Lifestyle Risk Factors for Ischemic Stroke and Transient Ischemic Attack in Young Adults in the Stroke in Young Fabry Patients Study

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Background and Purpose—Although many stroke patients are young or middle-aged, risk factor profiles in these age groups are poorly understood.

Methods—The Stroke in Young Fabry Patients (sifap1) study prospectively recruited a large multinational European cohort of patients with cerebrovascular events aged 18 to 55 years to establish their prevalence of Fabry disease. In a secondary analysis of patients with ischemic stroke or transient ischemic attack, we studied age- and sex-specific prevalences of various risk factors.

Results—Among 4467 patients (median age, 47 years; interquartile range, 40–51), the most frequent well-documented and modifiable risk factors were smoking (55.5%), physical inactivity (48.2%), arterial hypertension (46.6%), dyslipidemia (34.9%), and obesity (22.3%). Modifiable less well-documented or potentially modifiable risk factors like high-risk alcohol consumption (33.0%) and short sleep duration (20.6%) were more frequent in men, and migraine (26.5%) was more frequent in women. Women were more often physically inactive, most pronouncedly at ages <35 years (18–24: 38.2%; 25–34: 51.7%), and had high proportions of abdominal obesity at age 25 years or older (74%). Physical inactivity, arterial hypertension, dyslipidemia, obesity, and diabetes mellitus increased with age.

Conclusions—In this large European cohort of young patients with acute ischemic cerebrovascular events, modifiable risk factors were highly prevalent, particularly in men and older patients. These data emphasize the need for vigorous primary and secondary prevention measures already in young populations targeting modifiable lifestyle vascular risk factors.


Key Words: cerebral infarct ■ ischemic stroke ■ risk factors ■ stroke in young adults ■ transient ischemic attack

Ischemic stroke remains a leading cause of death and disability worldwide.1 Planning cost-effective preventive strategies requires precise knowledge of stroke risk factors.2 Approximately 10% of ischemic strokes occur at ages <45 years,3 with major long-term socioeconomic consequences.4 Stroke prevention results in greater quality-weighted life-year
gain in younger patients than in elderly patients, but has received less attention.

In the general population and in patient cohorts, risk factor profiles changed with increasing age.5,6 Most studies of stroke patients aged <50 years were small and methodologically heterogeneous.7–10 In the largest single-center study including 1008 ischemic stroke patients aged 15 to 49 years,7 the most common risk factors were dyslipidemia (60%), smoking (44%), and arterial hypertension (39%), with accumulation in men and increasing age. However, only scarce data exist on the prevalence and risk potential of lifestyle risk factors such as physical inactivity, obesity,7,8,11 body mass index, waist circumference,12 and sleep pattern13,14 in the young.

The Stroke in Young Fabry Patients (sifap1) study15 prospectively recruited a large multinational European cohort of patients aged 18 to 55 years with cerebrovascular event (CVE) to establish their prevalence of Fabry disease. In a secondary analysis of patients with ischemic stroke and transient ischemic attack (TIA), we investigated frequencies of various stroke risk factors and specifically focused on those related to modifiable unfavorable lifestyle habits that may precede traditional risk factors and are associated with higher risk of subsequent stroke independently from traditional risk factors.16,17 We sought to define sex- and age-specific risk factor profiles to optimize targeted prevention strategies.

### Table 1. Risk Factors Stratified by Sex and Age Group

<table>
<thead>
<tr>
<th>Risk Factors (Valid n)</th>
<th>All</th>
<th>Males</th>
<th>Females</th>
<th>Age 18–44 Years</th>
<th>Age 45–55 Years</th>
<th>Sex, P Value*</th>
<th>Age, P Value†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonmodifiable risk factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (n=4467)</td>
<td>47 (40–51)</td>
<td>47 (42–51)</td>
<td>45 (39–50)</td>
<td>53.2</td>
<td>63.6</td>
<td>&lt;0.001</td>
<td></td>
</tr>
<tr>
<td>Male (n=4467)</td>
<td>59.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of any cerebrovascular event (n=4466)</td>
<td>17.0</td>
<td>17.1</td>
<td>16.8</td>
<td>14.5</td>
<td>18.6</td>
<td>0.997</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>History of transient ischemic attack (n=4409)</td>
<td>9.3</td>
<td>9.5</td>
<td>9.0</td>
<td>8.1</td>
<td>10.1</td>
<td>0.874</td>
<td>0.027</td>
</tr>
<tr>
<td>Family history of cardiovascular disease (n=4220)</td>
<td>41.3</td>
<td>37.9</td>
<td>46.3</td>
<td>38.2</td>
<td>43.4</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Family history of cerebrovascular disease (n=4232)</td>
<td>37.3</td>
<td>35.8</td>
<td>39.5</td>
<td>33.8</td>
<td>39.6</td>
<td>0.004</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Well-documented and modifiable risk factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco smoking† (n=4421)</td>
<td>55.5</td>
<td>59.3</td>
<td>50.1</td>
<td>54.7</td>
<td>56.1</td>
<td>&lt;0.001</td>
<td>0.968</td>
</tr>
<tr>
<td>Physical inactivity (n=4322)</td>
<td>48.2</td>
<td>46.6</td>
<td>50.4</td>
<td>44.5</td>
<td>50.6</td>
<td>0.011</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hypertension (n=4439)</td>
<td>46.6</td>
<td>51.6</td>
<td>39.3</td>
<td>29.3</td>
<td>58.2</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Dyslipidemia (n=4289)</td>
<td>34.9</td>
<td>39.3</td>
<td>28.5</td>
<td>23.7</td>
<td>42.3</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>High LDL cholesterol (≥3.37 mmol/L; n=3065)</td>
<td>41.5</td>
<td>44.2</td>
<td>37.4</td>
<td>34.0</td>
<td>46.1</td>
<td>0.002</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Low HDL cholesterol (≤1 mmol/L; n=3139)</td>
<td>28.0</td>
<td>37.8</td>
<td>13.5</td>
<td>26.7</td>
<td>28.8</td>
<td>&lt;0.001</td>
<td>0.475</td>
</tr>
<tr>
<td>Obesity (BMI ≥30 kg/m²; n=4463)</td>
<td>22.3</td>
<td>22.6</td>
<td>21.8</td>
<td>19.5</td>
<td>24.1</td>
<td>0.865</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Diabetes mellitus (n=4443)</td>
<td>10.3</td>
<td>12.6</td>
<td>7.0</td>
<td>5.9</td>
<td>13.3</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Cardiovascular disease (n=4348)</td>
<td>9.2</td>
<td>11.2</td>
<td>6.4</td>
<td>5.9</td>
<td>11.5</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Coronary heart disease (n=4407)</td>
<td>4.2</td>
<td>5.6</td>
<td>2.1</td>
<td>2.0</td>
<td>5.6</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Congestive heart failure (n=4429)</td>
<td>1.2</td>
<td>1.4</td>
<td>0.8</td>
<td>1.0</td>
<td>1.3</td>
<td>0.071</td>
<td>0.465</td>
</tr>
<tr>
<td>Myocardial infarction (n=4446)</td>
<td>3.1</td>
<td>4.3</td>
<td>1.4</td>
<td>1.4</td>
<td>4.3</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Peripheral arterial disease (n=4422)</td>
<td>2.2</td>
<td>2.7</td>
<td>1.5</td>
<td>1.0</td>
<td>3.1</td>
<td>0.027</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Valvular disease (n=4408)</td>
<td>2.3</td>
<td>2.3</td>
<td>2.4</td>
<td>2.4</td>
<td>2.2</td>
<td>0.650</td>
<td>0.795</td>
</tr>
<tr>
<td>Atrial fibrillation (n=4428)</td>
<td>2.4</td>
<td>2.8</td>
<td>1.8</td>
<td>1.5</td>
<td>3.0</td>
<td>0.100</td>
<td>0.003</td>
</tr>
<tr>
<td>Less well-documented or potentially modifiable risk factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High-risk alcohol consumption (n=4276)</td>
<td>33.0</td>
<td>41.9</td>
<td>20.1</td>
<td>31.1</td>
<td>34.2</td>
<td>&lt;0.001</td>
<td>0.821</td>
</tr>
<tr>
<td>Migraine, lifetime history (n=4352)</td>
<td>26.5</td>
<td>18.8</td>
<td>37.8</td>
<td>29.7</td>
<td>24.4</td>
<td>&lt;0.001</td>
<td>0.010</td>
</tr>
<tr>
<td>Sleep ≤6 h (n=4458)</td>
<td>17.9</td>
<td>20.6</td>
<td>13.9</td>
<td>15.9</td>
<td>19.2</td>
<td>&lt;0.001</td>
<td>0.031</td>
</tr>
<tr>
<td>Obstructive sleep apnea (n=4340)</td>
<td>3.3</td>
<td>4.5</td>
<td>1.6</td>
<td>2.4</td>
<td>3.9</td>
<td>&lt;0.001</td>
<td>0.034</td>
</tr>
</tbody>
</table>

BMI, body mass index; HDL, high-density lipoprotein; and LDL indicates low-density lipoprotein.

Data are median (interquartile range) or percentage.

*Multiple regressions adjusted for sex and center heterogeneity.
†Multiple regressions adjusted for age and center heterogeneity.
‡Currently smoking or quit within past 5 years before qualifying event.
and approved by the Ethics Committees at the leading study center (Rostock) and at each study site. All patients or their legal representatives gave written informed consent. Patients were recruited between April 2007 and January 2010, at 47 centers in 15 European countries. Inclusion criteria were CVE ≤3 months previously, age 18 to 55 years, and cerebral MRI ≤1 month of inclusion. Diagnostic procedures accorded with the European Stroke Organisation Guidelines. The present secondary analysis aimed to assess the frequency of various risk factors exclusively in patients with TIA (ie, symptoms <24 hours without infarction or hemorrhage on MRI) or ischemic stroke (ie, symptoms >24 hours without hemorrhage). According to current guidelines of the American Stroke Association, risk factors were classified with respect to their strength of evidence and potential for modification: (1) nonmodifiable (ie, age, sex, history of CVE, and family history of cardiovascular or cerebrovascular disease); (2) well-documented and modifiable (so-called traditional risk factors, ie, coronary artery disease, peripheral arterial disease, congestive heart failure, myocardial infarction, valvular disease, atrial fibrillation, diabetes mellitus, arterial hypertension, dyslipidemia, tobacco smoking, obesity, and physical inactivity); and (3) less well-documented or potentially modifiable (ie, history of migraine, obstructive sleep apnea, short sleep duration, and high-risk alcohol consumption). Detailed Methods are provided in the Online Data Supplement.

Statistical Analyses
Patients were categorized into groups of none to ≥4 (of 8) well-documented modifiable risk factors. Using Wilson method, we calculated 95% confidence intervals for the sex- and age-specific risk factor proportions. Frequencies were compared between sexes and patients aged 18 to 44 years and 45 to 55 years. Logistic regression models with random intercepts accounted for center heterogeneity. Statistical analyses used SPSS 19.0 and SAS 9.2. P <0.05 was considered statistically significant.

Role of the Funding Source
The sponsors of the study had no role in the study design, data collection, analysis, interpretation, writing of the manuscript, or the decision to submit the manuscript for publication. The corresponding author had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis, and had final responsibility for the decision to submit for publication.

Results
Among 5023 subjects enrolled in sifap1, 1071 (21.3%) had TIA, 3396 (67.6%) had ischemic stroke, and 271 (5.4%) had intracerebral hemorrhage (285 [5.7%] other and missing). In the present analyses, 4467 patients with TIA or ischemic stroke were considered; 59.4% were men; and women were younger than men (Table 1). Overall, only 238 (5.3%) patients were free from any of those 12 risk factors categorized as well documented and modifiable or as less well-documented or potentially modifiable. Furthermore, only 513 (11.5%) patients had none of the 8 risk factors classified as well-documented and modifiable. The proportion of patients without any well-documented and modifiable risk factor was smaller in older age groups. At ages 45 years and older, the proportion of men with ≥4 well-documented and modifiable risk factors was 29.2% compared with 20.3% in women (Figure 1).

Previous myocardial infarctions were rare, but nearly one-fifth reported a history of CVE. Smoking (55.5%), physical inactivity (48.2%), hypertension (46.6%), and dyslipidemia (34.9%) were the most common well-documented and modifiable risk factors (Table 1). Physical inactivity, arterial hypertension, dyslipidemia, obesity, and diabetes mellitus were more prevalent in older age groups. Cardiovascular diseases were relatively frequent in the youngest age group and showed a J-shaped form as a function of age. Atrial fibrillation was rare (Figure 2).

Regarding sex-specific differences, dyslipidemia, smoking, hypertension, cardiovascular disease, and diabetes mellitus were more prevalent among men. For dyslipidemia and cardiovascular disease, these differences were most apparent in age groups 35 years or older. In contrast, women were more often physically inactive, especially at younger ages.

Regarding less well-documented or potentially modifiable risk factors, high-risk alcohol consumption (33.0%), and migraine (26.5%) were most frequent. High-risk alcohol consumption, shorter nocturnal sleep, and obstructive sleep apnea were more common among men. In contrast, migraine was the only risk factor in this category that was significantly more prevalent in women at ages 25 years or older. Prevalence was high at all ages and slightly peaked at ages 35 to 44 years (42.0%) (Figure 3).
Details of behavioral risk factors and anthropometric measures are shown in Table 2. Overall, most risk factors were more frequent in men and in subjects aged 45 years or older. However, we observed some exceptions. Although general obesity was similarly prevalent in both sexes, men were more frequently overweight than women. In contrast, abdominal obesity was more often noted in women than in men, and it was highly more frequent in both sexes than was general obesity. The proportion of normal weight, normal waist circumference, and physical activity decreased with increasing age.

**Discussion**

Our prospectively recruited young European patients with acute CVE demonstrated high frequencies of both...
well-documented and less well-documented cerebrovascular risk factors. Importantly, modifiable risk factors linked to lifestyle, such as smoking, physical inactivity, obesity, and high-risk alcohol consumption, were among the most prevalent.

Unfavorable behavioral patterns may provide the first link in a cause-and-effect chain that promotes the development of well-documented vascular risk factors such as arterial hypertension, diabetes mellitus, or hyperlipidemia, and ultimately lead to atherosclerosis and ischemic stroke. Other medical conditions or habits like migraine with aura19 or excessive alcohol intake18 may bear an increased risk of stroke not mediated by atherosclerosis. Unhealthy lifestyle is associated not only with higher risk of subsequent stroke16,17 but also with higher all-cause mortality after stroke.20 The high prevalence of unhealthy lifestyle in our cohort underlines the importance of improving adherence to healthy lifestyle behavior among stroke patients.

Among the other less well-documented risk factors, migraine prevalence decreased with age and was clearly more frequent in women. This tallies with previous young stroke studies in which women had higher prevalence of migraine (12%–34%) than men (3%–20%).7–10 However, the prevalence of migraine in women was similar over age groups, which is opposite to previous findings,8 and may indicate a greater role of migraine in the pathogenesis of ischemic CVEs in young women.26

Both short and long nocturnal sleep duration are independently associated with cardiovascular diseases including stroke.13,14 This association may be especially prominent at younger ages and may even dissolve after the age of 75 years.15 In our study, short sleeping duration was more common among men and older age groups. This also may contribute to higher prevalence of CVE in young men. Another potential but less investigated risk factor related to sleep is daytime napping,27 which was more common in older patients. Daytime napping may be an epiphenomenon of nocturnal sleep disturbance, which itself may predict stroke14 but was

Figure 3. Age- and sex-specific proportions of less well-documented or potentially modifiable risk factors. White bars represent all patients, dark gray bars represent men, and light gray bars represent women. Error bars indicate 95% confidence interval.
Regarding the accumulation of risk factors, which increased with age, surprisingly few patients (≤5%) had none of the 12 potentially modifiable risk factors. Clinical implications of this high risk factor burden go beyond primary prevention (potentially) modifiable risk factors. Clinical implications of this high risk factor burden go beyond primary prevention because recent reports suggest an association between accumulation of risk factors and risk of atherothrombotic events in young adults after first-ever ischemic stroke.28

Only few studies specifically of young stroke patients provided age-specific comparisons of vascular risk factors. Dyslipidemia, hypertension, smoking, coronary heart disease, history of myocardial infarction, peripheral arterial disease, diabetes mellitus, and atrial fibrillation have been more commonly observed among older age groups of young stroke patients.7,8,10 This is in accordance with our observations. Notably, women of childbearing age (25–34 years) smoked less frequently than did those in other age groups.

Our study has certain limitations. It represents a patient series and, therefore, cannot explore the strength of association of individual risk factors on stroke risk in the population. Patients were predominantly central European white, whereas prevalence may vary across ethnic groups and geographic regions. Including consenting patients at selected hospitals might have caused selection bias. Taking more less well-established stroke risk factors like infections, antiphospholipid antibodies, and illicit drug use into account would have decreased the proportion of patients with none or few risk factors. The sifap1 protocol required confirmation of self-reported variables by reviewing medical records and performing laboratory tests and clinical examinations. However, sex disparities regarding self-reported risk factors and comorbidities may exist because patients’ awareness of

### Table 2. Anthropometric Measures and Behavioral Risk Factors According to Age Groups in Men and Women

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Woman</th>
<th>Age</th>
<th>Sex</th>
<th>P Value*</th>
<th>P Value†</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total (n=2653)</td>
<td>18–24 (n=46)</td>
<td>25–34 (n=195)</td>
<td>35–44 (n=709)</td>
<td>45–55 (n=1703)</td>
<td>18–24 (n=1814)</td>
</tr>
<tr>
<td>Body mass index</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Underweight, ≤18.5 kg/m²</td>
<td>20 (0.8)</td>
<td>2 (2.2)</td>
<td>3 (1.5)</td>
<td>5 (0.7)</td>
<td>11 (0.6)</td>
<td>45 (2.5)</td>
</tr>
<tr>
<td>Normal, 18.5–24.9 kg/m²</td>
<td>846 (31.9)</td>
<td>28 (60.9)</td>
<td>89 (45.6)</td>
<td>245 (34.6)</td>
<td>484 (28.4)</td>
<td>867 (47.9)</td>
</tr>
<tr>
<td>Overweight, ≥25.0–29.9 kg/m²</td>
<td>1187 (44.8)</td>
<td>14 (30.4)</td>
<td>72 (36.9)</td>
<td>304 (42.9)</td>
<td>797 (46.8)</td>
<td>504 (27.8)</td>
</tr>
<tr>
<td>Obesity ≥30.0 kg/m²</td>
<td>589 (22.6)</td>
<td>3 (6.5)</td>
<td>31 (15.9)</td>
<td>155 (21.9)</td>
<td>410 (24.1)</td>
<td>395 (21.8)</td>
</tr>
</tbody>
</table>

Data are presented as number (percentage).

*Multiple regressions adjusted for sex and center heterogeneity.
†Multiple regressions adjusted for age and center heterogeneity.
‡Not adjusted for center heterogeneity because of low frequencies in some categories.
risk factors and physicians’ adherence to treatment guidelines may differ between men and women.29,30

Conclusions
Young ischemic stroke and TIA patients showed a prominent accumulation of multiple well-documented and less well-documented risk factors that clearly were more pronounced among men. Our findings have implications for increasing awareness toward modifiable risk factors in principal prevention and in younger stroke patients.

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References
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SUPPLEMENTAL MATERIAL

ONLINE SUPPLEMENT

Lifestyle Risk-Factors for Ischemic Stroke and TIA in Young Adults in the Stroke in Young Fabry Patients (sifap1) Study

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Running title: Risk-Factors in Young Stroke Patients
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Supplemental Methods

Medical history, co-morbidities and family history were obtained by interviewing the patients or their caregivers, by reviewing medical records or by contacting their primary care physicians. Coronary artery disease, peripheral arterial disease, congestive heart failure, myocardial infarction, valvular disease, atrial fibrillation, obstructive sleep apnea, diabetes mellitus, arterial hypertension, and dyslipidemia were recorded if either this disease had been formerly diagnosed by a physician, the patient was on specific medication or if the disease was diagnosed during hospital treatment for the index stroke. Electrocardiograms, blood tests for glucose, LDL-cholesterol and HDL-cholesterol, systolic and diastolic arterial blood pressure measurement were performed in all patients and results were registered in the sifap1 database. A history of migraine was taken from all patients and was defined as either suffering from at least one migraine attack within the previous year or suffering from >10 attacks in lifetime, which all comply with the criteria of the International Headache Society. Tobacco smoking was classified as never, current or former smoking. The latter applied if the patient quit smoking at least five years prior to enrolment.

Sex-specific frequencies of risk-factors were stratified into four age groups: 18-24, 25-34, 35-44, and 45-55 years. Height (cm), body weight (kg), and waist circumference were measured at study inclusion. BMI as a marker for general obesity was categorized into: underweight (≤18.5), normal (18.6-24.9), overweight (25.0-29.9), and obese (≥30.0). According to reference values from the general population of north Glasgow, the cut-off for waist circumference as a marker for abdominal obesity was ≥94 cm for men and ≥80 cm for women. Physical activity was categorized into minimal (walking <1 mile/day), moderate (20-30 min three times per week) and intense physical activity (>30 min >3 times per week) according to Centers of Disease Control and Prevention (CDC) guidelines. Since even moderate physical activity is considered being effective for stroke prevention, we compared individuals with moderate or intense physical activity with those who reported only minimal activity. Regular alcohol consumption was defined as consumption of ≥1 drink per week. A drink was equal to 10-14 g of pure alcohol or a 8-12-oz. glass of beer, a 5-oz. glass of wine, or a 1.5-oz. “shot” of 80%-proof distilled spirits or liquor. High-risk alcohol consumption was defined as consuming >5 alcoholic drinks/day (i.e., >50-70 g pure alcohol/day) at least once/month within the previous year. We categorized nighttime sleep duration into ≤6, 7, 8, or ≥9 hours/night and compared individuals who slept at least 6 hours with those who slept more than 6 hours/night. Daytime nap was classified as napping once or several times a day as opposed to no or occasional napping.

Assessment of risk-factors was mandatory in sifap1. The response rate was >95% for all risk-factor variables.
References


