Effect of Statins on Intracerebral Hemorrhage Outcome and Recurrence

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Background and Purpose—3-hydroxy-3-methylglutaryl coenzyme A (HMG-CoA) reductase inhibitors, or statins, have been associated with improved outcome after ischemic stroke and subarachnoid hemorrhage but an increased risk of incident intracerebral hemorrhage (ICH). We investigated (1) whether statin use before ICH was associated with functional independence at 90 days, and (2) whether survivors exposed to statins after ICH had an increased risk of recurrence.

Methods—We analyzed 629 consecutive ICH patients with 90-day outcome data enrolled in a prospective cohort study between 1998 to 2005. Statin use was determined by patient interview at the time of ICH and supplemented by medical record review. Independent status was defined as Glasgow Outcome Scale 4 or 5. ICH survivors were followed by telephone interview every 6 months.

Results—Statins were used by 149/629 (24%) before ICH. There was no effect of pre-ICH statin use on the rates of functional independence (28% versus 29%, \( P = 0.84 \)) or mortality (46% versus 45%, \( P = 0.93 \)). Medical comorbidities and warfarin use were more common in statin users. Hematoma volumes were similar (median 28 cm\(^3\) in pre-ICH statin users compared to 22 cm\(^3\) in nonusers, \( P = 0.18 \)). The multivariable-adjusted odds ratio for independent status in pre-ICH statin users was 1.16 (95% CI 0.65 to 2.10, \( P = 0.62 \)). ICH survivors treated with statins after discharge did not have a higher risk of recurrence (adjusted HR 0.82, 95% CI 0.34 to 1.99, \( P = 0.66 \)).

Conclusions—Pre-ICH statin use is not associated with improved ICH functional outcome or mortality. Post-ICH statin use is not associated with an increased risk of ICH recurrence. (Stroke. 2008;39:2151-2154.)

Key Words: intracerebral hemorrhage ■ outcome ■ statins
not performed or was missing in 467/795 (6%), and other data were missing in 19/795 subjects (3%), leaving 730 subjects with complete baseline information.

Death within 30 days occurred in 251/730, leaving 479/730 30-day survivors. Consenting survivors or a proxy informant (together representing 273/479 of the 30-day survivors, 57%), were interviewed by telephone at 90 days to determine the Glasgow Outcome Scale (GOS) score. To reduce bias we also retrospectively determined GOS at ≥90 days from the medical records of 105/206 nonparticipating ICH survivors. The 101/206 registry subjects without follow-up information had similar baseline characteristics as subjects with follow-up information, except fewer had lobar ICH location (P = 0.02). Therefore, in sum, 90-day GOS was determined in a total of 629/730 potential subjects (86%).

Statins and Risk of Recurrence in ICH Survivors
ICH survivors at 90 days were recruited into a prospective longitudinal cohort study designed to find predictors of ICH recurrence. Of 273 eligible survivors, 229 participated (82%). Subjects were followed by telephone every 6 months. Dates of initiation and discontinuation of statins were determined based on subject interview supplemented by available medical records. Dose information was not collected. When the date of statin initiation or discontinuation could not be recalled, it was assigned as the midpoint between successive interviews.

Statistical Analysis
Independent status was defined as GOS 4 or 5. Logistic regression models were constructed to determine whether pre-ICH statin use was associated with independent status or mortality. ICH volume was log-transformed, because of a nonnormal distribution, when analyzed as the dependent variable in multivariable linear regression.

Results
Pre-ICH Statin Use and ICH Outcome
Pre-ICH statin use was not associated with independent status or mortality (Table 1). Multivariable logistic regression models showed that pre-ICH statin use was not associated with independent status after adjustment for potential confounders (Table 2). Pre-ICH statin use was associated with a nonsignificant 19% increase in ICH volume on admission CT (95% CI −7% to +51%, P = 0.16) in a linear regression model controlling for other variables associated with ICH volume (male sex, hypertension, diabetes, previous ICH, and ICH location).

We considered whether the effect of statins use might vary according to outcome definition or patient subgroups. There was no difference in 30-day or 90-day survival in pre-ICH statin users (data not shown). Because statin withdrawal may worsen stroke outcome we performed additional analyses subtracting subjects in whom statins were discontinued (n = 22), or adding subjects in whom statins were started (n = 25), and found similar results (data not shown). To test for a dose-response effect, those with dose information (105/149, 70%) were dichotomized according to whether the statin dose was ≥50% of the maximum dose recommended by the manufacturer’s labeling. Users of higher-dose statins (n = 25), compared to nonusers (n = 480), were not more likely to have independent status (P = 0.78). Finally, we failed to confirm a hypothesis that statins would have a better effect in subjects with higher GCS (GCS > 10) or smaller ICH volumes (<30 cm³), tested using interaction terms in the regression models (P > 0.50 for both).

Post-ICH Statin Use and Risk of Recurrence in ICH Survivors
Statins were used after ICH discharge in 79/229 (35%) of participating ICH survivors; 57 were discharged on statins and 22 started statins after discharge. Mean follow-up was 1.91 ± 1.58 years, with a total of 437.5 person-years of follow-up and 140.8 person-years of post-ICH statin exposure. Post-ICH statin users were more likely to be older, male, to have been on warfarin before the index ICH, and to have CHD and diabetes (P < 0.05 for all comparisons).

Table 1. Baseline Characteristics According to Presence of Statin Use Before ICH

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Statin Use</th>
<th>No Statin Use</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>72.4 ± 9.4</td>
<td>71.9 ± 12.7</td>
<td>0.65</td>
</tr>
<tr>
<td>Male</td>
<td>64</td>
<td>50</td>
<td>0.005</td>
</tr>
<tr>
<td>Hypertension</td>
<td>89</td>
<td>75</td>
<td>0.0003</td>
</tr>
<tr>
<td>CHD</td>
<td>47</td>
<td>15</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Diabetes</td>
<td>32</td>
<td>15</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>29</td>
<td>18</td>
<td>0.005</td>
</tr>
<tr>
<td>Pre-ICH cognitive impairment</td>
<td>15</td>
<td>15</td>
<td>0.99</td>
</tr>
<tr>
<td>Ischemic stroke</td>
<td>23</td>
<td>14</td>
<td>0.01</td>
</tr>
<tr>
<td>Previous ICH</td>
<td>9</td>
<td>6</td>
<td>0.19</td>
</tr>
<tr>
<td>Warfarin</td>
<td>38</td>
<td>18</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>GCS</td>
<td>12</td>
<td>12</td>
<td>0.83</td>
</tr>
<tr>
<td>ICH location</td>
<td>Deep hemispheric</td>
<td>44</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>Lobar</td>
<td>44</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>Brainstem</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Cerebellum</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>ICH volume, cm³</td>
<td>28</td>
<td>22 (8, 54)</td>
<td>0.15</td>
</tr>
<tr>
<td></td>
<td>Intraventricular extension</td>
<td>56</td>
<td>53</td>
</tr>
<tr>
<td>90-day independence (GOS 4 or 5)</td>
<td>28</td>
<td>29</td>
<td>0.84</td>
</tr>
<tr>
<td>90-day mortality</td>
<td>46</td>
<td>45</td>
<td>0.93</td>
</tr>
</tbody>
</table>

Continuous variables displayed as mean ± SD, or median (25th percentile, 75th percentile). CHD indicates coronary heart disease; ICH, intracerebral hemorrhage; GCS, Glasgow Coma Scale.

*Chi-square test for distribution of hemorrhages across all locations.
mg of atorvastatin per day increased the risk of ICH. We did not detect a difference in outcomes in patients taking statins before ICH, even after adjustment for medical comorbidities. The relationship between cholesterol levels and ICH recurrence could not be determined in our study because hemorrhagic stroke characteristics may themselves have been affected by pre-ICH statin use. Finally a third model was constructed with the same variables as the model B, but excluding subjects with negative prognostic features: deep coma (GCS 3 to 5), pre-ICH cognitive impairment, brainstem or cerebellar location, or ICH volume >60 cm³. The subject population of the Model C was therefore similar to that studied in recent clinical trials of ICH.

GOS indicates Glasgow Outcome Scale; ICH, intracerebral hemorrhage.

(OR 0.77, 95% CI 0.32 to 1.86, P=0.56) or when adjusting for other predictors (Table 3).

Discussion

We did not detect a difference in outcomes in patients taking statins before ICH, even after adjustment for medical comorbidities. By contrast, treatment with statins improved sensorimotor recovery in 2 animal models of ICH. There may be biological differences, however, between animals and humans in the type of injury that occurs after ICH. In contrast to the animal studies, our subjects were taking various types and dosages of statins. A recent study suggested that statins are derived from Model C (Table 3), for independent status in the univariate analysis (P=0.20): GCS, ICH volume, and presence of intraventricular hemorrhage. The 2 models were constructed separately because hemorrhagic stroke characteristics may themselves have been affected by pre-ICH statin use. Finally a third model was constructed with the same variables as the model B, but excluding subjects with negative prognostic features: deep coma (GCS 3 to 5), pre-ICH cognitive impairment, brainstem or cerebellar location, or ICH volume >60 cm³. The subject population of the Model C was therefore similar to that studied in recent clinical trials of ICH.

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Disclosures

None.

References


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