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.  

Key Words: epidemiology ■ sickle cell trait ■ stroke
sequences: Forward-CCAAGACACCATTGTGACAT, Reverse-CCCAACAGGGCAGTAAAGC, VIC-CGACTCCTGGAGGAGA-MGB, 6FAM-CTGACTCTCTGGAGGAGA-MGB. Hemoglobin C was identified from single-nucleotide polymorphism rs33930165 (missense change [Glu7Lys]), using custom primer and probe sequences: Forward-AAACAGACACCATTGTGACAT, Reverse-CCCAACAGGGCAGTAAAGC, VIC-CGACTCCTGGAGGAGA-MGB (designed on the complement strand). For quality assurance, blind duplicate genotyping 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-reported signs and symptoms. Based on the responses, a computer algorithm 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 specificity of 71.9%.16

Incident Stroke
Incident stroke during the course of follow-up was captured by hospital surveillance, as previously described.17 Medical records from hospitals 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 adjudicated by a second physician reviewer. Agreement rates between the physician reviewer and computer algorithm were 78%.17 In the majority of discordant diagnoses (65%), the physician adjudicator agreed with the physician reviewer, rather than the computer algorithm.17

Clinical Covariates
Medical histories and clinical covariates were ascertained at the study baseline by home interviews, health questionnaires, and clinical examinations. 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 antihypertensive medication use. Fasting cholesterol and glucose were assessed by ARIC central laboratories. Hypercholesterolemia was considered a total fasting cholesterol ≥262 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 medications. Standardized, 12-lead ECGs were performed and assigned a Minnesota Code18 by the ARIC ECG Reading Center. Arrhythmia 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 hemoglobin 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), hemoglobin 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 continuous 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 traditional 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 adjusted Cox regression model. Proportional hazards assumptions were verified by plotting Martingale residuals and assessing deviations 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 additive 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) rate reference of 5.55 strokes per 1000 person-years. With an assumed sample size of 3200 and SCT prevalence of 8%, we expected 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 relatedness. 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 hypercholesterolemia. 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 participants with SCT and HbAA genotypes; however, baseline neurological history was missing for 737 (21%).

Study participants were prospectively followed a median of 22 (15–23) years, contributing to a total of 65371 person-years. During this time frame, 401 experienced a stroke. The majority of strokes, 355 (89%), were ischemic, and of these 76% were considered definite. The overall frequency of ischemic stroke (10%) was similar in those excluded for missing covariates or relatedness (9%). Among study participants with SCT, 29 (13%) experienced incident ischemic stroke, compared 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 rate 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 individuals with HbAA (Table 2).

In multivariable regression analysis adjusted for traditional 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>PValue</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>

*Per 1000 person-years.
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.\(^3\)\(^1\) The spleen was the most common site of infarction in SCT cases, followed by the kidneys, lung, and notably, the brain.\(^3\)\(^1\) 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.\(^3\)\(^2\) Dolichoectasia, characterized by tortuous, dilated vessels causing bidirectional blood flow, stasis, and thrombus formation, has been associated with lacunar stroke in the general population.\(^3\)\(^3\) White matter hyperintensities, often indicative of cerebral hyperperfusion and axon demyelination, have been correlated with cognitive decline\(^4\)\(^1\) and future stroke.\(^3\)\(^3\) 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 with 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 (NHBLI) contracts (HHSN268201100005C, HSN268201100006C, HHSN268201100007C, HHSN268201100008C, HHSN268201100009C, HHSN268201100100C, HHSN268201100101C, 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; 5RC2HL102419). 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. published online August 19, 2014;
Stroke is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2014 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/early/2014/08/19/STROKEAHA.114.006110

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/