Reflux Esophagitis and Stroke:
Which is the Cause?

To the Editor:

It is with great interest that I read “Reflux Esophagitis and the Risk of Stroke in Young Adults: A 1-Year Population-Based Follow-Up Study” by Sheu et al,1 which first addressed the relation between reflux esophagitis (RE) and the risk of stroke in a young Taiwanese population. From an epidemiologic point of view and because it is known that classic risk factors such as current smoking greatly influence the risk of stroke subtypes, the lack of such data in the present analysis, particularly for a perceived confounder in multivariate modeling, may lend a certain bias to the effect of RE on stroke. Interestingly, although current smoking was found to be a risk factor in previous Taiwanese hospital-based studies, it was not significantly associated with the risk of ischemic stroke in a longitudinal, community-based study.2 In China, a marginal association between smoking and risk of stroke was found in stroke patients from 36 hospitals (38.8% and 33.3% for cases and controls, respectively).3 More quality research on the risk factors for stroke, such as smoking, in the Chinese population is therefore warranted. This may further confirm not only the effect of smoking on stroke but also the effect of other potential predictors, such as RE, on the risk of stroke after controlling for current smoking as a potential confounder in the Chinese population.

In addition, the only epidemiologic study on RE and stroke and other cardiovascular disease in a Norwegian population mentioned by the authors in fact showed an association between a history of stroke and RE (odds ratio = 1.3; 95% CI, 1.0 to 1.7).4 Thus, the present study did not confirm a link between prior stroke and RE but a questionable link between prior RE and stroke. In this context, it is a bit risky to conclude that RE is a new risk factor for stroke. On the other hand, it would be interesting to know the relation between a history of stroke and RE in this cohort compared with Western populations, such as Norwegian. Before any conclusion can be drawn, the shared risk factor profile for the risk of stroke and RE needs to be well considered. Again, from a Taiwanese hospital-based study, it was shown that alcohol consumption (odds ratio = 2.2; 95% CI, 1.5 to 3.3) had a strong effect rather than smoking (odds ratio = 1.3; 95% CI, 0.8 to 2.2) on the risk of esophagitis.5 Apparently, potential confounders other than smoking for both stroke and RE should be well taken into account in future analyses.

Disclosures

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