Altered Fibrin Clot Structure/Function in Patients With Cryptogenic Ischemic Stroke

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Background and Purpose—We tested the hypothesis that fibrin structure/function is unfavorably altered in patients with cryptogenic ischemic stroke.

Methods—Ex vivo plasma fibrin clot permeability, turbidimetry, and efficiency of fibrinolysis were determined in 89 patients with patent foramen ovale (PFO) and a history of first-ever stroke, 58 patients with first-ever stroke and no PFO, and 120 healthy controls.

Results—Stroke patients, evaluated 3 to 19 months after the event, and controls did not differ with regard to age, sex, smoking, and fibrinogen. Stroke patients with or without PFO had lower clot permeability (P<0.0001), higher fibrin polymerization (P<0.0001), prolonged clot lysis time (P<0.0001), higher maximum D-dimer levels released from clots (P<0.0001), and maximum rate of D-dimer release (P=0.02) than controls. Time from stroke occurrence showed no association with any clot variables. Scanning electron microscopy of fibrin clots showed increased fiber diameter and density in stroke patients. Clots from stroke patients with PFO were more permeable and showed shorter lysis time compared to those without PFO, and this was related to lower proportion of smokers in the former group.

Conclusions—Altered fibrin clot structure and resistance to fibrinolysis are associated with cryptogenic stroke. (Stroke. 2009;40:1499-1501.)

Key Words: fibrin clot ■ fibrinolysis ■ stroke
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blinded to the origin of the samples (intraassay and interassay coefficients were determined at least in duplicates by technicians).

In citrated plasma (vol/vol, 9:1 of 3.2% sodium citrate), the following variables were determined at least in duplicates by technicians blinded to the origin of the samples (intraassay and interassay coefficients of variation, 5% to 8%), as previously described in detail.

Fibrin Clot Permeation using a pressure-driven system, with calculation of a permeation coefficient $(K_p)$, which indicates the pore size. Lower $K_p$ values indicate reduced permeability.

1. Fibrin clot permeation using a pressure-driven system, with calculation of a permeation coefficient $(K_p)$, which indicates the pore size. Lower $K_p$ values indicate reduced permeability.

2. The lag phase of the turbidity curve, which reflects the time required for initial protfibril formation and maximum absorbance at 405 nm at the plateau phase $(\Delta \text{Abs})$, indicating the number of protfibris per fiber.

3. Clot lysis time, defined as the time required for a 50% decrease in clot turbidity at 405 nm $(t_{50\%})$, induced by 1 μg/mL recombinant tissue plasminogen activator (Boerhinger Ingelheim).

4. Maximum rate of increase in D-dimer levels (American Diagnostica) and maximum D-dimer concentrations measured every 30 minutes in a buffer containing 0.2 μmol/L recombinant tissue plasminogen activator (Boerhinger Ingelheim) percolating through fibrin clots formed as for permeation evaluation.

**Scanning Electron Microscopy**

Clots from 5 stroke patients and 5 controls with similar fibrinogen levels were fixed by permeating them with a 2.5% glutaraldehyde solution for 2 hours, recovered from the tubes, and further processed by dehydration. Samples were photographed digitally in 5 different areas with a Hitachi S-4700 SEM. Fiber thickness was measured as described.

**Statistical Analysis**

Data were given as mean±SD or otherwise stated. The significance of between-group differences was tested by analysis of variance with Scheffe adjustment. Categoric values were analyzed using the $\chi^2$ test or Fisher exact test. The Mann-Whitney U test or Student t test was used to test differences between 2 groups as appropriate. Post hoc comparisons were made using Tukey test. Correlations were assessed by the Spearman test. A value of $P<0.05$ was considered significant.

**Results**

**Stroke Patients vs Healthy Controls**

A total of 147 patients who experienced stroke at a median of 8 (3–19) months before enrollment were studied. Table 1 shows characteristics of the patients and controls. Most patients were using low-dose aspirin (8–22 months). Lipid profile, glucose, and creatinine were similar in both groups (data not shown).

**Table 1. Characteristics of Stroke Patients and Healthy Controls**

<table>
<thead>
<tr>
<th></th>
<th>Stroke Patients</th>
<th>Stroke Patients With PFO</th>
<th>Stroke Patients Without PFO</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$(n=147)$</td>
<td>$(n=89)$</td>
<td>$(n=58)$</td>
<td>$(n=120)$</td>
</tr>
<tr>
<td>Age, yr, male, n (%)</td>
<td>44.2±4.5 (30.6)</td>
<td>42.7±14.26 (29.2)</td>
<td>46.0±4.18 (32.8)</td>
<td>44.8±12.4 (33.3)</td>
</tr>
<tr>
<td>Current smokers, n (%)</td>
<td>45 (30.6)</td>
<td>18 (20.2)*</td>
<td>27 (46.5)*</td>
<td>0</td>
</tr>
<tr>
<td>Hypertension, n (%)</td>
<td>57 (38.8)*</td>
<td>30 (33.7)*</td>
<td>27 (46.5)*</td>
<td>0</td>
</tr>
<tr>
<td>Aspirin, n (%)</td>
<td>138 (93.9)*</td>
<td>80 (89.9)*</td>
<td>58 (100)*</td>
<td>0</td>
</tr>
<tr>
<td>Statins, n (%)</td>
<td>49 (33.3)*</td>
<td>28 (31.5)*</td>
<td>21 (36.2)*</td>
<td>0</td>
</tr>
<tr>
<td>β-blockers, n (%)</td>
<td>52 (35.4)*</td>
<td>28 (31.5)*</td>
<td>24 (41.4)*</td>
<td>0</td>
</tr>
<tr>
<td>ACE inhibitors, n (%)</td>
<td>49 (33.3)*</td>
<td>13 (28.9)*</td>
<td>36 (62.1)*†</td>
<td>0</td>
</tr>
<tr>
<td>Fibrinogen, g/L</td>
<td>3.19±0.96</td>
<td>3.28±0.95</td>
<td>3.0±0.96</td>
<td>2.98±0.82</td>
</tr>
<tr>
<td>CRP, mg/L</td>
<td>1.81±1.35</td>
<td>2.09±1.60</td>
<td>1.37±0.64†</td>
<td>1.61±0.97</td>
</tr>
<tr>
<td>D-dimer, mg/dL</td>
<td>180.2±81.3</td>
<td>195.2±81.0</td>
<td>157.1±76.9</td>
<td>166.4±48.4</td>
</tr>
<tr>
<td>tPA, ng/mL</td>
<td>9.82±3.17*</td>
<td>9.50±3.27</td>
<td>10.30±2.98*</td>
<td>8.58±3.17</td>
</tr>
<tr>
<td>PAI-1, ng/mL</td>
<td>14.38±6.63*</td>
<td>13.6±6.53</td>
<td>15.5±6.88*</td>
<td>12.04±4.46</td>
</tr>
<tr>
<td>F1.2, nmol/L</td>
<td>0.72±0.18</td>
<td>0.75±0.20</td>
<td>0.71±0.15</td>
<td>0.73±0.20</td>
</tr>
</tbody>
</table>

ACE indicates angiotensin-converting enzyme; CRP, C-reactive protein; PAI-1, plasminogen activator inhibitor-1; tPA, tissue plasminogen activator.

*P<0.05 compared to controls.
†P<0.01 compared to stroke patients with PFO.

**Table 2. Fibrin Clot Variables**

<table>
<thead>
<tr>
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<td>$(n=58)$</td>
<td>$(n=120)$</td>
</tr>
<tr>
<td>$K_p$, 10⁻⁹ cm²</td>
<td>6.98±1.62*</td>
<td>7.50±1.62*</td>
<td>6.20±1.27†</td>
<td>9.06±1.56†</td>
</tr>
<tr>
<td>Lag phase, sec</td>
<td>38.14±3.78*</td>
<td>37.63±3.58*</td>
<td>38.91±3.97*</td>
<td>44.89±4.25†</td>
</tr>
<tr>
<td>$\Delta \text{Abs}$ (405 nm)</td>
<td>0.90±0.11*</td>
<td>0.91±0.11*</td>
<td>0.90±0.12*</td>
<td>0.73±0.07†</td>
</tr>
<tr>
<td>$t_{50%}$, min</td>
<td>9.39±1.31*</td>
<td>9.14±1.25*</td>
<td>9.77±1.31†</td>
<td>7.80±1.08†</td>
</tr>
<tr>
<td>D-D max, mg/L</td>
<td>4.11±0.56*</td>
<td>4.09±0.56*</td>
<td>4.14±0.57*</td>
<td>3.58±0.44†</td>
</tr>
<tr>
<td>D-D rate, mg/L/min</td>
<td>0.074±0.008*</td>
<td>0.075±0.008*</td>
<td>0.073±0.008</td>
<td>0.072±0.009†</td>
</tr>
</tbody>
</table>

$\Delta \text{Abs}$ (405 nm) indicates maximum absorbance of fibrin gel at 405 nm in turbidimetry; D-D max, maximum D-dimer levels in the lysis assay; D-D rate, maximum rate of increase in D-dimer levels in the lysis assay; $K_p$, permeability coefficient; $t_{50\%}$, lysis time.

*P<0.05 compared to controls.
†P<0.01 compared to stroke patients with PFO.

(American Diagnostica); antigens of tissue-type plasminogen activator; and plasminogen activator inhibitor-1 (American Diagnostica).
Only tissue plasminogen activator and plasminogen activator inhibitor-1 antigen levels were slightly higher in the patients.

Stroke patients had lower clot permeability, longer lysis time, a shorter lag phase, and greater maximum ΔAbs (Table 2). Time-courses of the D-dimer release from clots demonstrated that maximum rates of fibrinolysis and maximum D-dimer levels in the effluent were higher in the patients (Table 2). No differences in clot features associated with gender, smoking, hypertension, medication, or the time that elapsed from the ischemic event were observed. Overall fiber diameter and an average number of fibrin fibers were greater in stroke patients than stroke-free subjects (169 [157–180] vs 148 [145–150] nm; P=0.009; and 14.8 [14.7–14.8] vs 11.4 [11.0–12.1]; P=0.01; respectively; Figure).

**Stroke Patients With and Without PFO**

While comparing stroke patients with and without PFO (Table 1), we found fewer smokers and angiotensin-converting enzyme inhibitor-treated patients, and higher C-reactive protein in the former group.

Clots made from plasma of stroke patients with PFO were more permeable and showed shorter lysis time compared to stroke patients without PFO, without any intergroup differences in other clot parameters (Table 2). There was an association between lower percentage of smokers and more favorable clot features in stroke patients with PFO (P=0.02). None of the clot variables correlated with the time from the PFO closure or stroke occurrence.

**Discussion**

This study demonstrates that altered clot properties are associated with cryptogenic stroke. In stroke patients, both with and without PFO, fibrin clots were formed more rapidly and had a compact structure composed of thicker fibers compared to those made from plasma obtained from healthy controls. Compact clot structure results in impaired transport of proteins through networks and regardless of fiber thickness is associated with slow fibrinolysis, as shown also in this study.

Mechanisms behind altered clot structure/function in stroke patients are not clear. Fibrinogen is a major predictor of fibrin clot properties.3,8 Of note, differences between stroke patients and controls in these properties were observed despite similar fibrinogen levels. Fibrin clot properties are likely even worse in stroke patients not receiving aspirin that increases clot permeability and facilitates fibrin lysis.3,5,9 Alterations in fibrin function/structure in stroke patients with PFO cannot be attributed to the activation of coagulation observed shortly after PFO closure.11 Higher clot permeability and faster lysis in stroke patients with PFO than in those without PFO is likely explained by lower proportion of smokers in the former group. Smoking is known to unfavorably alter clot properties.3 We cannot exclude that lipoprotein(a) or homocysteine affecting clot properties,3,6,12 or genetic factors, not measured in the present study, might be implicated in stroke-related clot abnormalities.

Our study has limitations. The number of study participants was limited. We determined variables at a single time point. Exclusion of subjects with multiple strokes as well other than cryptogenic strokes resulted in uncertainty whether our findings refer also to these patients. Our stroke patients with PFO had atrial septal aneurysm in 66%; therefore, it is unclear whether our results can be extrapolated to other PFO subjects. Finally, statistical associations do not necessarily mean the cause–effect relationship and further studies are needed.

In conclusion, patients with cryptogenic stroke, both with and without PFO, are characterized by formation of dense fibrin clots resistant to lysis. Our study provides new insights into the pathophysiology of ischemic stroke that might have practical implications.

**Disclosures**

None.

**References**

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