Association of Vascular Risk Factors With Cervical Artery Dissection and Ischemic Stroke in Young Adults

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Background—Little is known about the risk factors for cervical artery dissection (CEAD), a major cause of ischemic stroke (IS) in young adults. Hypertension, diabetes mellitus, smoking, hypercholesterolemia, and obesity are important risk factors for IS. However, their specific role in CEAD is poorly investigated. Our aim was to compare the prevalence of vascular risk factors in CEAD patients versus referents and patients who suffered an IS of a cause other than CEAD (non-CEAD IS) in the multicenter Cervical Artery Dissection and Ischemic Stroke Patients (CADISP) study.

Methods and Results—The study sample comprised 690 CEAD patients (mean age, 44.2 ± 9.9 years; 43.9% women), 556 patients with a non-CEAD IS (44.7 ± 10.5 years; 39.9% women), and 1170 referents (45.9 ± 8.1 years; 44.1% women). We compared the prevalence of hypertension, diabetes mellitus, hypercholesterolemia, smoking, and obesity (body mass index ≥ 30 kg/m²) or overweightness (body mass index ≥ 25 kg/m² and < 30 kg/m²) between the 3 groups using a multinomial logistic regression adjusted for country of inclusion, age, and gender. Compared with referents, CEAD patients had a lower prevalence of hypercholesterolemia (odds ratio 0.55; 95% confidence interval, 0.42 to 0.71; P < 0.0001), obesity (odds ratio 0.37; 95% confidence interval, 0.26 to 0.52; P < 0.0001), and overweightness (odds ratio 0.70; 95% confidence interval, 0.57 to 0.88; P = 0.002) but were more frequently hypertensive (odds ratio 1.67; 95% confidence interval, 1.32 to 2.1; P < 0.0001). All vascular risk factors were less frequent in CEAD patients compared with young patients with a non-CEAD IS. The latter were more frequently hypertensive, diabetic, and current smokers compared with referents.

Conclusion—These results, from the largest series to date, suggest that hypertension, although less prevalent than in patients with a non-CEAD IS, could be a risk factor of CEAD, whereas hypercholesterolemia, obesity, and overweightness are inversely associated with CEAD. (Circulation. 2011;123:1537-1544.)

Key Words: stroke ■ dissection ■ hypercholesterolemia ■ hypertension ■ obesity
Little is known about the risk factors of cervical artery dissection (CEAD),\textsuperscript{1–2} one of the major causes of ischemic stroke (IS) in young adults.\textsuperscript{3} Hypertension, diabetes mellitus, smoking, hypercholesterolemia, and obesity are important risk factors for vascular disease, increasing the incidence of IS, myocardial infarction, and critical limb ischemia.\textsuperscript{4–7} However, their specific impact on the occurrence of CEAD is poorly understood. Indeed, although the relationship of CEAD with vascular risk factors has been investigated in the past, studies were performed in small cohorts,\textsuperscript{8–19} and only 2 studies were specifically designed to assess this relationship.\textsuperscript{16,19} A few studies reported a lower prevalence of vascular risk factors in CEAD patients compared with young patients with an IS of a cause other than CEAD (non-CEAD IS),\textsuperscript{8–10} whereas others did not observe any significant association.\textsuperscript{11–14} Studies including referents are scarce\textsuperscript{15–17,19} and yielded contradictory results: 1 study found no association\textsuperscript{17}; another observed a lower body mass index (BMI)\textsuperscript{19}; and 2 other studies found an increased prevalence of hypertension in CEAD patients compared with referents.\textsuperscript{15,16}

**Clinical Perspective on p 1544**

The aim of the present analysis was to compare the prevalence of vascular risk factors in CEAD patients and in both young patients with a non-CEAD IS and referents in the setting of the multicenter Cervical Artery Dissection and Ischemic Stroke Patients (CADISP) study, comprising the largest collection of CEAD patients to date.

**Methods**

**Study Population**

The structure and methods of the CADISP study have been described previously.\textsuperscript{20} Between 2004 and 2009, across 20 centers in 9 countries, we included consecutive patients evaluated in a neurology department with a diagnosis of CEAD or non-CEAD IS and referents. The study protocol was approved by relevant local authorities in all participating centers and was conducted according to the national rules concerning ethics committee approval and informed consents.\textsuperscript{20}

**Patients**

Patients were recruited both prospectively and retrospectively. Retrospective patients had a qualifying event before the beginning of the study in each center and were identified through local registries of CEAD patients. The vast majority of patients had a qualifying event between 1999 and 2009 (<4% had a qualifying event before 1999). Patients in the CEAD and non-CEAD IS groups were recruited in the same centers; non-CEAD IS patients were frequency matched on age (by 5-year intervals) and gender with CEAD patients. The primary aim of the CADISP consortium was to perform a genetic association study to identify genetic susceptibility factors of CEAD.\textsuperscript{20} All but 2 centers also participated in a clinical study including detailed screening of putative environmental risk factors and clinical and radiological characteristics using a standardized questionnaire. The CADISP clinical study comprises 983 CEAD and 658 non-CEAD IS patients recruited in 18 centers from 8 countries (Argentina, Belgium, Finland, France, Germany, Italy, Switzerland, and Turkey; Figure I in the online-only Data Supplement). Of these, 293 CEAD and 102 non-CEAD IS patients from Germany, Switzerland, Argentina, and Turkey were excluded because country-, gender-, and age-matched referents with detailed vascular risk factor data were not available (Figure II in the online-only Data Supplement). Thus, the present study comprises 690 CEAD and 556 non-CEAD IS patients from Belgium, Italy, Finland, and France. Detailed inclusion criteria are available online (Figure III in the online-only Data Supplement). Briefly, CEAD patients had to present a mural hematoma, aneurysmal dilatation, long tapering stenosis, intimal flap, double lumen, or occlusion >2 cm above the carotid bifurcation revealing an aneurysmal dilatation or a long tapering stenosis after recanalization in a cervical artery (internal carotid or vertebral); purely intracranial or iatrogenic dissections were not included. The non-CEAD IS group comprised patients with a recent IS confirmed on brain imaging in whom magnetic resonance or computed tomography angiography performed within 7 days after the IS ruled out CEAD; patients with iatrogenic IS, cardiopathies at very high embolic risk, arterial vasospasm after subarachnoid hemorrhage, or autoimmune or monoegenic disease possibly explaining the IS were not included.

**Variable Definitions**

Hypertension was defined by a history of elevated blood pressure (systolic blood pressure ≥140 mm Hg or diastolic blood pressure ≥90 mm Hg) diagnosed by the treating physician or use of a blood pressure-lowering therapy. Because blood pressure is modified at the acute phase of vascular events, blood pressure levels during the hospital stay were not taken into account. Hypercholesterolemia was defined as a fasting total cholesterol ≥2.0 mmol/L or low-density lipoprotein cholesterol ≥1.0 mmol/L, measured within 48 hours after admission to the hospital or diagnosed by the treating physician, or use of a cholesterol-lowering therapy. Because cholesterol levels were not measured in Finnish referents, we did not include the Finnish sample in analyses involving hypercholesterolemia. Diabetes mellitus was defined as a history of diabetes mellitus diagnosed by the treating physician with a fasting glucose >7.0 mmol/L or use of an antidiabetic therapy. Smokers were categorized on the basis of current smoking status. Body mass index was calculated as the ratio of weight (kg) to the square of height (m²). Weight and height were reported for CADISP patients (at the date of the qualifying event) and Finnish referents and measured for referents from the MONA-LISA and Vobarno studies. Overweight was defined as BMI ≥25 kg/m² and <30 kg/m² and obesity as BMI ≥30 kg/m². Patients with a non-CEAD IS were classified into IS subtypes according to the Trial of Org 10172 in Acute Stroke Treatment (TOAST) classification.\textsuperscript{23,24}

**Statistical Analyses**

We compared the prevalence of hypertension, diabetes mellitus, hypercholesterolemia, past and current smoking, and obesity/overweightness and the mean BMI between the following groups: CEAD patients versus referents, non-CEAD IS patients versus referents, and CEAD versus non-CEAD IS patients. We used a multinomial logistic regression (generalized logit model) adjusting for country of inclusion, age, and gender to test the association between outcome variable (3
levels: CEAD, non-CEAD IS, and referent) and each vascular risk factor. We compared the association between CEAD and each vascular risk factor across countries by adding an interaction term with country and running analyses stratified on the country of inclusion.

In a secondary analysis, we included all vascular risk factors in the same multinomial logistic regression (except BMI, which is redundant with obesity/overweightness). We also ran a stepwise logistic regression with country of inclusion, age, and gender forced in and P=0.10 as a significance threshold for entering into and staying in the model. We tested whether associations with CEAD were maintained in the following CEAD subgroups: internal carotid or vertebral artery dissection (patients with both were excluded from this secondary analysis), presence or absence of cerebral ischemia, and retrospective or prospective recruitment. We used a multinomial logistic regression comparing CEAD subgroups with all referents; heterogeneity between odds ratios for different CEAD subgroups was assessed with logistic regression analysis restricted to CEAD patients (case-only analysis) with the CEAD characteristic as the outcome variable. Using a similar strategy, we also tested whether associations with non-CEAD IS were similar to those for IS resulting from classic causes (large-artery atherosclerosis, small-vessel disease, cardioembolic) and IS resulting from other determined causes or of undetermined cause.

Results
Clinical characteristics of the study population are shown in Table 1. The majority of CEAD patients had suffered an internal carotid artery dissection, and more than three quarters of CEAD patients sustained a cerebral ischemia as a consequence of the dissection. In the non-CEAD IS group, most ISs were cardioembolic or of undetermined origin.

Age, gender, and vascular risk factor distributions in each group, overall and by country, are given in Table 2. CEAD and non-CEAD IS patients were slightly younger than referents (P<0.001 and P=0.02 respectively). Except for 2 CEAD patients who were siblings, all participants were unrelated. One CEAD patient had biologically confirmed vascular Ehlers-Danlos syndrome.

CEAD Patients Versus Referents
Hypertension was significantly more frequent in CEAD patients compared with referents (Table 3). Hypercholester-
Table 3. Comparison of Vascular Risk Factor Prevalence Between Cervical Artery Dissection Patients, Referents, and Non–Cervical Artery Dissection Ischemic Stroke Patients

<table>
<thead>
<tr>
<th></th>
<th>CEAD Patients vs Referents</th>
<th>Non-CEAD IS Patients vs Referents</th>
<th>CEAD Patients vs Non-CEAD IS Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OR (95% CI)</strong>*</td>
<td><strong>P</strong></td>
<td><strong>OR (95% CI)</strong>*</td>
<td><strong>P</strong></td>
</tr>
<tr>
<td>Hypertension†</td>
<td>1.67 (1.32–2.12)</td>
<td>&lt;0.0001</td>
<td>2.89 (2.27–3.68)</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>0.54 (0.29–1.02)</td>
<td>0.06</td>
<td>2.65 (1.72–4.08)</td>
</tr>
<tr>
<td>Current smoking</td>
<td>1.22 (0.99–1.50)</td>
<td>0.07</td>
<td>2.53 (2.04–3.14)</td>
</tr>
<tr>
<td>Hypercholesterolemia</td>
<td>0.55 (0.42–0.71)</td>
<td>&lt;0.0001</td>
<td>1.12 (0.86–1.46)</td>
</tr>
<tr>
<td>Obesity</td>
<td>0.37 (0.26–0.52)</td>
<td>&lt;0.0001</td>
<td>1.03 (0.76–1.40)</td>
</tr>
<tr>
<td>Overweight</td>
<td>0.70 (0.57–0.88)</td>
<td>0.002</td>
<td>1.13 (0.89–1.43)</td>
</tr>
<tr>
<td>BMI‡</td>
<td>0.92 (0.90–0.95)</td>
<td>&lt;0.0001</td>
<td>0.99 (0.97–1.02)</td>
</tr>
</tbody>
</table>

CEAD indicates cervical artery dissection; IS, ischemic stroke; OR, odds ratio; CI, confidence interval; and BMI, body mass index.

†OR (95% CI)*Multinomial logistic regression adjusted for age, gender, and country of inclusion.

‡Global $P$ for difference between the 3 groups.

§In total, 13.1% of CEAD patients, 22.7% of non-CEAD IS patients and 11.4% of referents were on antihypertensive treatment ($P<0.0001$ for CEAD versus referents, $P<0.0001$ for non-CEAD IS and $P<0.0001$ for non-CEAD IS versus referents in multinomial logistic regression adjusted for country, age, and gender; global $P<0.0001$).

The associations of vascular risk factors with CEAD were substantially unchanged when stratifying on dissection site (carotid versus vertebral) and on the presence or absence of cerebral ischemia (Table 5). Results were similar for patients included retrospectively or prospectively and after exclusion of participants <35 years of age (Table II in the online-only Data Supplement).

Table 4. Association of Vascular Risk Factors With Cervical Artery Dissection by Country of Inclusion

<table>
<thead>
<tr>
<th>Country</th>
<th>France/Belgium OR (95% CI)*</th>
<th>P</th>
<th>Finland OR (95% CI)*</th>
<th>P</th>
<th>Italy OR (95% CI)*</th>
<th>P</th>
<th>$P$ for Interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>1.18 (0.84–1.66)</td>
<td>0.34</td>
<td>2.06 (1.33–3.20)</td>
<td>0.001</td>
<td>3.21 (1.82–5.65)</td>
<td>&lt;0.0001</td>
<td>0.003</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>0.76 (0.32–1.83)</td>
<td>0.54</td>
<td>0.08 (0.01–0.62)</td>
<td>0.01</td>
<td>1.45 (0.41–5.13)</td>
<td>0.57</td>
<td>0.08</td>
</tr>
<tr>
<td>Current smoking</td>
<td>0.91 (0.67–1.22)</td>
<td>0.51</td>
<td>1.92 (1.26–2.92)</td>
<td>0.002</td>
<td>1.34 (0.86–2.10)</td>
<td>0.20</td>
<td>0.01</td>
</tr>
<tr>
<td>Hypercholesterolemia</td>
<td>0.73 (0.53–1.01)</td>
<td>0.05</td>
<td>NA</td>
<td></td>
<td>0.29 (0.18–0.47)</td>
<td>&lt;0.0001</td>
<td>0.002</td>
</tr>
<tr>
<td>Obesity</td>
<td>0.40 (0.25–0.63)</td>
<td>&lt;0.0001</td>
<td>0.37 (0.19–0.70)</td>
<td>0.003</td>
<td>0.34 (0.15–0.81)</td>
<td>0.01</td>
<td>0.43</td>
</tr>
<tr>
<td>Overweight</td>
<td>0.69 (0.50–0.93)</td>
<td>0.01</td>
<td>0.94 (0.61–1.46)</td>
<td>0.80</td>
<td>0.58 (0.36–0.93)</td>
<td>0.02</td>
<td></td>
</tr>
<tr>
<td>BMI†</td>
<td>0.92 (0.89–0.95)</td>
<td>&lt;0.0001</td>
<td>0.95 (0.90–0.99)</td>
<td>0.02</td>
<td>0.91 (0.85–0.96)</td>
<td>0.002</td>
<td>0.33</td>
</tr>
</tbody>
</table>

OR indicates odds ratio; CI, confidence interval; BMI, body mass index.

*Multinomial logistic regression comparing cervical artery dissection (CEAD) patients with referents adjusted for age, gender, and country of inclusion (comparisons of CEAD versus non-CEAD ischemic stroke [IS] patients and of non-CEAD IS patients versus referents are shown in Tables III and V in the online-only Data Supplement).

†Per 1-kg/m² increase.
Table 5. Association of Vascular Risk Factors With Different Subgroups of Cervical Artery Dissection

<table>
<thead>
<tr>
<th>Vascular Risk Factor</th>
<th>OR (95% CI)*</th>
<th>P</th>
<th>OR (95% CI)*</th>
<th>P</th>
<th>P for Heterogeneity†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carotid artery dissection (n=416)</td>
<td></td>
<td></td>
<td>Vertebral artery dissection (n=243)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>1.56 (1.19–2.05)</td>
<td>0.001</td>
<td>Hypertension</td>
<td>1.73 (1.21–2.46)</td>
<td>0.002</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>0.30 (0.12–0.75)</td>
<td>0.01</td>
<td>Diabetes mellitus</td>
<td>0.94 (0.39–2.28)</td>
<td>0.90</td>
</tr>
<tr>
<td>Current smoking</td>
<td>1.17 (0.91–1.51)</td>
<td>0.21</td>
<td>Current smoking</td>
<td>1.39 (1.02–1.89)</td>
<td>0.03</td>
</tr>
<tr>
<td>Hypercholesterolemia‡</td>
<td>0.57 (0.42–0.78)</td>
<td>0.0003</td>
<td>Hypercholesterolemia‡</td>
<td>0.48 (0.30–0.77)</td>
<td>0.002</td>
</tr>
<tr>
<td>Obesity</td>
<td>0.38 (0.25–0.57)</td>
<td>&lt;0.0001</td>
<td>Obesity</td>
<td>0.33 (0.18–0.59)</td>
<td>0.0002</td>
</tr>
<tr>
<td>Overweight</td>
<td>0.69 (0.53–0.89)</td>
<td>0.004</td>
<td>Overweight</td>
<td>0.77 (0.55–1.07)</td>
<td>0.11</td>
</tr>
<tr>
<td>BMI§</td>
<td>0.92 (0.89–0.94)</td>
<td>&lt;0.0001</td>
<td>BMI§</td>
<td>0.93 (0.90–0.97)</td>
<td>0.0003</td>
</tr>
</tbody>
</table>

CEAD with cerebral ischemia (n=541)  CEAD without cerebral ischemia (n=149)

| Hypertension                 | 1.45 (1.12–1.88) | 0.005 | Hypertension | 2.37 (1.61–3.48) | <0.0001| 0.02                |
| Diabetes mellitus            | 0.54 (0.27–1.10) | 0.09  | Diabetes mellitus | 0.51 (0.15–1.67) | 0.25  | 0.93                |
| Current smoking              | 1.27 (1.01–1.59) | 0.04  | Current smoking | 0.98 (0.66–1.45) | 0.92  | 0.17                |
| Hypercholesterolemia‡        | 0.53 (0.39–0.71) | <0.0001| Hypercholesterolemia‡ | 0.59 (0.35–0.97) | 0.04  | 0.81                |
| Obesity                      | 0.33 (0.22–0.49) | <0.0001| Obesity       | 0.52 (0.28–0.94) | 0.03  | 0.42                |
| Overweight                   | 0.69 (0.54–0.87) | 0.002 | Overweight    | 0.79 (0.53–1.18) | 0.25  |                      |
| BMI§                         | 0.91 (0.89–0.94) | <0.0001| BMI§          | 0.95 (0.91–0.99) | 0.03  | 0.11                |

OR indicates odds ratio; CI, confidence interval; BMI, body mass index; and CEAD, cervical artery dissection.

*Multinomial logistic regression comparing subgroups of CEAD patients with all referents adjusted for age, gender, and country of inclusion.

†Assessed with logistic regression restricted to CEAD patients with the CEAD characteristic as the outcome variable.

§Per 1-kg/m² increase.

Non-CEAD IS Patients Versus Referents

Hypertension, diabetes mellitus, and current smoking were significantly more frequent in non-CEAD IS patients compared with referents (Table 3). Similar results were observed when all risk factors were included in the same model (Table 3). The associations with hypertension, diabetes mellitus, and current smoking were homogeneous across countries (Table V in the online-only Data Supplement). Associations also did not differ between patients with an IS of classic origin (large-artery atherosclerosis, small-vessel disease, and cardioembolism) and patients with an IS of another determined cause or undetermined origin (Table VI in the online-only Data Supplement).

Discussion

Compared with country-, gender-, and age-matched referents, CEAD patients were more frequently hypertensive and had a lower prevalence of hypercholesterolemia, obesity, and overweightness. These associations were similar for internal carotid and vertebral artery dissections and in CEAD patients with or without cerebral ischemia. All vascular risk factors were less frequent in CEAD patients compared with country-, gender-, and age-matched patients with a non-CEAD IS. Young patients with a non-CEAD IS were more often hypertensive, diabetic, and current smokers compared with referents.

In the Context of the Current Literature

Although hypertension is usually considered one of the major risk factors for aortic dissection,25,26 its association with CEAD is controversial. Two studies described an increased prevalence of hypertension in CEAD patients15,16 (restricted to CEAD patients with cerebral ischemia in 1 study,16 which partly overlaps with our Italian subsample), whereas 2 other studies reported no association.17,19 In the present sample, we found a significantly higher frequency of hypertension in CEAD patients compared with referents, regardless of the presence or absence of cerebral ischemia. Although a lower prevalence of hypercholesterolemia has been described in CEAD patients compared with non-CEAD IS patients,16 to the best of our knowledge, no such association has been reported in comparison with referents.

The lower mean BMI and lower prevalence of obesity and overweightness in CEAD patients compared with referents are in agreement with recently published results from an independent French group for 239 patients and 516 referents.19 The lower prevalence of vascular risk factors in CEAD patients compared with young non-CEAD IS patients is in line with previous publications.2–10 Although the association of vascular risk factors with IS risk is well established in older individuals, few data are available in young adults.27 We found that, as in older individuals, hypertension, diabetes mellitus, and current smoking were significantly more frequent in young non-CEAD IS patients compared with referents regardless of IS subtype.

Underlying Mechanisms

As for dissection in other arteries, CEAD probably results from multiple coexisting pathological processes, leading to a weakening of or increased stress on the arterial wall.29 From earlier observations that structural and functional arterial anomalies are more frequent in CEAD patients than in referents,14,28–31 it has been postulated that CEAD patients could have a constitutional weakness of the vessel wall, on top of which acute events such as minor cervical trauma or infection could act as triggers.1 Elevated blood pressure could contribute to CEAD risk by increasing carotid stiffness32; alternatively, CEAD patients could have a constitutionally elevated arterial stiffness,31 leading to an
increase in systolic pressure. The inverse association of CEAD with hypercholesterolemia and BMI, as well as the young age of occurrence of CEAD, are in contrast to aortic dissection, which is most commonly associated with old age and atherosclerosis. Although we did not screen specifically for atherosclerotic lesions, the vascular risk factor profile of CEAD patients suggests that atherosclerosis is probably not a predisposing condition to CEAD. Recently, an increase in wall material stiffness with a heterogeneous echostucture was described in CEAD patients. With aging and arteriosclerosis, the echostucture becomes more homogeneous, with an increase in collagen and elastin cross-links, making it less prone to dissection. This process could be accelerated in individuals with hypercholesterolemia and elevated BMI, analogous to diabetes mellitus, which is associated with an increased synthesis and reduced degradation of the extracellular matrix, an increased number of covalent cross-links between proteins, and a reduced incidence of abdominal aortic aneurysms. One could also speculate that lean persons, with less adipose tissue protecting the arteries from minor cervical traumas, might be more prone to developing CEAD as a result of increased vulnerability to such traumas. Low cholesterol and BMI could also be mere confounders reflecting a common underlying genetic disorder or susceptibility factor. Patients with inherited connective tissue disorders such as Marfan syndrome tend to be taller and have a lower BMI than referents. Although Marfan syndrome itself seems to be only marginally associated with CEAD, there is some evidence that other connective tissue disorders, and possibly other genetic susceptibility factors in connective tissue genes, may be important predisposing conditions to CEAD.

Strengths and Limitations

The main strengths of this study are the large sample size and the comparison to both referents and age-matched non-CEAD IS patients. Despite being one of the main causes of IS in young adults, CEAD is rare in the general population (incidence, 2.6/100,000 per year); thus, only an international multicenter effort could achieve a sufficiently large sample size for this analysis. The coherence of associations in different patient subgroups and countries strengthens our findings. CEAD and non-CEAD IS patients were recruited in the same centers according to a unique protocol, thus allowing optimal comparisons. We were limited by the heterogeneity in recruitment methods and risk factor evaluation for referents across countries; on the other hand, this heterogeneity enabled us to test the robustness of our findings. For Italy and Finland, the fact that referents were selected to be free of vascular disease may have inflated the association of CEAD and non-CEAD IS with vascular risk factors, but this is unlikely to have affected our results substantially because the prevalence of vascular disease is very low in this age category in the general population. In the Finnish sample, some of the associations, especially with BMI and obesity/overweightness, may have been weakened by assortative mating, but this effect should be marginal because only 6% of Finnish referents were spouses of patients. The imbalance in the proportion of participants <35 years of age between patients and referents in the French-Belgian and Italian samples could have artificially inflated the inverse association of hypercholesterolemia and obesity/overweightness with CEAD. However, these associations were still significant after the exclusion of all individuals <35 years of age. Another limitation is that weight and height were measured in French-Belgian and Italian referents, whereas reported values were used for the other groups; reported weight tends to be an underestimation of the true measure, which could artificially inflate the inverse association of BMI with CEAD. We also cannot formally exclude nonrandom misclassification of hypertension history if the number of individuals with less prior access to care and therefore less opportunity for diagnosis of hypertension differed between groups. Our study sample is not perfectly representative of the general population. Patients in the CEAD and non-CEAD IS groups were recruited through neurology departments, often in tertiary centers, which are biased toward more complicated cases and rare causes. Persons with CEAD causing only local signs or minor strokes, which may be underdiagnosed, and CEAD patients with very severe strokes requiring intensive care were less likely to be included. Referents recruited through health surveys and epidemiological studies generally have fewer risk factors and less disease than persons who do not participate. Finally, we did not correct for multiple comparisons, but given the strength of the associations and the homogeneity of findings across countries and subgroups, false-positive associations seem unlikely.

Implications

Our findings, if confirmed in independent data sets, could improve the understanding of the mechanisms underlying CEAD, a major cause of IS in young adults, in whom the impact of stroke-related disability is particularly dramatic from a personal and socioeconomic point of view. Hypertension was associated with CEAD, but the relationship seems weaker than with IS resulting from other causes in young adults of the same age. Further studies testing whether hypertension is also associated with an increased risk of CEAD recurrence could be important for preventive purposes. These studies should include long-term follow-up of consecutive CEAD patients and ascertainment of hypertension on the basis both of history before the dissection and on blood pressure measurements at a distance of the vascular event. The inverse association of CEAD with hypercholesterolemia could have implications in terms of secondary stroke prevention, because statins are commonly prescribed after an IS, including in CEAD patients in some instances. In addition to validating these associations, future studies could include a simultaneous assessment of the carotid wall structure and genetic susceptibility factors of hypertension, obesity, and hypercholesterolemia to explore the underlying mechanisms.

Conclusions

The vascular risk factor profile of CEAD patients differs from referents and young adults with a non-CEAD IS. Hypertension was associated with an increased risk of CEAD, whereas an inverse association with hypercholesterolemia, obesity, and overweightness was observed.
Appendix

CADISP Investigators

Belgium: Department of Neurology, Erasmus University Hospital; Laboratory of Experimental Neurology, Université Libre de Bruxelles, Brussels (Shérine Abdoub, Massimo Pandolfo); Leuven University Hospital, Leuven (Vincent Thijs). Finland: Department of Neurology, Helsinki University Central Hospital, Helsinki (Tina Metso, Antti Metso, Turgut Tatlisumak). France: Departments of Neurology, Lille University Hospital-EA2691, Lille (Marie Bodenart, Stéphanie Debette, Didier Leys, Paul Ossou); Saint-Anne University Hospital (Fabien Louillot, Jean-Louis Mas, Emmanuel Touzé); Pitié-Salpêtrière University Hospital, Paris (Sara Leder, Anne Léger, Sandrine Deltour, Sophie Croizille, Isabelle Méresse, Yves Samson); Amiens University Hospital, Amiens (Sandrine Canaple, Olivier Godfroy, Chantal Lamy); Dijon University Hospital, Dijon (Yannick Béot, Maurice Giroud); Besançon University Hospital, Besançon (Pierre Decavel, Elizabeth Medeiros, Paola Montiel, Thierry Moulin, Fabrice Vuillier); Inserm U744, Pasteur Institute, Lille (Philippe Amouyel, Jean Dallongeville, Stéphanie Debette). Germany: Departments of Neurology, Heidelberg University Hospital, Heidelberg (Caspar Grond-Ginsbach, Manja Kloss, Christoph Lichy, Tina Wiest, Inge Werner, Marie-Luise Arnold); University Hospital of Ludwigshafen, Ludwigshafen (Michael Dos Santos, Armin Grau); University Hospital of Munich, Munich (Martin Dichgans); Department of Dermatology, Heidelberg University Hospital (Ingrid Haussner); Department of Rehabilitation, Schneider-Klinik, Heidelberg (Tobias Brandt, Constanze Thomas-Feles, Ralph-Weber). Italy: Department of Neurology, Brescia University Hospital, Brescia (Elisabetta Del Zotto, Alessia Giossi, Irene Volonghi, Alessandro Padovani, Alessandro Pezzini); Perugia University Hospital, Perugia (Valeria Caso); Milan University Hospital, Milan (Anna Bersano, Silvia Lanfranconi, Pierluigi Baron); University of Milano Bicocca, San Gerardo Hospital, Monza (Simone Beretta, Carlo Ferrarese); Milan Scientific Institute San Raffaele University Hospital, Milan (Maria Sessa, Giacomo Giacalone); Department of Rehabilitation, Santa Lucia Hospital, Rome (Stefano Paolucci). Switzerland: Department of Neurology, Basel University Hospital, Basel (Stefan Engel, Felix Fluri, Florian Hatz, Dominik Gisler, Margareth Amort, Philippe Lyser). United Kingdom: Clinical Neuroscience, St. George’s University of London (Hugh Markus). Turkey: Department of Neurology, University Hospital of Istanbul (Ayse Altintas). Argentina: Department of Neurology, University Hospital Sanatorio Allende, Cordoba (Juan Jose Martin).

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Disclosures

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References

Cervical artery dissection (CEAD), although rare in the general population, is a major cause of ischemic stroke (IS) in young adults. Little is known about its risk factors. Our aim was to compare the prevalence of vascular risk factors (hypertension, diabetes mellitus, hypercholesterolemia, current smoking, overweightness, and obesity) in CEAD patients versus referents and patients with IS of a cause other than CEAD (non-CEAD IS) in a multicenter setting. Compared with country-, gender-, and age-matched referents, CEAD patients were more frequently hypertensive and had a lower prevalence of hypercholesterolemia, obesity, and overweightness. All vascular risk factors were less frequent in CEAD patients compared with country-, gender-, and age-matched non-CEAD IS patients. These patients were more frequently hypertensive, diabetic, and current smokers compared with referents, as described in older cohorts of non-CEAD IS patients. Our findings, if confirmed in independent data sets, could improve the understanding of the mechanisms underlying CEAD, a major cause of IS in young adults, in whom the impact of stroke-related disability is particularly dramatic from a personal and socioeconomic point of view. They suggest that hypertension could be a risk factor of CEAD, although the relationship seems weaker than with non-CEAD IS. The inverse association of CEAD with hypercholesterolemia could be more pronounced in patients with spontaneous cervical artery dissection. Circulation. 2007;23:448–452.


Association of Vascular Risk Factors With Cervical Artery Dissection and Ischemic Stroke in Young Adults

Stéphanie Debette, Tiina Metso, Alessandro Pezzini, Shérine Abboud, Antti Metso, Didier Leys, Anna Bersano, Fabien Louillet, Valeria Caso, Chantal Lamy, Elisabeth Medeiros, Yves Samson, Caspar Grond-Ginsbach, Stefan T. Engelter, Vincent Thijs, Simone Beretta, Yannick Béjot, Maria Sessa, Maria Lorenza Muiesan, Philippe Amouyel, Maurizio Castellano, Dominique Arveiler, Turgut Tatlisumak and Jean Dallongeville

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Supplemental material

Supplemental Figure Legends

Supplemental Figure 1: CADISP centers

Supplemental Figure 2: Flow diagram of the participant selection and exclusion process

Supplemental Figure 3: CADISP inclusion criteria
CEAD: Cervical Artery Dissection; IS: Ischemic Stroke; MR: Magnetic Resonance; CT: Computed Tomography; *
Mural hematoma, aneurysmal dilatation, long tapering stenosis, intimal flap, double lumen, or occlusion > 2 cm above the carotid bifurcation revealing an aneurysmal dilatation or a long tapering stenosis after recanalization; †
Mechanical prosthetic valves, mitral stenosis with atrial fibrillation, intracardiac tumor, infectious endocarditis, myocardial infarction < 4 months; ‡ e.g. CADASIL, Fabry disease, MELAS, homocystinuria, sickle cell disease
**Supplemental Table 1:** Comparison of vascular risk factors in CEAD patients versus referents in a multivariable stepwise logistic regression

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>OR (95%CI)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>1.81 (1.33-2.45)</td>
<td>0.0001</td>
</tr>
<tr>
<td>Hypercholesterolemia</td>
<td>0.53 (0.40-0.70)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Obesity</td>
<td>0.35 (0.23-0.53)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Overweight</td>
<td>0.64 (0.49-0.83)</td>
<td>0.0009</td>
</tr>
</tbody>
</table>

BMI: Body Mass Index; CEAD: Cervical Artery Dissection; CI: confidence interval; IS: ischemic stroke; OR: odds ratio; 
*multivariable stepwise logistic regression comparing CEAD patients to referents and including age, gender, country of inclusion, hypertension, diabetes, current smoking, hypercholesterolemia and obesity/overweight as covariates, with age, gender and country of inclusion forced in: only the vascular risk factors retained in the final model are shown in the table (significance levels for entering into and staying in the model were set at 0.10).
### Supplemental Table 2: Association of vascular risk factors with CEAD according to the recruitment type and the age at inclusion

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Prospective CEAD patients (N=232 CEAD patients, N=1170 referents)</th>
<th>Retrospective CEAD patients (N=458 CEAD patients, N=1170 referents)</th>
<th>p heterogeneity§</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR (95% CI) p</td>
<td>OR (95% CI) p</td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>1.50 (1.05-2.14) 0.03</td>
<td>1.70 (1.31-2.22) &lt;0.0001</td>
<td>0.39</td>
</tr>
<tr>
<td>Diabetes</td>
<td>0.95 (0.41-2.16) 0.90</td>
<td>0.35 (0.15-0.84) 0.02</td>
<td>0.17</td>
</tr>
<tr>
<td>Current smoking</td>
<td>1.27 (0.93-1.73) 0.13</td>
<td>1.17 (0.92-1.49) 0.20</td>
<td>0.53</td>
</tr>
<tr>
<td>Hypercholesterolemia†</td>
<td>0.43 (0.28-0.65) &lt;0.0001</td>
<td>0.61 (0.45-0.83) 0.002</td>
<td>0.24</td>
</tr>
<tr>
<td>Obesity</td>
<td>0.49 (0.30-0.81) 0.005</td>
<td>0.31 (0.20-0.48) &lt;0.0001</td>
<td>0.13</td>
</tr>
<tr>
<td>Overweight</td>
<td>0.60 (0.43-0.85) 0.003</td>
<td>0.76 (0.59-0.98) 0.03</td>
<td></td>
</tr>
<tr>
<td>BMI*</td>
<td>0.93 (0.89-0.96) 0.0001</td>
<td>0.92 (0.89-0.95) &lt;0.0001</td>
<td>0.76</td>
</tr>
</tbody>
</table>

*After exclusion of persons aged < 35 (N=562 CEAD patients, N=1112 referents)*

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>OR (95% CI) p</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>1.54 (1.20-1.96) 0.0006</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>0.51 (0.27-0.97) 0.04</td>
<td></td>
</tr>
<tr>
<td>Current smoking</td>
<td>1.20 (0.96-1.51) 0.11</td>
<td></td>
</tr>
<tr>
<td>Hypercholesterolemia†</td>
<td>0.51 (0.38-0.68) &lt;0.0001</td>
<td></td>
</tr>
<tr>
<td>Obesity</td>
<td>0.34 (0.23-0.49) &lt;0.0001</td>
<td></td>
</tr>
<tr>
<td>Overweight</td>
<td>0.73 (0.57-0.92) 0.007</td>
<td></td>
</tr>
<tr>
<td>BMI*</td>
<td>0.92 (0.89-0.95) &lt;0.0001</td>
<td></td>
</tr>
</tbody>
</table>

BMI: Body Mass Index; CEAD: Cervical Artery Dissection; CI: confidence interval; OR: Odds Ratio; *per kg/m² increase; †N=188 prospective CEAD patients, N=327 retrospective CEAD patients, N=419 CEAD patients and 890 referents aged <35 years; multinomial logistic regression for CEAD subgroups vs. all referents adjusted for country of inclusion, age and gender; assessed using logistic regression restricted to CEAD patients with the CEAD characteristic as the outcome variable.
**Supplemental Table 3:** Association of vascular risk factors with cervical artery dissection (CEAD) compared to non-CEAD IS, by country of inclusion

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>France-Belgium</th>
<th>Finland</th>
<th>Italy</th>
<th>p for interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR* (95%CI)</td>
<td>p</td>
<td>OR* (95%CI)</td>
<td>p</td>
</tr>
<tr>
<td>Hypertension</td>
<td>0.49 (0.33-0.73)</td>
<td>0.0004</td>
<td>0.77 (0.49-1.22)</td>
<td>0.26</td>
</tr>
<tr>
<td>Diabetes</td>
<td>0.33 (0.13-0.84)</td>
<td>0.02</td>
<td>0.03 (0.005-0.26)</td>
<td>0.001</td>
</tr>
<tr>
<td>Current smoking</td>
<td>0.30 (0.21-0.42)</td>
<td>&lt;0.0001</td>
<td>0.88 (0.56-1.36)</td>
<td>0.56</td>
</tr>
<tr>
<td>Hypercholesterolemia</td>
<td>0.55 (0.37-0.81)</td>
<td>0.002</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Obesity</td>
<td>0.39 (0.22-0.66)</td>
<td>0.0006</td>
<td>0.28 (0.14-0.58)</td>
<td>0.0005</td>
</tr>
<tr>
<td>Overweight</td>
<td>0.70 (0.48-1.03)</td>
<td>0.07</td>
<td>0.51 (0.32-0.83)</td>
<td>0.006</td>
</tr>
<tr>
<td>BMI, kg/m²</td>
<td>0.93 (0.89-0.97)</td>
<td>0.001</td>
<td>0.92 (0.88-0.97)</td>
<td>0.002</td>
</tr>
</tbody>
</table>

BMI: body mass index; OR: odds ratio; CI: confidence interval; NA: not available; * Multinomial logistic regression comparing CEAD patients to non-CEAD IS patients, adjusted for age and gender and stratified on the country of inclusion.
**Supplemental Table 4**: Comparison of vascular risk factors in CEAD patients who sustained an IS (N=454) versus non-CEAD IS patients

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>OR (95%CI)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>0.51 (0.38-0.69)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Diabetes</td>
<td>0.22 (0.10-0.45)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Current smoker</td>
<td>0.50 (0.39-0.65)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Hypercholesterolemia</td>
<td>0.46 (0.34-0.64)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Obesity</td>
<td>0.35 (0.23-0.56)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Overweight</td>
<td>0.68 (0.51-0.91)</td>
<td>0.008</td>
</tr>
<tr>
<td>BMI, kg/m²</td>
<td>0.93 (0.90-0.96)</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

BMI: Body Mass Index; CEAD: Cervical Artery Dissection; CI: confidence interval; IS: ischemic stroke; OR: odds ratio; *Logistic regression comparing CEAD patients with an IS to non-CEAD IS patients, adjusted for age, gender and country of inclusion.
Supplemental Table 5: Association of vascular risk factors with non-CEAD IS, by country of inclusion

<table>
<thead>
<tr>
<th></th>
<th>France-Belgium</th>
<th>Finland</th>
<th>Italy</th>
<th>p for interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR* (95%CI) p</td>
<td>OR* (95%CI) p</td>
<td>OR* (95%CI) p</td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>2.39 (1.70-3.35) &lt;0.0001</td>
<td>2.68 (1.73-4.15) &lt;0.0001</td>
<td>6.30 (3.48-11.38) &lt;0.0001</td>
<td>0.10</td>
</tr>
<tr>
<td>Diabetes</td>
<td>2.27 (1.15-4.48) 0.02</td>
<td>2.31 (1.18-4.55) 0.01</td>
<td>4.03 (1.32-12.32) 0.01</td>
<td>0.86</td>
</tr>
<tr>
<td>Current smoking</td>
<td>3.01 (2.23-4.07) &lt;0.0001</td>
<td>2.19 (1.44-3.33) 0.0003</td>
<td>2.29 (1.44-3.64) 0.0004</td>
<td>0.30</td>
</tr>
<tr>
<td>Hypercholesterolemia</td>
<td>1.33 (0.96-1.84) 0.08</td>
<td>NA</td>
<td>0.72 (0.46-1.15) 0.17</td>
<td>0.01</td>
</tr>
<tr>
<td>Obesity</td>
<td>1.03 (0.67-1.57) 0.90</td>
<td>1.29 (0.75-2.23) 0.36</td>
<td>0.75 (0.34-1.66) 0.48</td>
<td>0.08</td>
</tr>
<tr>
<td>Overweight</td>
<td>0.98 (0.69-1.37) 0.89</td>
<td>1.85 (1.18-2.89) 0.007</td>
<td>0.89 (0.54-1.46) 0.65</td>
<td>0.08</td>
</tr>
<tr>
<td>BMI, kg/m²</td>
<td>0.98 (0.95-1.02) 0.37</td>
<td>1.03 (0.98-1.07) 0.25</td>
<td>0.98 (0.93-1.04) 0.51</td>
<td>0.15</td>
</tr>
</tbody>
</table>

BMI: body mass index; CEAD: cervical artery dissection; CI: confidence interval; IS: ischemic stroke; NA: not available; OR: odds ratio; * Multinomial logistic regression comparing non-CEAD IS patients to referents, adjusted for age and gender and stratified on the country of inclusion.
**Supplemental Table 6**: Association of vascular risk factors with non-CEAD IS, according to the etiology of IS

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>TOAST = LAA, SVD, or CE (N=321 non-CEAD IS patients)</th>
<th>TOAST = Other determined or undetermined (N=235 non-CEAD IS patients)</th>
<th>p heterogeneity §</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR (95%CI) †</td>
<td>p</td>
<td>OR (95%CI) ‡</td>
</tr>
<tr>
<td>Hypertension</td>
<td>2.95 (2.21-3.95)</td>
<td>&lt;0.0001</td>
<td>Hypertension</td>
</tr>
<tr>
<td>Diabetes</td>
<td>2.39 (1.42-4.01)</td>
<td>0.001</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Current smoker</td>
<td>2.46 (1.90-3.18)</td>
<td>&lt;0.0001</td>
<td>Current smoker</td>
</tr>
<tr>
<td>Hypercholesterolemia</td>
<td>1.19 (0.90-1.57)</td>
<td>0.22</td>
<td>Hypercholesterolemia</td>
</tr>
<tr>
<td>Obesity</td>
<td>1.18 (0.82-1.70)</td>
<td>0.38</td>
<td>Obesity</td>
</tr>
<tr>
<td>Overweight</td>
<td>1.20 (0.90-1.59)</td>
<td>0.21</td>
<td>Overweight</td>
</tr>
<tr>
<td>BMI</td>
<td>1.00 (0.97-1.03)</td>
<td>0.84</td>
<td>BMI</td>
</tr>
</tbody>
</table>

BMI: body mass index; CEAD: cervical artery dissection; CE: cardioembolism; CI: confidence interval; IS: ischemic stroke; LAA: large artery atherosclerosis; OR: odds ratio; SVD: small vessel disease; TOAST: Trial of Org 10172 in Acute Stroke Treatment. †Italian and Finnish participants are not included in these analyses; ‡Italian participants are not included in these analyses; § Multinomial logistic regression comparing non-CEAD IS subgroups to all referents, adjusted for country of inclusion, age and gender; $ assessed using logistic regression analysis restricted to CEAD patients (case-only analysis) with the CEAD characteristic as the outcome variable.
Supplemental Figures

Supplemental Figure 1: CADISP centers
Supplemental Figure 2: Flow diagram of the participant selection and exclusion process

Patients included in the CADISP study, N=1787 (CEAD: N=1118; IS: N=669)

N=37 (CEAD: N=26; non-CEAD IS: N=11) patients were excluded because of non-compliance to inclusion criteria

Patients fulfilling inclusion criteria, N=1750 (CEAD: N=1092; IS: N=658)

N=109 (CEAD: N=109) patients were included only for the CADISP-genetics study, with limited clinical data (London, München [Supplemental Figure 2])

Patients included in the CADISP-clinical study, N=1641 (CEAD: N=983; non-CEAD IS: N=658)
-Argentina: N=16 (CEAD: N=13; non-CEAD IS: N=3)
-Belgium: N=51 (CEAD: N=38; non-CEAD IS: N=13)
-Finland: N=343 (CEAD: N=175; non-CEAD IS: N=168)
-France: N=556 (CEAD: N=315; non-CEAD IS: N=241)
-Germany: N= 227 (CEAD: N=187; non-CEAD IS: N=40)
-Italy: N=296 (CEAD: N=162; non-CEAD IS: N=134)
-Switzerland: N=150 (CEAD: N=91; non-CEAD IS: N=59)
-Turkey: N=2 (CEAD: N=2)

N=395 (CEAD: N=293; non-CEAD IS: N=102) patients were excluded from the present study because age- and sex-matched healthy controls with detailed vascular risk factor data were not available (countries: Germany, Switzerland, Argentina, Turkey)

Patients included in the present study:
N=1246 (CEAD: N=690; non-CEAD IS: N=556)
-Belgium: N=51 (CEAD: N=38; non-CEAD IS: N=13)
-Finland: N=343 (CEAD: N=175; non-CEAD IS: N=168)
-France: N=556 (CEAD: N=315; non-CEAD IS: N=241)
-Italy: N=296 (CEAD: N=162; non-CEAD IS: N=134)
**Supplemental Figure 3: CADISP inclusion criteria**

<table>
<thead>
<tr>
<th>Inclusion criteria</th>
<th>CEAD patients</th>
<th>Non-CEAD IS patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Typical radiological aspect of dissection* in a cervical artery (carotid, vertebral)</td>
<td>Recent ischemic stroke</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No signs of CEAD on ultrasound and angiography (MR or CT or conventional), performed &lt; 7 days after the stroke</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusion criteria</th>
<th>CEAD patients</th>
<th>Non-CEAD IS patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purely intracranial dissection</td>
<td></td>
<td>Possible IS with normal cerebral imaging</td>
</tr>
<tr>
<td>Lateralized dissection after endovascular procedure</td>
<td></td>
<td>CEAD cannot be ruled out (e.g. persistent arterial occlusion without mural hematoma)</td>
</tr>
<tr>
<td>Age &lt;18 years at inclusion</td>
<td></td>
<td>Endovascular or surgical procedure on coronary, cervical or cerebral arteries &lt;48h</td>
</tr>
<tr>
<td>For the genetic study only: monogenic disorder known to cause CEAD (e.g. vascular Ehlers-Danlos syndrome)</td>
<td></td>
<td>Cardiopathies with very high embolic risk †</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Arterial vasospasm after subarachnoid hemorrhage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Auto-immune disease possibly explaining IS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monogenic disease explaining IS ‡</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Age &lt; 18 years at inclusion</td>
</tr>
</tbody>
</table>