Risk Factor Stratification for Intracranial Stenosis in Taiwanese Patients With Cervicocerebral Stenosis

Yueh-Feng Sung, MD; Jiunn-Tay Lee, MD; Chia-Lin Tsai, MD; Chun-Chieh Lin, MD; Yaw-Don Hsu, MD; Jiann-Chyun Lin, MD, PhD; Chi-Ming Chu, PhD; Giia-Sheun Peng, MD, PhD

**Background**—Intracranial stenosis (ICS) is a major determinant of ischemic stroke in Asians. We determined the clinical significance of different risk factors and the role of ICS in Taiwanese patients with varied distributions of cervicocerebral stenosis.

**Methods and Results**—Presence of extracranial carotid stenosis (ECS, ≥70%) and ICS (>50%) was examined in 13 539 patients using ultrasonography and magnetic resonance angiography, respectively. Seven hundred thirty-three patients with non-ECS/ICS (n=372), isolated ICS (n=112), isolated ECS (n=121), or combined ECS/ICS (CEIS, n=128) were selected. Prevalence of ischemic stroke in each group was compared, and risk factors for stenosis were determined. The area under the receiver operating characteristic curve for each risk factor was calculated. Prevalence of ischemic stroke was highest in patients with CEIS (odds ratio 15.86; P<0.001), followed in decreasing order by those with isolated ICS (odds ratio 7.16; P<0.001), isolated ECS (odds ratio 1.77; P=0.011), and non-ECS/ICS. Multivariate logistic regression analysis revealed that hypertension, coronary artery disease, and smoking were risk factors for isolated ECS; hypertension, diabetes mellitus, coronary artery disease, and smoking were risk factors for isolated ICS; and diabetes mellitus, coronary artery disease, and smoking were risk factors for CEIS. Smoking, diabetes mellitus, and coronary artery disease were the greatest contributors to CEIS, isolated ICS, and isolated ECS, respectively.

**Conclusions**—CEIS was associated with higher odds of ischemic stroke compared with isolated ICS and isolated ECS. Smoking and diabetes mellitus, major determinants of CEIS and isolated ICS, should be targeted in therapeutic strategies to reduce the risk of ischemic stroke.

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**Key Words:** atherosclerosis • carotid arteries • risk factors • stenosis • stroke

Intracranial stenosis (ICS) is a well-known pathogenic factor for ischemic stroke. Previous studies have reported that the correlation of ICS and ischemic stroke is more prominent in Asians; in contrast, extracranial carotid stenosis (ECS) is more prevalent in whites.1–3 ICS is thought to be the cause of 33% to 84% of ischemic strokes in Asian populations4 and 8% to 10% of strokes in North America.5,6 Additionally, the annual stroke recurrence rate in patients with symptomatic ICS may be as high as 10% to 24%, even for patients receiving medical therapy7; on the other hand, the stroke recurrence rate is 7% to 13% in patients with symptomatic ECS who are treated with the appropriate medication.8,9

Variance in the distribution of cerebral atherosclerosis in different races is thought to be a result of differences in vascular risk factor profiles, lifestyles, and genetic susceptibility.6,10,11 Improving our understanding of the risk factors contributing to ICS in Asians with ischemic stroke is critical for the development and implementation of appropriate treatment strategies. While several vascular risk factors have been identified in ICS,6,12–14 these risk factors have varied among studies, possibly due to differences in study populations and methodologies. Therefore, in this study, we aimed to investigate the risk factor stratification of ICS in Taiwanese patients with different distributions of cervicocerebral stenosis.
Risk Factors of Intracranial Stenosis in Taiwanese

Methods

This retrospective cohort study was carried out within the certified Neurovascular Ultrasound Laboratory at Tri-Service General Hospital, Taipei, Taiwan. Between January 1, 2006, and December 31, 2012, a total of 13,539 consecutive patients were referred to the Neurovascular Ultrasound Laboratory due to stroke-related symptoms in 719 (53.1%), dizziness or syncope in 5205 (38.4%), coronary artery disease (CAD) or high risk for stroke in 842 (6.2%), cancer in 29 (0.2%), and other conditions or symptoms in 272 (2.0%). All patients were screened for carotid stenosis by 3 certified sonographers. Each individual underwent color-coded duplex ultrasonography of the cervical and retrobulbar vessels with the use of an ATL HDI 5000 ultrasound system (Philips) with an L12-5 linear 38-mm transducer. Degree of stenosis was determined according to the laboratory’s ultrasound criteria,15 which have been validated to correspond to the degree of stenosis on cerebral angiography measured by using the European Carotid Surgery Trial method,16 along with carotid endarterectomy findings. The entire process for each patient was recorded by using a digital video system, and examination data were reviewed by 2 neurovascular specialists. Written consent was provided by every patient before the examinations. The study was approved by the Institutional Review Board for Human Studies of the Tri-Service General Hospital (approval No. 2-101-05-030).

Selection of Study Patients With ECS or ICS

Among the 13,539 patients screened in this study, 9,408 had <30% stenosis of the extracranial carotid artery (ECA), including the common carotid and internal carotid arteries (ICAs) on both sides, while 353 had ≥70% stenosis of the ECA, including unilateral or bilateral lesions. After exclusion of patients with incomplete data or risk factors that were not associated with atherosclerosis, such as cardiogenic embolism, coagulopathy, dissection, Takayasu disease, cancer, and extracranial-to-intracranial bypass, a total of 733 patients (484 with stenosis of the ECA of <30% and 249 with stenosis of the ECA of ≥70%) were recruited for investigation of stenosis of the ICA (Figure 1). Grade of ICS was determined by using brain MRA. All intracranial vessels were evaluated, and severity of ICS was classified as normal to mild stenosis (≤50%) or moderate stenosis to occlusion (>50%), as described in previous reports.15,17,18 Consequently, a total of 733 patients were classified into 4 subgroups: non-ECS/ICS (NEIS; ECS <30% and ICS ≤50%; n = 372), isolated ICS (IICS; ECS <30% and ICS >50%; n = 112), isolated ECS (IECS; ECS ≥70% and ICS ≤50%; n = 121), and combined ECS/ICS (CEIS; ECS ≥70% and ICS >50%; n = 128).

Demographic Features and Clinical Characteristics

Ischemic stroke was evaluated by using brain MRI. All ischemic stroke types were included except for cardioembolism and nonatherosclerotic etiologies. Acute, recurrent, and old ischemic stroke were defined by using different MRI modalities, including T1/T2-weighted imaging, diffusion-weighted imaging, apparent diffusion coefficient, and fluid-attenuated inversion recovery. Patients were diagnosed as having acute first-ever stroke, recurrent stroke, or old stroke according to the presence of typical stroke symptoms and positive brain MRI findings. Demographic features and risk factors were recorded using a structured checklist that included hypertension (HTN), diabetes mellitus (DM), CAD, hypercholesterolemia, and hyperuricemia, defined as described previously.17 Smoking habit was defined as being a current smoker or having quit smoking <6 months earlier, while alcohol drinking was classified as either nonheavy (<1 drink per day for women or <2 drinks per day for men) or heavy (>1 drink per day for women or >2 drinks per day for men).

Statistical Analysis

Continuous variables were presented as mean±SD values, while categorical variables were expressed as numbers and percentages. Univariate logistic regression was performed to determine the risk of ischemic stroke in patients with IECS, IICS, and CEIS compared with that in patients with NEIS and to estimate unadjusted odds ratios (ORs) and corresponding 95% CIs. Multivariate logistic regression was performed to identify significant independent risk factors for IECS, IICS, and CEIS compared with NEIS and to estimate ORs and corresponding 95% CIs. Discrimination of significant risk factors for IECS, IICS, and CEIS was assessed by using area under the receiver operating characteristic (ROC) curves (AUC). An ROC curve area of 0.5 indicated no discrimination, whereas an ROC curve area of 1.0 indicated perfect discrimination. Statistical analyses were performed with SPSS.
version 19 (SPSS). Values were considered statistically significant at \( P < 0.05 \).

**Results**

A total of 13,539 patients were screened for ECS in the neurosonology laboratory (Figure 1). Of these patients, 9,408 (69.5%) were found to have no stenosis (EC \(< 30\%\) ), whereas 353 (2.6%) had ECS. Patients with ECS had higher rates of concomitant ICS compared with patients without ECS (51.4% \([128/249\text{ patients}]\) versus 23.1% \([112/484\text{ patients}]\) ).

According to brain MRA findings in patients with ICS (IECS, \( n = 128\); IICS, \( n = 112\) ), 123 patients (96.1%) with IECS had ICS in the anterior circulation; 81 (63.3%) had an isolated lesion in the anterior circulation, and 42 (32.8%) had lesions in both the anterior and posterior circulation. Eighty-three patients (74.1%) with IICS had ICS in the anterior circulation; 46 (41.1%) had an isolated lesion in the anterior circulation, and 37 (33.0%) had lesions in both the anterior and posterior circulation. Patients with CEIS had a significantly higher incidence of ICS in the anterior circulation compared with those with IICS (\( P < 0.001 \)).

Table 1 and Figure 2 show that the prevalence of total ischemic stroke was highest in the CEIS group (95.3%, OR 15.86, 95% CI, 6.81 to 36.91, \( P < 0.001 \)), followed in decreasing order by the IICS (90.2%, OR 7.16, 95% CI, 3.72 to 13.79, \( P < 0.001 \)), IECS (69.4%, OR 1.77, 95% CI, 1.14 to 2.74, \( P < 0.001 \)), and NEIS (56.2%, reference) groups.

Risk factors for different distributions of cervicocerebral stenosis are shown in Table 2. Multivariate logistic regression analysis revealed that CAD (OR 3.32, 95% CI, 2.01 to 5.51, \( P < 0.001 \)), HTN (OR 2.40, 95% CI, 1.34 to 4.29, \( P < 0.003 \)), and smoking (OR 1.75, 95% CI, 1.05 to 2.92, \( P = 0.033 \)) were significant risk factors for IECS. DM (OR 2.50, 95% CI, 1.59 to 3.96, \( P < 0.001 \)), smoking (OR 2.26, 95% CI, 1.34 to 3.98, \( P = 0.007 \)), HTN (OR 2.21, 95% CI, 1.24 to 3.94, \( P < 0.001 \)), and CAD (OR 2.03, 95% CI, 1.14 to 3.60, \( P = 0.016 \)) were significant risk factors for IICS.

Smoking (OR 4.41, 95% CI, 2.70 to 7.22, \( P < 0.001 \)), DM (OR 3.30, 95% CI, 1.92 to 5.69, \( P < 0.001 \)), and CAD (OR 0.580, 0.566, and 0.548, respectively) were significant risk factors for CEIS.

Figure 3 shows ROC curves demonstrating the sensitivity and specificity of different risk factors with respect to prediction of ICS, IECS, and CEIS. For prediction of ICS, the AUCs of CAD, HTN, and smoking were 0.619, 0.586, and 0.552, respectively. DM was the best factor for predicting IICS, with an AUC of 0.618, followed by HTN, smoking, and CAD (AUCs of 0.580, 0.566, and 0.548, respectively). Smoking was the best factor for predicting CEIS, with an
AUC of 0.657, followed by CAD and DM (AUCs of 0.589 and 0.560, respectively).

Discussion

Our study demonstrated that CEIS was more strongly associated with odds of ischemic stroke than were IICS and IECS in Taiwanese patients. Patients with IECs had lower odds of ischemic stroke compared with patients with IICS or CEIS. Moreover, while CAD was significantly associated with IECS, DM was the major determinant of IICS. Smoking, being a common risk factor for IECS, IICS, and CEIS, was the most important contributor to CEIS. These data provide important insights into the risk factors associated with ICS in Taiwanese patients.

Angiographic and pathologic evidence has shown that racial and ethnic differences exist in the distribution of cervicocerebral stenosis in patients with ischemic stroke.1 ICS is the most common vascular lesion in Asians with ischemic stroke.2–4 The estimated prevalence of middle cerebral artery stenosis among asymptomatic Asian patients ranges from 7.2% to 29.6%, while Asian patients with ischemic stroke have a higher ICS incidence of 33% to 84%.4,19 Further, concurrent atherosclerosis of intracranial and extracranial vessels is not uncommon in Asian populations.13,20–22 In fact, ≈20% to 50% of patients with ECS are reported to also have ICS.22–24 In this study, we found that 51.4% of patients with ECS had concurrent ICS. Compared with the IICS and IECS groups, the CEIS group had the highest prevalence of

Table 1. Odds Ratios of Ischemic Stroke in Patients With Different Distributions of Cervicocerebral Stenosis

|                        | NEIS (n=372) | IECS (n=121) | IICS (n=112) | CEIS (n=128) |
|------------------------|--------------|--------------|--------------|--------------|
| Ischemic stroke        |              |              |              |              |
| Acute, first-ever      | 209 (56.2)   | 84 (69.4)    | 29 (24.0)    | 113 (54.6)   |
| Recurrent              | 93 (30.4)    | 20 (16.6)    | 20 (17.9)    | 43 (34.0)    |
| Old                    | 13 (4.2)     | 13 (10.8)    | 13 (11.6)    | 43 (33.5)    |
| OR (95% CI)            | 1.77 (0.73–4.28) | 1.01 (0.35–3.06) | 1.29 (0.28–6.89) | 4.22 (2.59–6.88) |
| P Value                | <0.001       | 0.11         | <0.001       | <0.001       |

Values are expressed as n (%). Statistically significant differences were determined using univariate logistic regression. CIE indicates combined extracranial/intracranial stenosis; ICS indicates isolated intracranial stenosis; IECs, isolated extracranial stenosis; NEIS, nonextracranial/intracranial stenosis; OR odds ratio.

Figure 2. Odds ratio of ischemic stroke in IECS, IICS, and CEIS groups. The odds ratio of ischemic stroke was highest in the CEIS group (OR 15.86, 95% CI 6.81 to 36.91), followed in decreasing order by the IICS (OR 7.16, 95% CI 3.72 to 13.79), IECS (OR 1.77, 95% CI 1.14 to 2.74), and NEIS (reference) groups. CEIS indicates combined extracranial/intracranial stenosis; IECs, isolated extracranial stenosis; ICS, isolated intracranial stenosis; NEIS, nonextracranial/intracranial stenosis; OR odds ratio.
### Table 2. Multivariate Logistic Regression Analysis for Vascular Risk Factors in Patients With Different Distributions of Cervicocerebral Stenosis

|                | NEIS (n=372) | ICS (n=121) | aOR (95% CI) | P Value  | ICS (n=112) | aOR (95% CI) | P Value  | CEIS (n=128) | aOR (95% CI) | P Value  |
|----------------|--------------|-------------|-------------|----------|-------------|-------------|----------|-------------|-------------|----------|
| Male           | 301 (80.9)   | 97 (80.2)   | 88 (78.6)   | 0.003    | 94 (83.9)   | 2.21 (1.24–3.94) | 0.007    | 99 (77.3)   | 1.44 (0.85–2.43) | 0.176    |
| Age, mean±SD, y| 71.1±13.4    | 73.1±11.3   | 72.4±11.6   |          | 70.9±11.6   |             |          |             |             |          |
| HTN            | 253 (68.0)   | 103 (85.1)  | 2.40 (1.34–4.29) | 0.003    | 94 (83.9)   | 2.21 (1.24–3.94) | 0.007    | 99 (77.3)   | 1.44 (0.85–2.43) | 0.176    |
| DM             | 98 (26.3)    | 36 (29.8)   | 1.03 (0.63–1.68) | 0.912    | 56 (50.0)   | 2.50 (1.59–3.96) | <0.001   | 49 (38.3)   | 1.77 (1.10–2.83) | 0.018    |
| CAD            | 47 (12.6)    | 44 (36.4)   | 3.32 (2.01–5.51) | <0.001   | 25 (22.3)   | 2.03 (1.14–3.60) | 0.016    | 39 (30.5)   | 3.30 (1.92–5.69) | <0.001   |
| H/C            | 106 (28.5)   | 51 (42.1)   | 1.51 (0.95–2.39) | 0.080    | 32 (28.6)   | 0.80 (0.48–1.33) | 0.392    | 46 (35.9)   | 1.09 (0.68–1.76) | 0.714    |
| Hyperuricemia   | 41 (11.0)    | 27 (22.3)   | 1.65 (0.92–2.96) | 0.093    | 8 (7.1)     | 0.48 (0.21–1.12) | 0.089    | 29 (22.7)   | 1.74 (0.96–3.16) | 0.070    |
| Smoking        | 84 (22.6)    | 40 (33.1)   | 1.75 (1.05–2.92) | 0.033    | 40 (35.7)   | 2.26 (1.34–3.82) | 0.002    | 69 (53.9)   | 4.41 (2.70–7.22) | <0.001   |
| Alcohol drinking|             |             |             |          |             |             |          |             |             |          |
| Nonheavy       | 35 (9.4)     | 22 (18.2)   | 1.73 (0.90–3.34) | 0.102    | 15 (13.4)   | 1.06 (0.51–2.22) | 0.872    | 29 (22.7)   | 1.45 (0.77–2.73) | 0.245    |
| Heavy          | 20 (5.4)     | 3 (2.5)     | 0.50 (0.14–1.81) | 0.291    | 5 (4.5)     | 0.66 (0.23–1.95) | 0.455    | 8 (6.3)     | 0.90 (0.36–2.52) | 0.820    |

Values are expressed as n (%) unless otherwise noted. Statistically significant differences were determined using multivariate logistic regression after adjusting for other factors. aOR indicates adjusted odds ratio; CAD, coronary artery disease; CEIS, combined extracranial/intracranial stenosis; DM, diabetes mellitus; H/C, hypercholesterolemia; HTN, hypertension; IICS, isolated intracranial stenosis; IECS, isolated extracranial stenosis; NEIS, nonextracranial/intracranial stenosis.

Several risk factors, such as age, HTN, hyperlipidemia, DM, smoking, and hyperuricemia are regarded as major contributors to CMS, particularly in Asian populations. Aggressive metabolic syndrome, smoking, and DM are significant risk factors, and aggressive strategies in these high-risk groups may achieve better outcomes. Other studies have shown that the differential effects of age, HTN, and hyperlipidemia on ECS were found in Asian populations, further indicating that CMS-related stroke is a major problem worldwide and is likely the most common stroke subtype in Asian populations. In particular, DM has been identified as a common vascular risk factor for CMS in different races.32 After multivariate logistic regression, smoking was found to be associated with CMS in Europeans.55,56 Several risk factors, such as age, HTN, hyperlipidemia, smoking, and DM are regarded as major risk factors in CMS.28,29,57,58 Recently, one study found a much higher prevalence of CMS in Europeans.55,56 suggesting that CMS-related stroke is a major problem worldwide and is likely the most common stroke subtype in Asian populations.28,29,57,58
The significance of IECS in clinical practice is still relevant. Based on our results, which showed a close correlation between CAD and IECS, patients with ECS should undergo detailed examinations for presence of CAD to facilitate early diagnosis and treatment, potentially reducing CAD-related morbidity and mortality.

This study provided strong evidence in a large patient pool (n = 13,539), and all included patients were strictly evaluated by using color-coded duplex ultrasonography and brain MRI/MRA. Additionally, we enrolled 4 distinct patient groups: CEIS, IICS, IECS, and NEIS. This allowed for clear identification of the risk factors for each distribution of atherosclerosis. However, when interpreting data from an institutional series, the limitations of a retrospective analysis, such as patient selection biases as well as lack of a temporal relationship and adequate outcome assessment, must be considered. We used propensity scores with age and sex as covariates to match the patients. Therefore, the impact of age and sex on distribution of atherosclerosis could not be evaluated. Most of the patients referred for color-coded duplex ultrasonography were symptomatic suspect of relating to a vascular lesion, which may reflect the high prevalence of ischemic stroke in our population. Moreover, patients who did not undergo an MRI/MRA study were excluded, which could influence the results regarding prevalence of ICS and ischemic stroke. Meanwhile, it is possible that some patients experienced a stroke after ECS or ICS, and then a new lesion developed after the stroke. However, duration from onset of stroke to date of examination was not recorded in this study.

Some diseases have been proved to be independent predictors for cardiovascular disorders but were not discussed in this study. For example, obstructive sleep apnea and chronic obstructive pulmonary disease are related to a systemic inflammatory condition and are significantly associated with cardiovascular events. Dolicocharotids, an anatomic variation of cervical ICA, are also a relative risk factor for stroke. Some medications have been linked to risk control against atherosclerotic progression. Therefore, history of medication use, including drug types and treatment durations, may be an influential factor for the varied distribution of cervicocranial vessel lesions. Future clinical trials are warranted to test the benefit of medication against vascular progression and for better clinical outcomes. This study population was hospital based rather than community based; thus, generalization of the results may be limited. In addition, MRA may overestimate stenosis of the major arteries. Conventional digital subtraction angiography is still the gold standard for confirming cervicocerebral stenosis. Finally, embolic disease could not be completely excluded in this study. Embolic occlusion with partial recanalization can angiographically resemble stenosis.

| Risk factors | AUC   | 95% CI      |
|--------------|-------|-------------|
| CAD          | 0.619 | 0.557 – 0.680 |
| HTN          | 0.586 | 0.530 – 0.641 |
| Smoking      | 0.552 | 0.492 – 0.613 |
| DM           | 0.618 | 0.557 – 0.679 |
| HTN          | 0.580 | 0.522 – 0.637 |
| Smoking      | 0.566 | 0.503 – 0.628 |
| CAD          | 0.548 | 0.486 – 0.611 |
| Smoking      | 0.657 | 0.599 – 0.714 |
| CAD          | 0.589 | 0.529 – 0.649 |
| DM           | 0.560 | 0.501 – 0.618 |

**Figure 3.** Receiver operating characteristic curve, demonstrating the associations of risk factors and prediction of IECS, IICS, and CEIS. A, CAD was the most predictive factor (highest AUC value) for IECS, followed in decreasing order by HTN and smoking. B, DM was the most predictive factor for IICS, followed in decreasing order by HTN, smoking, and CAD. C, Smoking was the most predictive factor for CEIS, followed in decreasing order by CAD and DM. AUC indicates area under the receiver operating characteristic curve; CAD, coronary artery disease; CEIS, combined extracranial/intracranial stenosis; DM, diabetes mellitus; HTN, hypertension; IECS, isolated extracranial stenosis; IICS, isolated intracranial stenosis.
Conclusion
In this study, we found that patients with CEIS had the highest odds of ischemic stroke. Moreover, patients with CEIS or IICS had higher odds of ischemic stroke than those with IECS. The identification of risk factors contributing to the varied distribution of cervicocerebral stenosis in this study may provide important insights into appropriate clinical practices and methods. Patients with newly diagnosed DM may benefit from undergoing advanced neuroimaging or neurosonology tests to screen for ICS. Smoking, which was a common risk factor for CEIS, IICS, and IECS, should be strictly controlled. Patients with ECS should undergo detailed examinations for the presence of CAD. Early identification of these risk factors and aggressive management are essential for reducing the risk of ischemic stroke and improving outcomes.

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Disclosures
None.

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