The following full text is a publisher's version.

For additional information about this publication click this link.
http://hdl.handle.net/2066/47487

Please be advised that this information was generated on 2019-10-04 and may be subject to change.
Cerebral Venous Sinus Thrombosis: Prevention of Recurrent Thromboembolism
B.F.L. van Nuenen, M. Munneke and B.R. Bloem

Stroke. 2005;36:1822-1823
doi: 10.1161/01.STR.0000176582.17934.82
Stroke is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2005 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/36/9/1822

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/
Protein Z Levels, Protein Z G79A Polymorphism, and Prothrombotic Conditions

To the Editor:

We read with great interest the article on protein Z gene polymorphisms, protein Z concentrations, and ischemic stroke published by Staton et al. The authors examine protein Z concentrations and 2 common polymorphisms of the protein Z gene in patients with a first-ever ischemic stroke and conclude that high levels of protein Z are prothrombotic and that the 79AA genotype of the G79A polymorphism is protective for the ischemic stroke.

The conclusions drawn by Staton et al seem questionable because of several flaws.

First, the hypothesis that high levels of protein Z are prothrombotic is, to date, not supported by the pathophysiology, because the role of protein Z has been demonstrated to be the inhibition of activated factor X through the formation of a complex with protein Z–dependent protease inhibitor. Consequently, low levels of protein Z are expected to be prothrombotic. In line with this theory, the majority of the studies in this field have reported low levels of protein Z in association with prothrombotic conditions. Actually, only 2 studies have reported that high levels of protein Z are prothrombotic, but methodological biases are detectable. In the former, the investigators modified the commercial assay and used a normal plasma pool. In the latter, the control group included subjects with a previous vascular event.

Second, Staton et al reported lower levels of protein Z plasma in controls with respect to all the other case-control studies present in the literature, including reports with a greater number of subjects analyzed. This might be attributable to the presence of subjects with a previous vascular event (not better clarified) included in the control group. Actually, patients with vascular diseases have been reported to have low levels of protein Z. Third, the significant result of the 79A allele as a protective factor for the ischemic stroke has been performed by pooling data from a previous study. Actually, a pooled analysis in case-control studies, especially for the evaluation of genetic polymorphisms, is rather a questionable approach. To perform this kind of analysis, the 2 populations should be homogenous and similar for the main parameters investigated. Conversely, the Staton et al do not explain how they tested the homogeneity of the 2 populations, particularly with regard to genetic background and prevalence of the traditional cardiovascular risk factors. Too many differences (first of all, age) between such distant and different populations are detectable to correctly perform this analysis.

In fact, the analysis performed in their single population demonstrated no significant relationship between both the polymorphisms and the ischemic stroke; the only significant result derives from pooling data from the study by Lichy et al and is also determined by an overall low number of homozygotes for the AA genotype (n = 32), thereby not reaching a sufficient statistical power.

In consideration of all these limitations, we do not believe that the conclusions stated by Staton et al, ie, high levels of protein Z prothrombotic and 79A allele protective for the ischemic stroke, can be drawn from this study. Because low protein Z plasma levels have been reported in several studies to be associated with different prothrombotic conditions, it can be hypothesized that protein Z is either simply a marker of the disease or influenced by the acute phase, but it is at least questionable, to date, to postulate that high levels of protein Z are associated with prothrombotic conditions and that 79AA genotype is protective for the ischemic stroke.

Response:

Dr Sofi and colleagues question our conclusion that the consistency of the association between protein Z genotype, elevated blood concentrations of protein Z, and ischemic stroke strengthens the evidence that increased blood concentrations of protein Z concentrations are causally associated with the risk of ischemic stroke. First, they propose that our conclusion is not supported by pathophysiology, citing methodological bias as an explanation for previous reports of elevated blood concentrations protein Z in stroke patients. However, they provide no explanation of how the use of a normal plasma pool may have biased the results of the study by Kobelt et al. In the study by McQuillan et al, removal of control subjects with a previous vascular event from the analysis does not change the results or conclusions.

Second, as indicated by Sofi et al, blood concentrations of protein Z in our study were lower than previously reported in several other studies, including their own. The reason for this is unclear, although could potentially be related to prolonged storage of blood samples before measuring protein Z levels. However, irrespective of the cause, our within-study comparisons of protein Z concentrations in stroke cases and controls remain valid because the duration of storage of samples for cases and controls was similar and all laboratory samples were collected, processed, stored, and analyzed in the same manner.

Third, Sofi and colleagues question our approach of pooling results from case-control studies to clarify the association between protein Z polymorphisms and ischemic stroke. However, this is a well-established technique that is commonly used for aggregating previous research when individual studies have...
insufficient power to detect an association.\textsuperscript{5} Taken together with the data by Lichy et al.,\textsuperscript{6} we believe that our study results are consistent with the conclusion that elevated blood concentrations of protein Z are prothrombotic.

**Cerebral Venous Sinus Thrombosis:**

**Prevention of Recurrent Thrombembolism**

*To the Editor:* Patients who have recovered from cerebral venous sinus thrombosis (CVST) are at risk for sustaining a recurrence of CVST or other thrombotic events (Table). For example, in the recent International Study on Cerebral Vein and Dural Sinus Thrombosis (ISCVT) that was performed in 624 patients with cerebral vein or dural sinus thrombosis, the cumulative risk for recurrent CVST or other thrombotic events after CVST was 6.5%.\textsuperscript{1} Recurrent thrombosis is potentially fatal. Therefore, an important clinical question is whether recurrence of CVST or other thrombotic events after stopping anticoagulation therapy can occasionally run a fatal course.\textsuperscript{6}

We, therefore, suggest that, to reduce recurrence of thrombotic events after CVST, it may be prudent to treat these patients with long-term anticoagulation therapy. Future research should determine the optimal duration and intensity of oral anticoagulation therapy that is necessary to optimally reduce the risk for recurrence of thrombotic events.

**Cumulative Risk for Recurrence of Thrombotic Events After a First Episode of CVST (Overview of Published Studies)**

<table>
<thead>
<tr>
<th>Study</th>
<th>No. of Patients</th>
<th>Mean Follow-Up (Months)</th>
<th>Duration of OAC Treatment (Months)</th>
<th>Cumulative Recurrence of Thromboembolism (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISCVT study\textsuperscript{1}</td>
<td>624</td>
<td>18</td>
<td>-</td>
<td>6.5</td>
</tr>
<tr>
<td>Preter et al\textsuperscript{1}</td>
<td>77</td>
<td>78</td>
<td>Mean of 7.7</td>
<td>3 to 4</td>
</tr>
<tr>
<td>Breteau et al\textsuperscript{2}</td>
<td>55</td>
<td>36</td>
<td>6 (56.4% of patients)</td>
<td>6–36 (12.7% of patients)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&gt;36 (30.9% of patients)</td>
</tr>
<tr>
<td>VENOPORT study\textsuperscript{2}</td>
<td>Not reported</td>
<td>22</td>
<td>Not reported</td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{1}Two patients with protein S deficiency. OAC indicates oral anticoagulation.
Inosine, Calcium Channels, and Neuroprotection Against Ischemic Brain Injury

To the Editor:

We read with great interest the article by Shen et al., dealing with neuroprotective effects of inosine against ischemic brain injury. The results of their study demonstrated that intracerebroventricular administration of inosine before middle cerebral artery occlusion in rats resulted in a higher level of locomotor activity and less cerebral infarction. In addition, they indicated that coadministration of selective A3 receptor antagonist MRS1191 significantly attenuated inosine-mediated protection. In the electrophysiological study, it was shown that inosine antagonized glutamate-induced excitation in cerebral cortical neurons. The authors proposed that inosine may inhibit glutamate postsynaptic responses and reduce cerebral infarction via the activation of A3 receptors.

Several studies have shown the mechanisms for glutamate-induced excitation of neural cells. In a study we presented earlier, changes in acetylcholine (ACh) release evoked by glutamate was investigated in rat central nervous system. In an in vitro study, we showed that glutamate increased the release of ACh from rat cerebral cortex. The combined effects of inosine and calcium channel blockers might have therapeutic potential as a neuroprotective agent against stroke-induced damage.
Comment on the Phosphodiesterase 4D Replication Study by Bevan et al

To the Editor:

We observe with interest the results of the study by Bevan et al, where they attempted to replicate our findings associating the PDE4D gene with stroke. We appreciate the effort by the authors and their presentation of their data in some detail. The latter allowed us to compare their results with ours, including some unpublished results. In our original publication, the main findings are summarized in Figure 4, where haplotypes are grouped into 3 categories: the at-risk haplotypes, the “wild-type,” and the protective haplotype. Although the definition of the at-risk haplotypes involved multiple markers, the protective haplotype, in our data, is characterized by one single-nucleotide polymorphism, specifically allele A of SNP45. This makes it particularly suitable for a replication in a different population. In Table I of Bevan et al, allele A has frequency of 15.4% in 621 stroke patients and 18.7% in 848 controls. We calculated that this corresponds to 191 copies of allele A and 1051 Gs in stroke patients, and 317 As and 1379 Gs in controls. Applying Fisher exact test gives a 2-sided probability value of 0.02 and a 1-sided probability value of 0.01. For the same allele counts, estimated risk of A relative to G is 0.79, or equivalently risk of G relative to A is 1.26. This agrees well with our estimated relative risk of 1.33 for allele G for all stroke patients (in Table 1 of Gretarsdottir et al). Hence, even though Bevan et al did not consider this result as significant, which could be attributable to the use of somewhat different statistical tests and adjustment for multiple comparisons, we are nonetheless encouraged by these results, especially because we have obtained similar results for SNP45 in a replication study of ours (Gretarsdottir et al, unpublished data, 2005). In summary, we appreciate the difficulties of getting definitive results for a replication study when the effect of the variant may only be modest and proper care has to be taken to adjust for multiple testing of variants and phenotypes. And we agree with the authors that further investigation is needed to develop a better understanding of the role of PDE4D in stroke.

Solveig Gretarsdottir, PhD
Jeffrey Gulcher, MD, PhD
Gudmar Thorleifsson, PhD
Augustine Kong, PhD

Kari Stefansson, MD, DrMed
DeCODE Genetics
Reykjavik, Iceland