6-year mean observation period was 1.3% in the no EPA group and 1.5% in the EPA group among patients without a history of stroke and 10.5% in the

Table 2. Selected Parameters During the Observation Period

<table>
<thead>
<tr>
<th>Parameter</th>
<th>No EPA Group</th>
<th>EPA Group</th>
<th>% Change</th>
<th>HR, 95% CI</th>
<th>P Value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total stroke</td>
<td>114 (1.3%)</td>
<td>133 (1.5%)</td>
<td>0.80 (0.95–1.22)</td>
<td>0.244</td>
<td></td>
</tr>
<tr>
<td>Cerebral thrombosis</td>
<td>41 (0.5%)</td>
<td>36 (0.4%)</td>
<td>0.93 (0.74–1.17)</td>
<td>0.548</td>
<td></td>
</tr>
<tr>
<td>Cerebral embolism</td>
<td>13 (0.1%)</td>
<td>11 (0.1%)</td>
<td>0.91 (0.60–1.36)</td>
<td>0.634</td>
<td></td>
</tr>
<tr>
<td>TIA</td>
<td>13 (0.1%)</td>
<td>9 (0.1%)</td>
<td>0.82 (0.53–1.25)</td>
<td>0.357</td>
<td></td>
</tr>
<tr>
<td>Undetermined cerebral infarction</td>
<td>20 (0.2%)</td>
<td>34 (0.4%)</td>
<td>1.30 (0.99–1.73)</td>
<td>0.057</td>
<td></td>
</tr>
<tr>
<td>Cerebral hemorrhage</td>
<td>18 (0.2%)</td>
<td>28 (0.3%)</td>
<td>1.25 (0.93–1.70)</td>
<td>0.129</td>
<td></td>
</tr>
<tr>
<td>Subarachnoid hemorrhage</td>
<td>12 (0.1%)</td>
<td>16 (0.2%)</td>
<td>1.15 (0.80–1.70)</td>
<td>0.448</td>
<td></td>
</tr>
<tr>
<td>Other cerebrovascular events (details unknown)</td>
<td>4 (0.0%)</td>
<td>2 (0.0%)</td>
<td>0.70 (0.26–1.60)</td>
<td>0.405</td>
<td></td>
</tr>
<tr>
<td>Total stroke</td>
<td>48 (10.5%)</td>
<td>33 (6.8%)</td>
<td>0.80 (0.64–0.997)</td>
<td>0.047</td>
<td></td>
</tr>
<tr>
<td>Cerebral thrombosis</td>
<td>23 (5.0%)</td>
<td>13 (2.7%)</td>
<td>0.72 (0.50–1.00)</td>
<td>0.052</td>
<td></td>
</tr>
<tr>
<td>Cerebral embolism</td>
<td>2 (0.4%)</td>
<td>6 (1.2%)</td>
<td>1.65 (0.79–4.31)</td>
<td>0.190</td>
<td></td>
</tr>
<tr>
<td>TIA</td>
<td>1 (0.2%)</td>
<td>2 (0.4%)</td>
<td>1.45 (0.45–6.73)</td>
<td>0.536</td>
<td></td>
</tr>
<tr>
<td>Undetermined cerebral infarction</td>
<td>13 (2.8%)</td>
<td>7 (1.4%)</td>
<td>0.71 (0.44–1.12)</td>
<td>0.140</td>
<td></td>
</tr>
<tr>
<td>Cerebral hemorrhage</td>
<td>7 (1.5%)</td>
<td>4 (0.8%)</td>
<td>0.77 (0.39–1.40)</td>
<td>0.390</td>
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</tr>
<tr>
<td>Subarachnoid hemorrhage</td>
<td>2 (0.4%)</td>
<td>1 (0.2%)</td>
<td>0.69 (0.15–2.23)</td>
<td>0.528</td>
<td></td>
</tr>
<tr>
<td>Other cerebrovascular events (details unknown)</td>
<td>1 (0.2%)</td>
<td>0 (0.0%)</td>
<td>...</td>
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<td></td>
</tr>
</tbody>
</table>

Primary and secondary prevention subgroups; adjusted for age, gender, hypertension, diabetes mellitus, and smoking.

HR indicates hazard ratio; 95% CI, 95% confidence interval; TIA, transient ischemic attack.

Table 3. Incidence of Stroke and Cox Hazard Ratio for Stroke

<table>
<thead>
<tr>
<th>Stroke Event Type</th>
<th>No EPA Group</th>
<th>EPA Group</th>
<th>HR, 95% CI</th>
<th>P Value*</th>
</tr>
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no EPA group and 6.8% in the EPA group among patients with a history of stroke, indicating a 5- to 8-fold higher incidence among patients with a history of stroke. We have already reported the finding that EPA reduced coronary events in the primary end point analysis of the JELIS. Analysis of stroke as an end point demonstrated the aforementioned effects of EPA on recurrence, particularly of ischemic events, among patients with a history of stroke, who have a high recurrence rate.

The Nurses’ Health Study, a cohort study that investigated the relationship between fish intake and stroke, showed that fish intake reduces ischemic events, a finding that is consistent with our results. The Nurses’ Health Study also reported that fish intake significantly reduced incidence of lacunar infarction among ischemic events, and that similar results were obtained in terms of ω3 polyunsaturated fatty acids intake. Taken together, these 2 studies suggest that EPA may reduce the risk of thrombotic infarction. However, because the clinical categories of thrombotic infarction (lacunar or atherothrombotic infarction) had not been determined in the JELIS, the type of disease affected by EPA could not be specified based on the present results.

Because we used highly purified EPA rather than fish oil, which contains many fatty acids other than EPA, the present study differs from previous studies that used fish or fish oil in that the preventive effects on stroke can be attributed to EPA. In addition, because EPA possesses a diverse range of pharmacological actions including antihyperlipidemic, antithrombotic, antiplatelet, antiinflammatory, and antirhythmic properties, the reduction in risk of ischemic events may be related to multiple properties. Possible mechanisms of action for the reduction of ischemic events by EPA are described below. In a randomized controlled trial, administration of fish oil to patients awaiting carotid endarterectomy resulted in plaque regression as well as increases in EPA and DHA within plaque and reduction in macrophage count. In addition, ω3 polyunsaturated fatty acids reduce the expression of adhesion molecules on endothelial cell and macrophage, and EPA decrease foam cell size and increase collagen fibers in fibrous caps in a plaque model. Macrophage infiltration is an important factor in plaque inflammation and destabilization. These effects of EPA on atherosclerotic tissue were thought to have led to inhibition of the progression of vascular pathogenesis in atherosclerotic cerebral thrombosis. In addition, EPA may have directly acted on platelets and inhibited platelet aggregation and thrombus formation at the affected region. Furthermore, other effects of EPA, including vasodilation, reduction of blood viscosity, and enhancement of red cell deformability, may have contributed to reduction of the risk of lacunar infarction by improving cerebral microcirculation.

In a recent study, recurrence of stroke was reduced by a potent low-density lipoprotein cholesterol lowering therapy using atorvastatin. Lowering of low-density lipoprotein cholesterol was effective to some degree for preventing recurrence of stroke. However, because no differences in low-density lipoprotein cholesterol level were observed between the no EPA and the EPA groups during the study period in the present study, the effects of EPA were unlikely to have been mediated by reductions in low density lipoprotein cholesterol. In addition, no effects were observed on systolic blood pressure and diastolic blood pressure during the study period. Reduction of triglycerides by EPA treatment was significant but limited, 0.17 mmol/L, compared to the no EPA group in the secondary prevention subgroup. Therefore, EPA administration was thought to be a new therapeutic option for preventing recurrence among hypercholesterolemic patients with a history of stroke.

The EPA concentration among Japanese individuals, given as the EPA concentration in the no EPA group of the JELIS in secondary prevention group, was 2.8 mol%, which was approximately 10-fold higher than that of white Americans. In the secondary prevention subgroup, plasma EPA concent-
trations during the observation period were more than 2 times higher in the EPA group (5.9 mol%) compared to the no EPA group. This suggests that even among Japanese individuals, who have relatively high plasma EPA concentrations, further increases in EPA concentration may lead to prevention of recurrence of stroke. Meanwhile, in the primary prevention subgroup, there were more hemorrhagic stroke and undetermined cerebral infarctions in the EPA group, although the difference was not significant. No such signal occurred in secondary prevention subgroup, but sample size was much smaller. Further study is needed regarding cerebral hemorrhage in patients with a history of stroke treated with EPA.

Limitations of this study were its open-label design and the mean low density lipoprotein cholesterol value of 4.65 mmol/L, which was higher than the current treatment target, during the observation period.

Conclusion
EPA could be a therapeutic option for preventing recurrence of stroke in Japanese hypercholesterolemic patients in whom low density lipoprotein cholesterol is suboptimally treated. Further research is needed to replicate these findings and to determine whether EPA is of benefit in populations with lower levels of fish intake and more optimally managed risk factors.

Acknowledgments
This study was presented in part at the 47th Annual Conference on Cardiovascular Disease Epidemiology and Prevention in association with the Council on Nutrition, Physical Activity, and Metabolism, Orlando, Florida, USA, February 28 to March 3, 2007. We are indebted to all the trial participants, the large numbers of doctors, nurses, and hospital staff for their long-term commitment to the study, and to all the patients who participated in the trial. The principal investigator prepared the first draft of this article, while all members of the JELIS Steering Committee contributed to the writing of the final version and had final responsibility for the decision to submit the manuscript for publication.

Sources of Funding
This study was supported by grants from Mochida Pharmaceutical Co Ltd, Tokyo, Japan. Commercially available capsules containing 300 mg EPA ethyl ester were supplied by Mochida Pharmaceutical Co Ltd.

Disclosures
The committee members and investigators received no remuneration for conducting this study. K. Tanaka received travel costs from Mochida Pharmaceutical Co Ltd, Tokyo, Japan, to participate in that scientific meeting. The other authors have no conflicts to report.

References


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*Stroke*. 2008;39:2052-2058; originally published online May 1, 2008;
doi: 10.1161/STROKEAHA.107.509455
*Stroke* is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 0039-2499. Online ISSN: 1524-4628

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/content/39/9/e149.full.pdf

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In the article entitled “Reduction in the Recurrence of Stroke by Eicosapentaenoic Acid for Hypercholesterolemic Patients: Subanalysis of the JELIS Trial” by Tanaka et al., in the “Study Design and Patients” section (page 2053), line 4, “men aged over 40 to 70 years” should read “men aged over 40 to 75 years.” The authors regret this error.

The corrected version can be viewed online at http://stroke.ahajournals.org.