BMJ Open Vitamin B\textsubscript{12} deficiency and hyperhomocysteinaemia in outpatients with stroke or transient ischaemic attack: a cohort study at an academic medical centre

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ABSTRACT

Objective We sought to assess the current magnitude of the opportunity for secondary stroke prevention with B vitamins.

Design A cohort study.

Setting The Urgent TIA (Transient Ischaemic Attack) Clinic at an academic medical centre.

Main outcome measures We assessed the prevalence of biochemical vitamin B\textsubscript{12} deficiency (B\textsubscript{12}Def, serum B\textsubscript{12} <156 pmol/L), hyperhomocysteinaemia (HHcy; plasma total homocysteine [tHcy] >14 pmol/L) and metabolic B\textsubscript{12} deficiency (MetB\textsubscript{12}Def, serum B\textsubscript{12} <258 pmol/L and HHcy) between 2002 and 2017, by age group and by stroke subtype.

Results Data were available in 4055 patients. B\textsubscript{12}Def was present in 8.2% of patients overall; it declined from 10.9% of patients referred before 2009 to 5.4% thereafter (p=0.0001). MetB\textsubscript{12}Def was present in 10.6% of patients, and HHcy was present in 19.1% of patients. Among the patients aged \textgreater;80 years, MetB\textsubscript{12}Def was present in 18.1% and HHcy was present in 35%. Among the 3410 patients whose stroke subtype was determined, HHcy was present in 18.4% of patients: 23.3% of large artery atherosclerosis, 18.1% of cardioembolic, 16.3% of small vessel disease, 10.8% of other unusual aetiologies and 13.6% of undetermined subtypes (p=0.0001).

Conclusions Despite a decline in our referral area since 2009, B\textsubscript{12}Def, MetB\textsubscript{12}Def and HHcy remain common in patients with stroke/TIA. Because these conditions are easily treated and have serious consequences, all patients with stroke/TIA should have their serum B\textsubscript{12} and HHcy measured.

INTRODUCTION

There is a commonly held belief that “Homocysteine is dead.” This apparently has its origins in a widely quoted statement made by Dr Kaare Harald Bønaa in September 2005 at the European Society of Cardiology Congress in Stockholm.\textsuperscript{8} Indeed, this very phrase was cited by an official at the National Institute for Health and Care Excellence (NICE) in the UK as the reason that NICE recommends that measurement of plasma total homocysteine (tHcy) not be paid for with public funds (Professor David Smith, personal communication, 15 June 2018).

However, B vitamin therapy for lowering homocysteine to prevent stroke was

Strengths and limitations of this study

- We have data on a large number of patients (4055) referred to the Urgent TIA (Transient Ischaemic attack) Clinic at an academic medical centre, over 15 years, with data on age, sex, serum B\textsubscript{12}, and plasma total homocysteine and creatinine.
- As we could not rigorously exclude patients who were taking B\textsubscript{12} supplements at the time of referral, our findings probably represent an underestimate of the prevalence of hyperhomocysteinaemia and metabolic B\textsubscript{12} deficiency among patients with TIA/stroke, absent supplementation.
- Furthermore, we analysed all patients referred to the Urgent TIA Clinic, so we could not exclude patients with stroke mimics; including them would probably have exaggerated the underestimate.
- However, we have in place a triaging system, whereby the clinic nurse practitioner redirects referrals that seem inappropriate, and we track appropriateness of referrals; our percentage of stroke mimics is <10% of cases.
- Another limitation is that the biochemical methods changed over time, as described in the methods, and different assays may give different results; however, the changes in the reference ranges were small, and the changes in methods did not coincide with the probable increase in B\textsubscript{12} supplementation after 2009.
- Stroke subtype classification was not available in all patients; however, it was available in a substantial number (3410; 84% of cases).
resurrected by the China Stroke Primary Prevention Trial (CSPPT), in which folic acid reduced ischaemic stroke by 24% in primary prevention. In higher risk groups, the reduction of stroke was greater: among patients with low-density lipoprotein cholesterol >2 mmol/L, the reduction in ischaemic stroke was 36%, and in patients with tHcy >15 and low platelet counts it was 70%. Folic acid did not reduce the risk of haemorrhagic stroke. A recent meta-analysis indicated that B vitamin combinations and folic acid reduced the risk of stroke; the authors recommended folic acid for this purpose in countries where folate fortification does not exist.

Restricting the recommendation to folic acid is problematic, as in countries where folate fortification is in place, the main nutritional determinant of tHcy is deficiency of vitamin B₁₂. It has become apparent in the light of the CSPPT trial that in the early trials of B vitamins for stroke prevention, harm from cyanocobalamin among study participants with renal failure obscured the benefit among participants with good renal function. It is likely that instead of cyanocobalamin, we should be using methylcobalamin or oxocobalamin for stroke prevention.

An important opportunity for prevention of stroke and dementia is metabolic B₁₂ deficiency, which is often missed because most physicians do not realise that a serum total B₁₂ in the ‘normal’ range (~180–670 pmol/L) does not define adequacy of functional vitamin B₁₂. It has become apparent in the light of the CSPPT trial that in the early trials of B vitamins for stroke prevention, harm from cyanocobalamin among study participants with renal failure obscured the benefit among participants with good renal function. It is likely that instead of cyanocobalamin, we should be using methylcobalamin or oxocobalamin for stroke prevention.

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In this study, we sought to assess the current magnitude of the opportunity for stroke prevention with B vitamins by determining the prevalence of hyperhomocysteinemia (HHcy) and metabolic B₁₂ deficiency in patients with TIs or minor strokes.

**METHODS**

**Patient population**

Data were obtained from outpatients with TIA or minor stroke referred to the Urgent TIA Clinic at University Hospital in London, Ontario, Canada. Data for 3410 patients referred between 2000 and 2012 were obtained from the database of a study on secular trends in stroke subtypes, data on an additional 1776 patients referred between 2012 and 2017 were obtained from the electronic medical records of the hospital during a 3-month visit by SA, undertaken within a Flexible and Enhanced Learning programme of the University of British Columbia Medical School. Because of the limited time available, data collected on patients referred since 2012 were restricted to age, sex and variables pertinent to the diagnosis of metabolic B₁₂ deficiency and HHcy: serum B₁₂ plasma tHcy and creatinine. Among the 3410 patients referred between 2000 and 2012, stroke subtypes had been assigned using the Subtypes of Ischaemic Stroke Classification System (SPARKLE) classification, which incorporates high carotid plaque burden in the large artery atherosclerosis subtype.

**Blood tests and analyses**

Serum B₁₂, EDTA tHcy and lithium heparin plasma creatinine were measured at the Department of Pathology and Laboratory Medicine of London Health Sciences Centre, London, Ontario, Canada.

Between 2000 and May 2004, serum B₁₂ levels were measured by immunoassay on a Siemens Centaur analyser (reference intervals [RIs]: normal 181–672 pmol/L, indeterminate 155–181 pmol/L, deficient <155 pmol/L). The analysis on this platform continued until January 2014, but in May 2004 the RIs changed to 200–672 pmol/L for normal, 156–200 pmol/L for indeterminate and <156 pmol/L for deficient. Serum B₁₂ was then measured by immunoassay on a Roche e602 with generation I of reagent (RIs: 156–698 pmol/L) until November 2015, and then on Roche e602 and E170 analysers with generation II of reagent (RIs: 145–569 pmol/L) beyond 2017.

Plasma tHcy was measured by high-pressure liquid chromatography (RI: ≤13.5 µmol/L) from 2000 until December 2001. It was then measured by immunoassay on a Siemens Immulite or Immulite 2000 (RI: 5.0–12.0 µmol/L) until May 2011. From May 2011 until February 2014, tHcy was measured by immunoassay on a Siemens Centaur (RI: 3.7–13.9 µmol/L), then using an ELISA from Immuno-Biological Laboratories (RIs: male 4.8–11.8 µmol/L, female 4.3–10.9 µmol/L) until December 2015, and then by immunoassay on an Abbott Architect (RIs: male 5.1–15.4 µmol/L, female 4.4–13.6 µmol/L) beyond 2017.

Plasma creatinine was measured by the Jaffe method on Beckman CX4, CX7 and LX20 analysers from 2000 until November 2008, and then by an enzymatic method on Roche P-Modules beyond 2017. The RIs throughout this entire time were 62–120 µmol/L for male 12 years to adult and 55–100 µmol/L for female 12 years to...
adult. Biochemical $B_{12}$ deficiency was defined as a serum $B_{12} <156 \text{pmol/L}$. Metabolic $B_{12}$ deficiency was defined, as recommended by Stabler et al, by a serum $B_{12} <258 \text{pmol/L}$ and tHcy $>14 \text{µmol/L}$.

Because tHcy is high in patients with renal failure, a second estimate of metabolic $B_{12}$ deficiency excluded patients with an estimated glomerular filtration rate (eGFR) $<60 \text{ml/min per} \ 1.73 \text{m}^2$, computed by the Modification of Diet in Renal Disease (MDRD) equations.17

**Involvement of patients and the public**
There was no involvement of patients other than their data. The public were also not involved.

**Statistical methods**
Continuous variables were summarised by mean±SD and categorical variables by %. Differences in categorical variables were compared using $X^2$; post-hoc differences were assessed by computing standardised residual scores for each cell. Continuous variables were assessed by analysis of variance. All tests were performed using SPSS V.25.

**RESULTS**
Data were available in 4282 patients with values for serum $B_{12}$ and tHcy. There were 218 patients who had unphysiologically high serum $B_{12}$ levels from 700 to 2661 pmol/L, indicating that they were probably taking $B_{12}$ supplements (other possibilities would include laboratory error or errors in data entry): 5.2% of patients before 2009 and 8.1% thereafter ($p=0.0001$). There were also nine patients whose serum $B_{12}$ was impossibly low (between 1 and 31 pmol/L, possibly due to laboratory error or errors in data entry). After excluding these patients there remained 4055 patients whose results are presented here.

A Consolidated Standards of Reporting Trials diagram is shown in online supplementary material. Analyses including the patients with serum $B_{12} >700 \text{pmol/L}$ are presented in online supplementary eTable 1 and eTable 2; online supplementary eFigure 1 shows the distribution of serum $B_{12}$ and tHcy from 2002 to 2017. It is certain from the medication lists in the clinic notes that there were many patients with a serum $B_{12} <700 \text{pmol/L}$ who were also taking $B_{12}$ supplements, but data on $B_{12}$ supplementation were not collected, so those patients were included in the analyses. Folate supplementation of the grain supply was implemented in Canada in 1989, and we know from observation in the clinic that very few patients took folate supplements; a substantial proportion (~20%) do take a multivitamin tablet daily.

Biochemical $B_{12}$ deficiency was present in 8.2% of patients overall; it declined from 10.9% of patients referred before 2009 to 5.4% thereafter ($p=0.0001$). Metabolic $B_{12}$ deficiency was present in 10.6% of patients, and HHcy was present in 19.1% of patients. Among patients aged ≥80 years, metabolic $B_{12}$ deficiency was present in 18.1% and HHcy in 35%. Among the 3410 patients whose stroke subtype was determined, HHcy was present in 18.4% of patients: 23.3% of large artery atherosclerosis, 18.1% of cardioembolic, 16.3% of small vessel disease, 10.8% of other unusual aetiologies and 13.6% of undetermined subtypes ($p=0.0001$).

Figure 1 shows the distribution of serum $B_{12}$ and tHcy from 2002 to 2008 versus 2009–2017. The distributions were significantly different by a Kruskal-Wallis test ($p=0.0001$). Online supplementary data eFigure 1 shows the distribution of serum $B_{12}$ and tHcy in all the cases, including those with serum $B_{12} >700 \text{pmol/L}$.

**Table 1** shows the characteristics of the patients by metabolic $B_{12}$ status. Patients with metabolic $B_{12}$ deficiency were significantly older, male and had smoked more tobacco.

**Table 2** shows the prevalence of tHcy ≥14 and of metabolic $B_{12}$ deficiency by age group.

Both increased significantly with age. At ages 70–80, 23.5% of patients had tHcy ≥14, and at age ≥80 it was 35%. Figure 2 shows the distribution of tHcy and serum $B_{12}$ by age.

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quartiles of eGFR. It is clear that patients with impaired renal function have higher tHcy, so metabolic B₁² deficiency would not be appropriately defined in them by a \( tHcy \geq 14 \). After excluding patients with eGFR <60, metabolic B₁² deficiency was present in 9.2% of patients at ages 70–80, and at age \( \geq 80 \) it was 12.3%. Figure 2 shows the serum B₁² and tHcy by age groups.

Table 3 shows the prevalence of tHcy and metabolic B₁² deficiency by stroke subtypes. Post-hoc tests for differences are shown in online supplementary material.

Both were significantly more prevalent in patients with large artery disease and cardioembolic stroke, and less prevalent in patients with other rare causes or undetermined causes of stroke. Among the 3410 patients whose stroke subtype was determined, HHcy was present in 18.4% of patients; this differed significantly by stroke subtype: 23.3% of large artery atherosclerosis, 16.3% of small vessel disease, 10.8% of other unusual aetiologies and 13.6% of undetermined subtypes (p=0.0001) (figure 3).

Table 4 shows the baseline characteristics by stroke subtype.

DISCUSSION

We found that despite evidence of probable increasing B₁² supplementation in the community, metabolic B₁²...
deficiency and HHcy remain common among patients referred for TIA or minor stroke.

The shift to higher serum $B_{12}$ levels over time is unlikely to be due to reasons other than $B_{12}$ supplementation. The high end of the reference range of 698 pmol/L represents the 95th percentile for all patients, including those who received supplements; plasma levels above 700 pmol/L are unlikely to be physiological, and are therefore probably due to supplementation. Figure 4B shows that the percentage of patients with a serum $B_{12} >700$ pmol/L increased after 2014 from ~5% of patients to 17.5%; this is very unlikely to be due to anything other than supplements. As the principal dietary source of $B_{12}$ is meat, changes to a healthier lifestyle would not account for increases in serum $B_{12}$. It appears therefore that an increase in awareness and treatment of $B_{12}$ deficiency since 2009 in our referral area has resulted in a decline in recent years in the prevalence of metabolic $B_{12}$ deficiency and HHcy among patients referred with stroke or TIA. This is supported by the decline in HHcy since the 2009 report from this clinic population (from 40% of patients aged >80 to 35%) and the decline in the prevalence of HHcy since the 2006 report (from 30% of patients aged ≥71 to 15.9% aged ≥80). Nevertheless, $B_{12}$ deficiency and HHcy remain common in this patient population.

Including some patients who probably received $B_{12}$ supplementation in the analyses probably resulted in an underestimate of the prevalence of metabolic $B_{12}$ deficiency and HHcy that would be observed among patients with stroke/TIA, absent supplementation.

HHcy and low eGFR were more common in patients with large artery disease, who were older than patients with other stroke subtypes. Plasma tHcy has previously been reported to be associated with carotid total plaque area. Renal function declines with age, and tHcy levels increase with age.

We found that despite probable increases in $B_{12}$ supplementation in our community, HHcy and metabolic deficiency are still common in patients with stroke, particularly in older patients. These findings are important on several counts. As discussed above, B vitamins to lower tHcy reduce the risk of stroke. Besides increasing the risk of stroke by raising tHcy, $B_{12}$ deficiency also causes neuropathy, myelopathy and dementia. Cognitive decline is common in patients with stroke, and treating $B_{12}$ deficiency and HHcy can prevent dementia. In a recent meta-analysis, patients with higher blood levels of $B_{12}$, $B_6$ and folate had a reduced risk of developing atrial fibrillation, a known risk factor for cardioembolic strokes. Falls in the elderly, an important cause of disability, are probably also increased by loss of position sense with $B_{12}$ deficiency.

### Table 3 Stroke subtypes, hyperhomocysteinaemia and metabolic $B_{12}$ deficiency, n (%)

<table>
<thead>
<tr>
<th>Stroke subtype</th>
<th>tHcy &gt;14*</th>
<th>Cardioembolic</th>
<th>Other rare or unusual aetiologies</th>
<th>Undetermined</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large artery disease</td>
<td>256 (23.3)†</td>
<td>238 (18.1)</td>
<td>57 (16.3)</td>
<td>21 (10.8)†</td>
<td>72 (13.6)†</td>
</tr>
<tr>
<td>Biochemical $B_{12}$ deficiency‡</td>
<td>111 (10.1)</td>
<td>104 (7.9)</td>
<td>28 (8.5)</td>
<td>23 (11.3)</td>
<td>45 (8.5)</td>
</tr>
<tr>
<td>Metabolic $B_{12}$ deficiency§</td>
<td>139 (12.7)†</td>
<td>121 (9.2)</td>
<td>31 (8.8)</td>
<td>11 (5.4)†</td>
<td>44 (8.1)</td>
</tr>
<tr>
<td>Metabolic $B_{12}$ deficiency 2¶</td>
<td>49 (10.9)</td>
<td>48 (6.8)</td>
<td>11 (6.2)</td>
<td>4 (4.3)</td>
<td>15 (5.2)†</td>
</tr>
</tbody>
</table>

* tHcy, plasma total homocysteine µmol/L.
†Statistically significant difference from other categories in post-hoc testing.
‡Serum $B_{12} <156$ pmol/L.
§Serum $B_{12} <258$ and pmol/L and tHcy >14 µmol/L.
¶Excluding patients with estimated glomerular filtration rate <60.


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**Figure 2** Plasma total homocysteine (tHcy) and serum $B_{12}$ by quartiles of estimated glomerular filtration rate (eGFR). (A) tHcy was clearly elevated with impaired renal function. (B) Serum $B_{12}$ was not significantly affected by renal impairment.
It also seems likely that patients in other regions and patients with more severe strokes may have a greater prevalence of both these conditions. In the Newcastle 85+ study, the lowest quartile of plasma B12 was <170 pmol/L, with tHcy 19.9 (95% CI 16.3 to 24.6); that is, 25% of UK patients whose age in 2006 was 85 years had metabolic B12 deficiency. B12 deficiency is very common in India, in part because of a high prevalence of vegetarianism. Even in adolescents, B12 deficiency was reported in 32% of study participants in the Haryana region.24 In Pakistan 58.3% of patients with ischaemic stroke were reported to have HHcy defined as tHcy >15 µmol/L 25; in China the prevalence of tHcy >30 µmol/L among patients with hypertension was 16.7%.26 It would therefore be important to assess the prevalence of HHcy and metabolic B12 deficiency in other stroke populations. It would also be very important to assess serum B12 and tHcy in patients with cognitive impairment.20 27 28

CONCLUSION
Despite a probable increase in B12 supplementation in our referral area in recent years, metabolic B12 deficiency and

Figure 3  Plasma tHcy by age group and frequency of hyperhomocysteinaemia by stroke subtype. (A) tHcy clearly increases with age (ANOVA p=0.0001). (B) Stroke subtypes are shown for patients referred between 2002 and 2012; hyperhomocysteinaemia differed significantly by stroke subtype ($\chi^2$=0.0001). ANOVA, analysis of variance; CE, cardioembolic; LAA, large artery atherosclerosis; Other, other unusual aetiologies; SVD, small vessel disease; tHcy, total homocysteine; UE, undetermined aetiology.

<table>
<thead>
<tr>
<th>Table 4</th>
<th>Baseline characteristics by stroke subtype for cases with serum B12 &lt;700 pmol/L</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Large artery</strong></td>
<td>Cardioembolic</td>
</tr>
<tr>
<td><strong>Continuous variables, mean±SD (ANOVA)</strong></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>70.08±10.93</td>
</tr>
<tr>
<td>Systolic pressure (mm Hg)</td>
<td>143.82±20.81</td>
</tr>
<tr>
<td>Diastolic pressure (mm Hg)</td>
<td>80.26±12.44</td>
</tr>
<tr>
<td>Total cholesterol (mmol/L)</td>
<td>4.71±1.21</td>
</tr>
<tr>
<td>Triglycerides (mmol/L)</td>
<td>1.94±1.30</td>
</tr>
<tr>
<td>HDL cholesterol (mmol/L)</td>
<td>1.28±0.40</td>
</tr>
<tr>
<td>LDL cholesterol (mmol/L)</td>
<td>2.60±1.04</td>
</tr>
<tr>
<td>Smoking (pack-years)</td>
<td>25.29±23.34</td>
</tr>
<tr>
<td>Serum B12 (pmol/L)</td>
<td>298.44±129.85</td>
</tr>
<tr>
<td>tHcy (µmol/L)</td>
<td>11.96±5.34</td>
</tr>
<tr>
<td>Plasma creatinine (µ mol/L)</td>
<td>94.29±32.21</td>
</tr>
<tr>
<td>eGFR</td>
<td>68.04±20.77</td>
</tr>
<tr>
<td>Categorical value, n (%)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>668 (62.2)*</td>
</tr>
</tbody>
</table>

Post-hoc testing for continuous variables is shown in online supplementary material.
*Statistically significant difference from other categories in post-hoc testing.
ANOVA, analysis of variance; eGFR, estimated glomerular filtration rate; HDL, high-density lipoprotein; LDL, low-density lipoprotein; tHcy, plasma total homocysteine.
HHcy remain common in patients with TIA or stroke. As these conditions have serious consequences and are easily treated, serum B12 and tHcy should be measured in all patients with ischaemic stroke.

Figure 4 Serum B12 by year of referral and per cent of patients with serum B12 >700 pmol/L at the time of referral. (A) Serum B12 levels increased among patients referred to our clinic after the 2009 report of a high prevalence of hyperhomocysteinemia in our patients. Before 2009 the mean serum B12 (SD) was 326.62 (214.68); thereafter it was 374.90 (234.29) (p=0.0001). (B) The per cent of patients with serum B12 >700 pmol/L increased markedly in recent years, indicating probable B12 supplementation.

REFERENCES