Inflammatory Mechanisms of Stroke

Mitchell S.V. Elkind, MD, MS

Abstract—Basic and clinical research provides evidence that inflammatory mechanisms play a central role in the pathogenesis and progression of atherosclerosis, plaque rupture, thrombosis, and stroke. Inflammatory biomarkers such as high-sensitivity C-reactive protein have been identified as predictors of first stroke and prognosis after stroke. The value of high-sensitivity C-reactive protein and other markers may depend on the characteristics of the study population; their utility may be less among populations with high vascular risk. A recent randomized, clinical trial suggests that the use of rosuvastatin therapy in otherwise healthy patients with high-sensitivity C-reactive protein >2 mg/dL can reduce the risk of a first stroke by 50%. The prognostic role of high-sensitivity C-reactive protein among patients after stroke, however, is less clear, and other biomarkers, including lipoprotein-associated phospholipase A2, may provide complementary information about the risk of stroke recurrence. Infections, moreover, may contribute to inflammation and stroke risk. Although no single infectious organism is likely to be identified as the direct cause of atherosclerosis, summary measures of multiple chronic infectious exposures, or “infectious burden,” have been associated with the risk of stroke and atherosclerosis affecting the carotid arteries. Acute infections have also been found to serve as stroke triggers in epidemiologic studies. Recommendations to vaccinate patients with cardiovascular disease against influenza represent the first specific anti-infective strategy to be used in vascular prophylaxis. Further studies are needed to determine the role of treatment of inflammation and infection in stroke prevention. (Stroke. 2010;41[suppl 1]:S3-S8.)

Key Words: atherosclerosis inflammation infection infectious burden statins stroke cerebral thrombosis risk factors

Basic and clinical research provides evidence that inflammatory mechanisms play a central role in the pathogenesis and progression of atherosclerosis, plaque rupture, thrombosis, and stroke. Inflammatory biomarkers such as high-sensitivity C-reactive protein (hsCRP) have been identified as predictors of stroke and prognosis after stroke. Infections, moreover, may contribute to inflammation and stroke risk. Although no single infectious organism is likely to be identified as the direct cause of atherosclerosis, summary measures of multiple chronic infectious exposures, or “infectious burden” (IB), have been associated with the risk of stroke and atherosclerosis affecting the carotid arteries. Acute infections have also been found to serve as stroke triggers. This article, based on a presentation given at the 2010 Princeton Conference, focuses on recent epidemiologic and clinical studies evaluating the hypotheses that inflammatory biomarkers and infections are associated with the risk of stroke, with an emphasis on the author’s own investigations.

Inflammatory Biomarkers in Primary Prevention

Epidemiologic Studies of hsCRP and Stroke Risk

Acute-phase proteins have been extensively studied as markers of coronary artery disease, and to a lesser extent, stroke. hsCRP, in particular, has many features that recommend it as a molecular marker of the risk of stroke associated with inflammation. A disadvantage to the assay is that it is very nonspecific, so acute increases in the levels of hsCRP may occur in the setting of acute infection or other illness. hsCRP has predicted incident cardiovascular events in several generally healthy populations. In multivariate models, hsCRP may improve the predictive ability of models over those containing lipid values and other risk factors alone (P<0.001).

The relation of hsCRP to incident stroke risk probably depends on the study design and population studied. In the Cardiovascular Health Study, among the elderly, hsCRP predicted incident ischemic stroke, although the effect was modest. In a study among elderly European subjects, hsCRP was associated not only with an increased risk of fatal stroke but also with a risk of death from all causes. A large individual-person meta-analysis of 54 prospective cohort studies (N=160 309) was recently performed. The risk ratio of ischemic stroke per 1-SD increase in the logCRP value was 1.44 (95% CI, 1.32 to 1.57) when adjusted for age and sex but was attenuated to 1.27 (95% CI, 1.15 to 1.40) when further adjusted for other risk factors. Of note, however, nonvascular mortality, including cancer, was also increased significantly and by a greater magnitude in these analyses (adjusted risk ratio=1.54; 95% CI, 1.40 to 1.68). These

Received July 6, 2010; accepted July 16, 2010.
From the Departments of Neurology and Epidemiology, Columbia University and New York-Presbyterian Hospital, New York, NY.
Correspondence to Mitchell S.V. Elkind, MD, MS, FAAN, 710 West 168th St, Box 182, New York, NY 10032. E-mail mse13@columbia.edu
© 2010 American Heart Association, Inc.

Stroke is available at http://stroke.ahajournals.org

DOI: 10.1161/STROKEAHA.110.594945

S3
results suggest that elevated CRP may be a marker of general illness rather than a specific marker of vascular disease risk.

Other studies have not confirmed a consistent, independent relation of hsCRP to stroke risk. In the Framingham Study, during >10 years of follow-up, men in the highest quartile of CRP had twice the risk of stroke as those in the lowest quartile, and women had 3 times the risk. For men, however, there was no increased risk after adjusting for confounders. Among healthy Japanese-American men in the Honolulu Heart Program, investigators found an almost 4-fold increase in stroke risk among those in the highest compared with the lowest quartile of hsCRP. The associations were strongest among those ≥55 years and in those without a history of hypertension or diabetes.

Our recent analysis of data from the Northern Manhattan Study (NOMAS) similarly did not confirm the ability of hsCRP to predict first stroke (Figure 1). NOMAS represents a stroke-free, multiethnic, community-based cohort study in participants age ≥40 years. hsCRP measurements were available for 2240 participants (mean±SD age, 68.9±10.1 years; 64.2% women; 18.8% white, 23.5% black, and 55.1% Hispanic). After a median follow-up of 7.9 years, compared with those with an hsCRP <1 mg/L, those with an hsCRP ≥3 mg/L were at increased risk of ischemic stroke in a model adjusted for demographics (hazard ratio [HR]=1.60; 95% CI, 1.06 to 2.41), but the effect was attenuated after adjusting for other risk factors (adjusted HR=1.20; 95% CI, 0.78 to 1.86; Figure 1A). Of note, an hsCRP ≥3 mg/L was also associated with risk of myocardial infarction (adjusted HR=1.70; 95% CI, 1.04 to 2.77; Figure 1B) and death (adjusted HR=1.55; 95% CI, 1.23 to 1.96) in the cohort. Other studies have similarly failed to confirm an association of hsCRP levels with stroke risk in the elderly.

The association between hsCRP and ischemic stroke is thus probably attenuated in certain older populations and in those with more risk factors. The finding of an association between hsCRP and stroke risk may depend on both the degree to which other risk factors are included in the analyses as well as on age and the absolute risk of stroke in the population. Those studies in which predictive associations are found, for example, tend to include relatively young, healthy cohorts. The relation between hsCRP and measures of subclinical cerebrovascular disease, as assessed by brain magnetic resonance imaging, is also uncertain. In NOMAS, an association between hsCRP and white-matter hyperintensity volume was not found, though other inflammatory biomarkers were associated with white-matter disease.

### Role of Statins in Preventing First Stroke Among Patients With Evidence of Inflammation

The hypothesis that statin treatment among apparently healthy men and women with elevated hsCRP values may be associated with a reduction in risk of vascular events was recently tested in a large randomized, clinical trial (Justification for the Use of Statins in Prevention: An Intervention Trial Evaluating Rosuvastatin [JUPITER]). Patients were eligible for enrollment if they had no evidence of cardiovascular disease, diabetes, or hyperlipidemia but had an hsCRP ≥2.0 mg/L. They were randomized to rosuvastatin or placebo. The study was stopped early because of evidence of benefit from rosuvastatin therapy, with a significant reduction in the incidence of major cardiovascular events, including stroke. There was a 48% relative reduction in risk of stroke (HR=0.52; 95% CI, 0.34 to 0.79) among those taking rosuvastatin.

There were several limitations to the study design, however, which have curbed enthusiasm regarding the use of statins as anti-inflammatory therapy to prevent vascular disease. First, the benefit was modest in absolute terms. Second, it was not tied to baseline levels of hsCRP, although there was some evidence that the greatest benefit was seen in those whose hsCRP was reduced to <2.0 mg/L. Third, it remains uncertain whether the mechanism through which statins appear to work is related to inflammation or to some other effect, with the effect on hsCRP a bystander or epiphenomenon. JUPITER provides only indirect evidence, therefore, that statins are of benefit among those with elevated hsCRP values, as the results may simply reflect a

---

**Figure 1.** hsCRP levels and risk of ischemic stroke (A) and myocardial infarction (B) in the NOMAS (N=2240; reference group hsCRP <1 mg/L).
general benefit of statin therapy among all patients, with the greatest magnitude seen among those at higher risk.

**Inflammatory Biomarkers in Secondary Stroke Prevention**

The utility of hsCRP measured after stroke as a predictor of long-term risk of recurrence is unsettled. In a secondary nested, case-control analysis from a multicenter secondary stroke prevention trial, those in the highest tertile of hsCRP had a modest increase in risk of recurrent ischemic stroke (odds ratio [OR] = 1.39; 95% CI, 1.05 to 1.85). Results were not, however, fully adjusted for all risk factors. In a data from NOMAS, elevated levels of hsCRP (top quartile) were associated with a doubling of the risk of death for several years after first ischemic stroke but were not associated with an increase in risk of recurrent stroke. Lipoprotein-associated phospholipase A2 (LpPLA2) was associated with risk of recurrent stroke and other vascular events. Because hsCRP was associated with stroke severity, however, whereas LpPLA2 was not, it seems likely that hsCRP serves as a measure of general illness and stroke severity, whereas LpPLA2 may be more specific to vascular inflammation. Both markers may therefore provide complementary information. The timing of measurement of hsCRP and LpPLA2 may have important implications for the results of these studies. hsCRP levels increase acutely after stroke and remain elevated for 28 days or more, whereas levels of LpPLA2 decrease. These changes imply that measurements made soon after stroke and myocardial infarction are not reflective of prestroke levels and may be less reliable for long-term risk stratification.

The decision to measure hsCRP or other markers in stroke patients may be based on Centers for Disease Control and Prevention/American Heart Association guidelines until further data are available. No data yet demonstrate the validity of such an approach, however, and no current guidelines recommend measurement of inflammatory markers in patients with stroke or even provide appropriate levels to determine absolute risk. Because of limitations in the available data, members of the CRP Pooling Project concluded that there was not yet enough data to routinely recommend hsCRP testing for prognostication in stroke patients. Ongoing studies are designed to test the prognostic utility of inflammatory measures after stroke (eg, the Levels of Inflammatory Markers in the Treatment of Stroke study, or LIMITS).

**Chronic Infection as a Risk Factor for Atherosclerosis and Stroke**

Among potential proinflammatory causes of atherosclerosis and stroke, infection remains 1 of the most controversial. Infection could contribute to risk in at least 2 ways. First, infections could serve as a chronic risk factor through effects on the vascular wall accumulating over many years, much like conventional risk factors such as hypertension. Alternatively, acute infections could contribute to short-term stroke risk (that is, a stroke trigger), a possibility considered in the next section.

With regard to infection as a chronic risk factor, individual organisms have been associated with atherosclerosis and stroke risk. Electron microscopy, immunocytochemistry, and polymerase chain reaction have demonstrated *Chlamydia pneumoniae* in diseased blood vessels, including cerebral and carotid arteries. Viable organisms have been cultured from carotid plaques. *C pneumoniae* is found more commonly in atherosclerotic tissue (52%) than in nonatherosclerotic tissue (5%). Data from seroepidemiologic studies provide conflicting evidence of an association between *C pneumoniae* and coronary artery disease. More recently, both case-control and prospective studies have found evidence for an association between serologic evidence of *C pneumoniae* and stroke risk, although other studies have not confirmed these findings.

Viruses have also been associated with atherosclerosis. Herpes simplex virus has been found in human early aortic atherosclerotic lesions. Cytomegalovirus (CMV) is a contributor to vasculopathy in heart transplant recipients, and CMV infection is also more common in coronary artery disease. Elevated CMV titers are associated with early carotid atherosclerotic changes (increased intima-media thickness) and later carotid stenosis. Prospective clinical studies, however, have not confirmed that CMV titers predict increased risk of clinical atherosclerotic events.

**Infectious Burden**

The variable results from these studies indicate that it is unlikely that a single “stroke germ” will be found. Instead, if infection plays a role at all, it is likely to be in a cumulative fashion. The concept of IB has been used to explain the role that infections in aggregate may play in atherosclerosis. According to this hypothesis, infections contribute to the overall inflammatory milieu of atherosclerotic plaque, together with other risk factors, and individuals with the greatest exposure to different infections throughout life are most likely to develop atherosclerosis and stroke (Figure 2). It is likely also the case that those individuals with a more robust inflammatory response to these organisms, perhaps due to polymorphisms in infection-response genes, are more likely to show vascular changes related to infection.

Some but not all studies have begun to provide evidence of an association between different measures of IB and subclinical measures of atherosclerosis and vascular disease. For stroke specifically, in a case-control analysis, cough with phlegm during 3 months per year (chronic bronchitis) was associated with stroke or transient ischemic
Infections as a Treatment Target

Recent guidelines recommend vaccination against influenza in patients with cardiovascular disease as a means to prevent cardiovascular events.66,67 This represents the first anti-infective treatment to be championed as a vascular prevention strategy. There are data from a prospective, uncontrolled study that suggest, however, that treatment of periodontal infection can lead to a reduction in endothelial dysfunction and intima-media thickness.68 Although pilot clinical trials provided some evidence that antibiotics, particularly macrolide antibiotics directed against *Chlamydiae*, might reduce the risk of recurrent coronary events in patients with atherosclerosis,69 subsequent definitive randomized, controlled trials were unable to confirm these findings.70,71 Currently, therefore, there is no indication for antibiotics in patients with atherosclerotic disease. It should be noted, however, that these studies were largely confined to patients with coronary disease. Similar trials of antibiotics for patients with stroke have not been performed, and it is possible that the effects for stroke would differ.

The identification of a short-term state of elevated stroke risk after acute infection could have direct therapeutic impli-
cations, however, independent of the use of antibiotics. For example, increased doses of antiplatelet agents or statins may be warranted during times of fever or infection, when benefits may outweigh the risks of dose-related side effects. In addition, the period during and soon after hospitalization for infection could constitute a “treatable moment,” during which patients could be evaluated for cardiovascular risk and standard preventive strategies instituted.

Sources of Funding
M.S.V.E. receives funding from the National Institute of Neurological Disorders and Stroke (NINDS R01 NS 48134 and NINDS R01 NS50724) for research discussed in this review.

Disclosures
M.S.V.E. discloses that he receives research funding from diaDexus, Inc and BMS-Sanofi Partnership for research related to stroke biomarkers. He is also a BMS-Sanofi Partnership Speakers Bureau.

References
51. Davis MM, Taubert K, Benin AL, Brown DW, Mensah GA, Baddour LM, Dunbar S, Krumholz HM; American Heart Association; American College of Cardiology; American Association of Cardiovascular and Pulmonary Rehabilitation; American Association of Critical Care Nurses; American Association of Heart Failure Nurses; American Diabetes Association; Association of Black Cardiologists, Inc; Heart Failure Society of America; Preventive Cardiovascular Nurses Association; American Academy of Nurse Practitioners; Centers for Disease Control and Prevention and the Advisory Committee on Immunization. Influenza vaccination as secondary prevention for cardiovascular disease: a science advisory from the American Heart Association/American College of Cardiology. Circulation. 2006;114:1549–1553.
Inflammatory Mechanisms of Stroke
Mitchell S.V. Elkind

Stroke. 2010;41:S3-S8
doi: 10.1161/STROKEAHA.110.594945
Stroke is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2010 American Heart Association, Inc. All rights reserved.
Print ISSN: 0039-2499. Online ISSN: 1524-4628

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://stroke.ahajournals.org/content/41/10_suppl_1/S3

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Stroke can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Stroke is online at:
http://stroke.ahajournals.org/subscriptions/