Background and Purpose—Numerous case reports describe stroke in individuals with sickle cell trait (SCT) in the absence of traditional risk factors for cerebrovascular disease. To date, no prospective epidemiological studies have investigated this association.

Methods—A population-based sample of blacks (n=3497; mean age=54 years; female=62%) was followed from 1987 to 2011 in the Atherosclerosis Risk in Communities (ARIC) study, contributing a total of 65 371 person-years. Hazard ratios and incidence rate differences for ischemic stroke were estimated, contrasting SCT to homozygous hemoglobin A. Models were adjusted for age, sex, smoking, diabetes mellitus, hypertension, total cholesterol, atrial fibrillation, and coronary heart disease.

Results—SCT was identified in 223 (6.4%) participants. During a median follow-up of 22 years, 401 subjects experienced incident stroke (89% ischemic). Incident ischemic stroke was more frequent among those with SCT (13%) than those with homozygous hemoglobin A (10%). SCT was associated with an ischemic stroke hazard ratio of 1.4 (1.0–2.0) and an incidence rate difference amounting to 1.9 (0.4–3.8) extra strokes per 1000 person-years.

Conclusions—We observed an increased risk of ischemic stroke in blacks with SCT. Further investigation of the incidence and pathophysiology of stroke in patients with SCT is warranted. (Stroke. 2014;45:2863-2867.)

Key Words: epidemiology ■ sickle cell trait ■ stroke
sequences: Forward-TCAAACAGACACCTGGTCAT, Reverse-
CCCCACAGGGCAGTAAGC, VIC-CTGACTCTCTGAGAGAA-
MGB, 6FAM-CTGACTCTCTGAGAGAA-MGB. Hemoglobin C
was identified from single-nucleotide polymorphism rs33930165
(missense change [Glu7Lys]), using custom primer and probe se-
quencies: Forward-AAACAGACACCTGGTCATCT, Reverse-
CCCCACAGGGCAGTAAGC, VIC-CTGACTCTCTGAGAGAA-
TC-MGB, 6FAM-CTGACTCTCTGAGAGAA-MGB (designed on
the complement strand). For quality assurance, blind duplicate geno-
typing of hemoglobin S and hemoglobin C was performed in a random
sample representing 5% of the total assays (k coefficients, 0.83 and
0.93, respectively).

Ancestry and Relatedness
Ancestry was quantified using EIGENSTRAT 5.0.1 (David Reich,
open source), based on genomic variation characterized by the
HumanExome BeadChip v1.0 (Affymetrix, Santa Clara, CA), as
previously described.13 First-degree relatives were identified by
PLINK (Shaun Purcell, http://pngu.mgh.harvard.edu/purcell/plink).14
Relatedness pairs were broken by randomly dropping 1 first-degree
relative from each set, irrespective of SCT status or stroke outcomes.

Stroke History
History of stroke was ascertained at the study baseline by self-re-
ported signs and symptoms. Based on the responses, a computer al-
diagnosed stroke and determined the vascular distribution involved.15
The algorithm performance was previously validated,
classifying prevalent stroke with a sensitivity of 87.8% and a speci-
city of 71.9%.16

Incident Stroke
Incident stroke during the course of follow-up was captured by hos-
pital surveillance, as previously described.17 Medical records from
hospitalizations with diagnosis codes 430 to 438 and neurological
deficits exceeding 24 hours were abstracted for physician review.
Stroke diagnosis was verified by the discharge summary, imaging
reports, neurological consults, and medical history and categorized
as either definite or probable.17 For quality assurance, diagnoses
were also determined by a computer algorithm. Any disagreements
between the physician diagnosis and computer algorithm were adju-
dicated by a second physician reviewer. Agreement rates between the
physician diagnosis and computer algorithm were adju-
dicated by a second physician reviewer. Agreement rates between the
physician diagnosis and computer algorithm were adju-
dicated by a second physician reviewer. Agreement rates between the
physician diagnosis and computer algorithm were adju-
dicated by a second physician reviewer. Agreement rates between the
physician diagnosis and computer algorithm were adju-
dicated by a second physician reviewer. Agreement rates between the
physician diagnosis and computer algorithm were adju-
dicated by a second physician reviewer. Agreement rates between the
physician diagnosis and computer algorithm were adju-
dicated by a second physician reviewer. Agreement rates between the
physician diagnosis and computer algorithm were adju-
dicated by a second physician reviewer. Agreement rates between the
physician diagnosis and computer algorithm were adju-
dicated by a second physician reviewer. Agreement rates between the
physician diagnosis and computer algorithm were adju-
dicated by a second physician reviewer. Agreement rates between the
physician diagnosis and computer algorithm were adju-

Clinical Covariates
Medical histories and clinical covariates were ascertainment at the study
baseline by home interviews, health questionnaires, and clinical ex-
aminations. Age, sex, race, and current smoking were self-reported.
Seated blood pressures were measured by random-zero mercury
manometers. Hypertension was considered a systolic blood pressure
≥140 mm Hg, a diastolic blood pressure ≥90 mm Hg, or antihyperten-
sive medication use. Fasting cholesterol and glucose were assessed by
ARIC central laboratories. Hypercholesterolemia was considered a
total fasting cholesterol ≥2.2 mmol/L. Diabetes mellitus was defined by
a fasting blood glucose level ≥7 mmol/L, nonfasting blood glucose
≥11.1 mmol/L, self-reported diabetes mellitus, or use of diabetic med-
ications. Standardized, 12-lead ECGs were performed and assigned a
Minnesota code18 by the ARIC ECG Reading Center. Atrial fibrillation
was identified by a Minnesota code of 8.3.1. Prevalent coronary heart
disease was defined by self-report, history of myocardial infarction,
coronary artery bypass graft, or percutaneous coronary intervention,
or ECG suggestive of prior myocardial infarction.

Final Study Population
A total of 4151 blacks were genotyped for hemoglobin S and hemo-
globin C. After excluding first-degree relatives (n=253), those with
missing or inadequate genotype calls (n=33), participants identified
with hemoglobin C trait (n=88), hemoglobin C disease (n=2), hemo-
globin SC disease (n=5), or sickle cell anemia (n=3) and those with
missing clinical covariates (n=270), a total of 3497 remained.

Statistical Analysis
All analyses were performed using SAS 9.3 (SAS Institute, Cary,
NC). Categorical variables were compared by a χ² test, and continu-
ous variables were compared by ANOVA. Categorical variables with
expected cell counts <5 were analyzed using Fisher exact test. Stroke
hazard ratios (HRs) contrasting SCT to homozygous hemoglobin A
(HbAA) were calculated with Cox regression, adjusting for the tra-
ditional risk factors for stroke (age, sex, smoking, diabetes mellitus,
hypertension, total cholesterol, atrial fibrillation, and coronary heart
disease). In a separate model, the effect of genetic admixture was
examined by including 10 ancestral principal components in the ad-
justed Cox regression model. Proportional hazards assumptions were
verified by plotting Martingale residuals and assessing deviations of
of observed suprema from 1000 simulated paths by Kolmogorov–
Smirnov testing.19 No Cox models were found to violate proportional
hazards. Stroke incidence rate differences were estimated by addi-
tive Poisson regression, adjusted for demographics and the traditional
risk factors for stroke. Goodness of fit was verified by the deviance to
degrees of freedom ratio. No Poisson models were found to be
overdispersed.

Power calculations for stroke HRs were calculated a priori. Based
on the previously reported age-adjusted ischemic stroke incidence
rates for ARIC participants aged 45 to 84 years (6.6/1000 person-
years for black men and 4.9/1000 person-years in black women),20
we estimated an age-adjusted, sex-standardized (38% men, 62%
women) reference rate of 5.55 strokes per 1000 person-years. With
an assumed sample size of 3200 and SCT prevalence of 8%, we ex-
pected 80% power to detect a HR of 1.5, with significance at α=0.05
(2 sided).

Results
In the final study population (n=3497) of blacks, 223 (6.4%) were
identified with SCT, which was similarly prevalent (7.2%) among those excluded for missing covariates or relat-
edness. The mean age at the study onset was 54 years, and
62% were women. Study participants with SCT were less
often smokers, but had a higher prevalence of hypercholes-
terolemia. Otherwise, cerebrovascular risk factors at the study
baseline did not differ by SCT classification (Table 1). History
of stroke was prevalent in 70 (2%) and was similar among par-
ticipants with SCT and HbAA genotypes; however, baseline
neurological history was missing for 737 (21%).

Study participants were prospectively followed a median
of 22 (15–25) years, contributing to a total of 65371 person-
years. During this time frame, 401 experienced a stroke. The major-
ity of strokes, 355 (89%), were ischemic, and of these
76% were considered definite. The overall frequency of isch-
emic stroke (10%) was similar in those excluded for missing covariates or relat-
edness (9%). Among study participants with
SCT, 29 (13%) experienced incident ischemic stroke, com-
pared with 326 (10%) of those with HbAA. The mean age at
incident ischemic stroke was 67±7 years and did not differ by
SCT status. The crude incidence of ischemic stroke was
7.1 strokes per 1000 person-years in participants with SCT,
compared with 5.3 strokes per 1000 person-years in individu-
als with HbAA (Table 2).

In multivariable regression analysis adjusted for tradi-
tional risk factors, the stroke rate among those with SCT was
Table 1. Baseline (1987–1989) Demographics and Clinical Characteristics of Black Participants in the ARIC Study

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>SCT (n=223)</th>
<th>HbAA (n=3274)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographics</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age, y</td>
<td>53±6</td>
<td>54±6</td>
<td>0.7</td>
</tr>
<tr>
<td>Female</td>
<td>113 (63)</td>
<td>1571 (62)</td>
<td>0.9</td>
</tr>
<tr>
<td><strong>Medical history</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current smoker</td>
<td>56 (25)</td>
<td>989 (30)</td>
<td>0.1</td>
</tr>
<tr>
<td>Hypertension</td>
<td>121 (54)</td>
<td>1826 (56)</td>
<td>0.7</td>
</tr>
<tr>
<td>Hypercholesterolemia</td>
<td>69 (31)</td>
<td>851 (26)</td>
<td>0.1</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>42 (19)</td>
<td>642 (20)</td>
<td>0.8</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>0</td>
<td>6 (0.2)</td>
<td>1.0</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>8 (4)</td>
<td>133 (4)</td>
<td>0.7</td>
</tr>
<tr>
<td>Body mass index, kg/m²</td>
<td>30±6</td>
<td>30±6</td>
<td>0.4</td>
</tr>
</tbody>
</table>

HbAA indicates homozygous hemoglobin A; and SCT, sickle cell trait.

Table 2. Crude Incidence Rates of Ischemic Stroke Occurring During Follow-Up Period (1987–2011), Stratified by SCT Status and Age at Study Baseline

<table>
<thead>
<tr>
<th>Genotype</th>
<th>n</th>
<th>Strokes</th>
<th>Person-Years</th>
<th>Crude Incidence Rate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCT</td>
<td>223</td>
<td>29</td>
<td>4063</td>
<td>7.1 (5.4–9.5)</td>
</tr>
<tr>
<td>&lt;55 y</td>
<td>134</td>
<td>17</td>
<td>2659</td>
<td>6.4 (4.5–9.0)</td>
</tr>
<tr>
<td>≥55 y</td>
<td>89</td>
<td>12</td>
<td>1404</td>
<td>8.5 (5.3–13.7)</td>
</tr>
<tr>
<td>HbAA</td>
<td>3274</td>
<td>326</td>
<td>61308</td>
<td>5.3 (4.9–5.8)</td>
</tr>
<tr>
<td>&lt;55 y</td>
<td>1892</td>
<td>149</td>
<td>38121</td>
<td>3.9 (3.5–4.4)</td>
</tr>
<tr>
<td>≥55 y</td>
<td>1382</td>
<td>177</td>
<td>23188</td>
<td>7.6 (6.8–8.6)</td>
</tr>
</tbody>
</table>

HbAA indicates homozygous hemoglobin A; and SCT, sickle cell trait.
*Per 1000 person-years.

found in frequency of hospital discharges for stroke; however, black controls were never confirmed to have HbAA genotypes, which may have resulted in substantial misclassification bias.

The second study, conducted in the French Caribbean colony of Guadeloupe, analyzed the prevalence of SCT in 295 hospitalizations for stroke. Interestingly, a 10-fold higher risk for hemorrhagic stroke and a 15-fold lower risk for ischemic stroke were observed in patients with SCT, compared with Guadeloupeans with normal hemoglobin. This study has been criticized for diagnosing stroke type by computed tomography, which may not distinguish between primary hemorrhages and hemorrhagic bleeding secondary to infarctions, causing possible underdiagnosis of ischemic stroke. It is also uncertain whether the Guadeloupe population, an admixture of European, African, Indian, and Amerindian ancestries, can be generalized to black Americans.

Finally, a recently conducted analysis based on 13,964 black adults (2642 with SCT and 139 with sickle cell anemia) registered with the Kaiser Permanente Northern California health system reported no differences in stroke diagnoses for patients with SCT, sickle cell anemia, or HbAA. However, the mean age of the study population was only 35 years. In adult populations, only pregnant black women are routinely tested for sickle hemoglobinopathies, and if positive, the fathers are tested as well. Because of the young age of the study population and low number of ischemic stroke events, this analysis was inadequately designed to detect differences in stroke prevalence by hemoglobin status.

Although studies examining SCT and cerebrovascular disease have been limited, many have established sickle cell anemia as a risk factor for stroke. Sickle cell anemia is characterized by hemolysis, acute chest syndrome, and pain and is further complicated by thrombosis, microvascular occlusions, vasculopathy, and intimal hyperplasia of the cerebral arteries. In the Cooperative Study of Sickle Cell Disease, which prospectively followed 4082 patients, 24% with sickle cell anemia experienced a first stroke by the age of 45. The association between sickle cell disease and stroke is further confirmed by administrative claims data. In patients with sickle cell disease aged 35 to 64 years, the incidence of ischemic stroke is reported to be 7.4 per 1000 person-years, much higher than 2.7 per 1000 person-years for blacks aged 35 to 64 years overall. These estimates yield a stroke incidence rate ratio of 2.7 and an incidence rate difference of 4.7 strokes per 1000 person-years; however, it is noteworthy that the reference group of blacks from the general population includes individuals with SCT.

Even in heterozygous carriers, hemoglobin S is associated with hypercoagulability, which may be a pathogenic pathway to stroke. Under conditions of exertion, dehydration, and high altitude, SCT erythrocytes are known to sickle and polymerize. The sickling deformation exposes phosphatidylserine on the cell membrane surface, facilitating the assembly of coagulation enzymatic complexes. Laboratory assays of healthy individuals with SCT show elevated markers of coagulation (prothrombin fragment 1+2, thrombin–antithrombin complex, and d-dimer), and epidemiological studies report twice the risk of pulmonary embolism and venous thrombosis. Increased prevalence of thrombotic infarctions has also...
been observed by postmortem examination. In an autopsy series of 128 patients with SCT, obvious visceral infarcts were observed in 18%, but were detected in <1% of similarly aged blacks without SCT.31 The spleen was the most common site of infarction in SCT cases, followed by the kidneys, lung, and notably, the brain.31 However, autopsy series are based on highly selected populations and may be subject to postmortem artifact.

In addition to hypercoagulability, the SCT phenotype has been associated with cerebral vasculopathy and subclinical small vessel disease. In a small case–control study examining children by cerebral MRI, ectasia of the basilar artery was observed in 19% and white matter hyperintensities in 10% of children with SCT; yet, neither of these findings were noted in HbAA sibling controls.32 Dolichoectasia, characterized by tortuous, dilated vessels causing bidirectional blood flow, stasis, and thrombus formation, has been associated with lacunar stroke in the general population.33 White matter hyperintensities, often indicative of cerebral hypoperfusion and axon demyelination, have been correlated with cognitive decline34 and future stroke.35 The presence of these lesions in children with SCT may herald future cerebrovascular events. However, to date, no large, epidemiological studies have examined associations between SCT and cerebral vasculopathy, and these results are yet to be replicated.

Despite the biological and observational evidence supporting our findings of an association between SCT and stroke, our analysis has important limitations. Observations were based on a relatively small number of stroke events in a single cohort and warrant validation in other populations. We were also unable to consider rare hemoglobinopathies or sickle β-thalassemia; however, the likelihood of these genotypes is low. In the United States, the birth prevalence of sickle β-thalassemia in black neonates is reported to be 0.02%, whereas the prevalence of compound hemoglobin S and hemoglobin E or hemoglobin S with hemoglobin D is reported to be 0.0016% each.5 Despite this limitation, the ARIC study is well suited for the analysis of SCT and stroke because of the large sample of older blacks with extensive genomic characterization, who were prospectively followed for >2 decades. Phenotypic data were meticulously collected with quality assurance, and study participant retention was excellent. To ensure the best possible measurement of exposure, we based our analysis on SCT that was genotyped, rather than imputed. Our estimations of stroke risk associated with SCT yielded an HR of 1.4, with a stroke rate that was 1.9 strokes per 1000 person-years higher than those with HbAA. This seems plausible, considering the reported stroke HR associated with sickle cell disease is 2.7 in black adults, with a stroke rate that is elevated by 4.7 strokes per 1000 person-years. It follows that the stroke risk (if any) associated with SCT would be attenuated, compared with sickle cell disease. In conclusion, we observed a greater ischemic stroke risk in blacks with SCT, compared with those with HbAA. If our findings are confirmed by other studies, further investigation into the pathophysiology of stroke in patients with SCT and potential interventions to mitigate risk would be warranted.

Acknowledgments
We thank the staff and participants of the ARIC study for their important contributions.

Sources of Funding
The Atherosclerosis Risk in Communities Study is performed as a collaborative study supported by National Heart, Lung, and Blood Institute (NHLBI) contracts (HHSN268201100005C, HHSN268201100006C, HHSN268201100007C, HHSN268201100008C, HHSN268201100009C, HHSN268201100010C, HHSN268201100011C, and SN268201100012C). Genotyping of hemoglobin S and hemoglobin C was funded by grant SK12HL087097. Support for ARIC exome chip genotyping was provided by Building on GWAS for NHLBI-diseases: the US CHARGE consortium through the National Institutes of Health (NIH) American Recovery and Reinvestment Act of 2009 (ARRA; SRC2HL102419). Dr Key was supported by grant 1U01HL117659 and the Doris Duke Foundation.

Disclosures
Dr Kshirsagar is a consultant for Fresenius Medical Care. The other authors report no conflicts.

References


Sickle Cell Trait and Incident Ischemic Stroke in the Atherosclerosis Risk in Communities Study
Melissa C. Caughey, Laura R. Loehr, Nigel S. Key, Vimal K. Derebail, Rebecca F. Gottesman, Abhijit V. Kshirsagar, Megan L. Grove and Gerardo Heiss

Stroke. 2014;45:2863-2867; originally published online August 19, 2014; doi: 10.1161/STROKEAHA.114.006110

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/45/10/2863

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/