Dear Editor

We made necessary changes according to your advice.

We will be very happy if you consider our manuscript for publication şn your journal.

Yours Sincerely

Dr. Devran Suer

***Comment 1-*** some corrections of language has been made on the text.

***Answer 1-*** some corrections of language has also be made.

***Comment 2-*** Your conclusion is not about usage of uricosuric drugs. Your conclusion is the relationship you found between high serum UA levels and LACI and PACI. You can only make a comment about drugs after stating the result of your study.

***Answer 2-*** We made necessary corrections and we highlighted the sentences in yellow colour in the text.

Future research with larger groups should focus on whether uric acid- lowering drugs have any beneficial effects on acute stroke and AF.’ was changed as ‘In our study, it was found that high SUA levels were related to LACI and PACI, respectively. Further studies with larger groups are needed.’ in the conclusion section of English Abstract.

‘Ürik asit düşürücü ilaçların akut inme ve AF üzerinde herhangi bir yararlı etkiye sahip olup olmadığı ile ilgili olarak daha büyük gruplar üzerinde yapılacak ileri çalışmalara ihtiyaç vardır.’ was changed as ‘**:** Çalışmamızda yüksek SUA düzeylerinin sırasıyla LACI ve PACI ile ilişkili olduğu saptanmış olup, daha büyük gruplarla yapılacak ileri çalışmalara ihtiyaç vardır.’ in the conclusion section of Turkish Abstract.

***Comment 3-*** Is the relationship between AF and extracranial atherosclerosis found in anterior or posterior circulation? You have contradictory statements in the abstract and text ,which must be corrected.

***Answer 3-*** ‘There was no statistically significant difference between serum uric acid levels and AF; no statistically significant correlation was found between AF and atherosclerotic intracranial~~-~~extracranial artery stenosis.’ was changed as “There was no statistically significant difference between serum uric acid levels and AF; no statistically significant correlation was found between AF and atherosclerotic intracranial artery stenosis. We only found a correlation between AF and extracranial atherosclerosis of the anterior circulation as contour irregularity and moderate stenosis (*p*=0.05)” in the 6th paragraph of discussion section.

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**Atherosclerosis and Serum Uric Acid Level Association in Acute Stroke**

Akut İnmede Ateroskleroz ile Serum Ürik Asit Düzeyi Arasındaki İlişki

**ABSTRACT**

**Objective:** We aimed to identify whether high uric acid levels were associated with atherosclerotic intracranial/extracranial arterial stenosis and atrial fibrillation (AF) and to determine if serum uric acid (SUA) levels were an independent risk factor.

**Methods:** One hundred seventy-four patients who presented with acute stroke within 24 hours of onset and were admitted to our hospital between December 2016 and September 2017 were included in the study. Bamford classification was used for Stroke classification. The degree of vascular stenosis was classified as lumen contour irregularity, mild, moderate and severe stenosis using the The North American Symptomatic Carotid Endarterectomy Trial (NASCET) criteria.

**Results:** The average age of 174 patients was 69 ± 12.7 years. Elevated serum uric acid levels were found in 66 patients. The mean SUA level was 7.33±1.02 mg/dL in these patients. Thirty-six patients were examined with AF and 14 of these patients had high SUA levels. It was found that high SUA levels were mostly related with lacunar infarct (LACI) and partial anterior circulation infarct (PACI), respectively. High SUA levels were seen more commonly in the anterior circulation, especially in the extracranial part of the carotid artery, but this was not statistically significant (*p*>0.05). We found a statistically significant relation between high SUA levels in moderate and severe stenosis of the extracranial portion of the posterior circulation in women (*p*=0.01). There was a relationship between atrial fibrillation and extracranial atherosclerosis of the anterior circulation as contour irregularity and moderate stenosis (*p*=0.05).

**Conclusions:** In our study, it was found that high SUA levels were related to LACI and PACI, respectively. Further studies with larger groups are needed.

**Keywords:** Stroke, Uric acid, Intracranial, Extracranial, Atherosclerosis, Atrial Fibrillation

**ÖZET**

**Amaç:** Bu çalışmada amacımız, serum ürik asit düzeyleri ile aterosklerotik intrakranial/ekstrakranial arteriyel skleroz ve atriyal fibrilasyon (AF) arasındaki ilişkiyi belirlemek ve yüksek serum ürik asit (SUA) düzeyinin bağımsız bir risk faktörü olup olmadığını saptamaktır.

**Yöntem:** Çalışmaya, Aralık 2016 ve Kasım 2017 tarihleri arasında hastanemize akut inmenin ilk 24 saati içerisinde gelen 174  hasta dahil edildi. İnme sınıflandırması için Bamford sınıflandırması kullanıldı. Vaskuler stenozun derecesi,  Kuzey Amerika Semptomatik Karotis Endarterektomi Çalışma kriterleri (NASCET)  kullanılarak, lümen kontur düzensizliği, hafif, orta ve ağır olarak sınıflandırıldı.

**Bulgular:** Çalışmaya alınan 174 hastanın yaş ortalaması 69 ± 12.7 idi. Serum ürik asit düzeyi 66 hastada yüksek bulundu. Bu hastalarda ortalama serum ürik asit seviyesi 7.33 ± 1.02 mg / dL idi. AF 36 hastada belirlendi ve bu hastaların 14'ünde yüksek SUA düzeyleri vardı. Yüksek SUA düzeylerinin daha çok sırasıyla laküner infarkt (LACI) ve parsiyel anterior sirkülasyon infarktı (PACI) ile ilişkili olduğu bulundu. Yüksek SUA düzeyleri anterior dolaşımda, özellikle karotis arterin ekstrakranyal kısmında daha sık görüldü, ancak bu istatistiksel olarak anlamlı değildi (*p*> 0.05). Kadınlarda posterior dolaşımın ekstrakraniyal kısmında orta ve ciddi derecede darlık ile yüksek SUA düzeyleri arasında istatistiksel olarak anlamlı bir ilişki bulundu (*p* = 0.01). Anterior dolaşımın ekstrakranial kısmında kontur düzensizliği ve orta derecede darlık ile atrial fibrilasyon arasında anlamlı bir ilişki saptandı (*p* = 0.05).

**Sonuç:** Çalışmamızda yüksek SUA düzeylerinin sırasıyla LACI ve PACI ile ilişkili olduğu saptanmış olup, daha büyük gruplarla yapılacak ileri çalışmalara ihtiyaç vardır.

**Anahtar kelimeler:** İnme, Ürik asit, Intrakranial, Ekstrakranial, Ateroskleroz, Atrial Fibrilasyon

**INTRODUCTION**

Stroke is the second most common cause of death globally (1). Stroke has various etiologic factors, and recently uric acid was also listed among these factors (1,2). Uric acid is the final enzyme product of purine metabolism, which appears as a result of nuclear material catabolism. Pathologically high uric acid levels are found to be associated with gout, renal stones, hypertension (HT), visceral obesity, insulin resistance, dyslipidemia, cardiovascular, and cerebrovascular diseases (3-5). Our aim in this study was to investigate whether high uric acid levels were an independent risk factor in atherosclerotic intracranial and extracranial artery stenosis, and to determine if there was any relation with a history of atrial fibrillation (AF).

**METHODS**

One hundred seventy-four patients who were admitted to Marmara University Pendik Training and Research Hospital within the first 24 hours of acute stroke onset between December 2016 and September 2017 were included in this prospective study. The study was approved by the ethics committee of the coordinating center (No: 83045809/604/02-12333). Blood uric acid levels were measured using standard laboratory techniques. Neuroimaging of each patient was performed using diffusion magnetic resonance imaging (MRI), and cranial and cervical MR angiography (MRA).

Uric acid levels were considered high if ≥ 6.9 mg/dL in males and ≥5.9 mg/dL in females. Patients with bleeding diathesis, gout, polycythemia, chronic renal failure, current uric acid level-lowering drug use, malignancies, and liver disease were excluded from the study. The degree of vascular stenosis was classified as lumen contour irregularity, mild, moderate and severe stenosis using the North American Symptomatic Carotid Endarterectomy Trial (NASCET) criteria. Blood samples of patients were examined in the first 48 hours of acute stroke onset. All analyses of serum were studied in the Central Biochemistry Laboratory of Marmara University Pendik Training and Research Hospital using a Roche Diagnostics Cobas 8000 C 701 series auto-analyzer with spectrophotometry, and the serum uric acid levels are presented as mg/dL.

*Statistical analysis*

Statistical tests were performed by using the IBM SPSS Statistics Version 17 software. Statistical comparisons between the groups were performed using descriptive methods, the Chi-square test, and T-test. Pearson’s correlation coefficient was used to measure the degree of linear relationship between quantitative variables. The statistical significance level was accepted as *p*<0.05.

**RESULTS**

This study was performed in Marmara University Pendik Training and Research Hospital. A number of total 315 patients were included. One-hundred forty one patients were excluded from the study because they did not meet the criteria. The mean age of 174 patients was 69 ± 12.7 (minimum-maximum: 33-94). Seventy (40%) of the patients were female and 104 (60%) were male. Sixty-six (38%) patients have elevated serum uric acid levels. The mean SUA level of these patients was 7.33±1.02 mg/dL. Thirty-six patients have AF and 14 of these patients (39 %) had high SUA levels.

An evaluation of co-morbid disease among the patients revealed that 71.8% of the patients had hypertension (HT), 37.9% had diabetes mellitus (DM), 64.4% of had hyperlipidemia, 20.6% had AF, and 20.11% had coronary artery disease (CAD). No significant relationship was found between serum uric acid levels and stroke risk factors (*p*>0.05).

Anterior/posterior system circulation and intracranial-extracranial atherosclerosis in patients with high uric acid levels were demonstrated in Table 1. Elevated SUA levels were mostly related with lacunar infarct (LACI) and partial anterior circulation infarct (PACI), respectively (Table 2). High SUA levels were seen more commonly in the anterior circulation, especially in the extracranial part of the carotid artery, but this was not statistically significant (*p*>0.05) (Table 3). We found a statistically significant relation between high SUA levels in moderate and severe stenosis of the extracranial portion of the posterior circulation in women (*p*=0.01) (Table 4). There was a relationship between atrial fibrillation and extracranial atherosclerosis of the anterior circulation as contour irregularity and moderate stenosis (*p*=0.05) (Table 5). No significant relationship between serum uric acid level and AF was found (Table 6).

**Table 1:** The numeric demonstration of anterior/ posterior system circulation and intracranial- extracranial atherosclerosis in patients with elevated serum uric acid levels

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Contour irregularity | Minimal  stenosis | Moderate  stenosis | Severe  stenosis |
| Anterior system intracranial atherosclerosis | 4 | 3 | 10 | 21 |
| Elevated serum uric acid level | 0 | 2 | 1 | 5 |
| Anterior system extracranial atherosclerosis | 80 | 14 | 25 | 33 |
| Elevated serum uric acid level | 31 | 2 | 6 | 9 |
| Posterior system intracranial atherosclerosis | 5 | 1 | 4 | 17 |
| Elevated serum uric acid level | 0 | 0 | 0 | 4 |
| Posterior system extracranial atherosclerosis | 11 | 3 | 4 | 16 |
| Elevated serum uric acid level | 3 | 0 | 0 | 3 |

The first line shows the number of patients with several degrees of atherosclerosis, the second line shows the number of patients with high uric acid levels.

**Table 2:** Serum uric acid levels and lesion localization association

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  | |  |  |  |
| Lesion localization | Mean ± SD  (Min-Max) | | Normal  n | Abnormal  n | % | *p* |
| TACI1 | 4.77±1.38  2.70±7.70 | | 10 | 2 | 16.7 | 0.06\* |
| PACI2 | 5.50±1.74  (2.30-10.7) | | 46 | 16 | 42 |
| POCI3 | 5.34±1.44  (2.70-9.00) | | 30 | 8 | 25.8 |
| LACI4 | 6.00±1.80  (0.80-9.40) | | 23 | 20 | 46.5 |

1TACI: Total anterior circulation infarct; 2PACI: Partial anterior circulation infarct; 3POCI: Posterior circulation infarct; 4LACI: Lacunary circulation infarct \* Chi-square test

**Table 3:** Uric acid levels related to sex in the anterior circulation

|  |  |  |  |
| --- | --- | --- | --- |
|  | Anterior circulation | Female | Male |
|  |  | *p* | *p* |
| Extracranial | Contour Irregularity | 0.67 | 0.93 |
| Mild Stenosis | 0.94 | 0.35 |
| Moderate Stenosis | 0.77 | 0.19 |
| Severe Stenosis | 0.28 | 0.88 |
| Total | 0.88 | 0.51 |
| Intracranial | Contour Irregularity | 0.84 | 0.88 |
| Mild Stenosis | 0.60 | 0.21 |
| Moderate Stenosis | 0.12 | 0.82 |
| Severe Stenosis | 0.76 | 0.24 |
| Total | 0.13 | 0.49 |

\*T-test

**Table 4:** Uric acid levels related to sex in the posterior circulation

|  |  |  |  |
| --- | --- | --- | --- |
|  | Posterior circulation | Female | Male |
|  |  | *p* | *p* |
| Extracranial | Contour Irregularity | 0.54 | 0.90 |
| Mild Stenosis | 0.54 | 0.35 |
| Moderate Stenosis | 0.01\* | 0.27 |
| Severe Stenosis | 0.01\* | 0.07 |
| Total | 0.01\* | 0.05 |
| Intracranial | Contour Irregularity | 0.21 | 0.99 |
| Mild Stenosis | 0.01\* | 0.26 |
| Moderate Stenosis | 0.34 | 0.89 |
| Severe Stenosis | 0.96 | 0.98 |
| Total | 0.67 | 0.95 |

\*T-test

**Table 5:** The relationship between atrial fibrillation and intracranial-extracranial atherosclerosis in anterior/posterior circulation

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | Posterior | Anterior |
|  |  | ***p*** | ***p*** |
| Intracranial | Contour Irregularity | 0.58 | 0.57 |
| Mild Stenosis | 0.99 | 0.82 |
| Moderate Stenosis | 0.57 | 0.69 |
| Severe Stenosis | 0.37 | 0.96 |
| Total | 0.26 | 0.48 |
|  |  | 0.37\* | |
| Extracranial | Contour Irregularity | 0.46 | 0.05\* |
| Mild Stenosis | 0.99 | 0.76 |
| Moderate Stenosis | 0.87 | 0.05\* |
| Severe Stenosis | 0.75 | 0.15 |
| Total | 0.60 | 0.95 |
|  |  | 0.64\* | |

\*T-test

**Table 6:** Evaluation of serum uric acid levels with atrial fibrillation

|  |  |  |  |
| --- | --- | --- | --- |
|  | Normal | Abnormal | *p* |
| Atrial fibrillation (+) | 22 | 14 | 0.84 |
| Atrial fibrillation(-) | 86 | 52 |

\* Chi-square test

**DISCUSSION**

Stroke is the most common neurologic disease and the second most common cause of death (1). Stroke has various etiologic factors such as, age, sex, HT, hyperlipidemia, DM, and AF, and recently uric acid was listed among these factors (2). Detecting risk factors is an important therapeutic strategy in the management of ischemic stroke.

An association between SUA levels and outcomes of ischemic stroke has been reported, but the results are controversial. Previous studies have shown that SUA levels are significantly correlated with cardiovascular and cerebrovascular diseases (6). The mechanisms through which uric acid induces cardiovascular and renal dysfunction as well as stroke have been documented in animal models and in vitro studies (7,8). Tissue hypoxia can induce purine catabolism, which then increases the production of SUA. This process contributes to the formation of reactive oxygen stress. Indeed, accumulating evidence supports a direct pathophysiologic role of uric acid in processing atherosclerosis because elevated SUA metabolism produces reactive oxygen species, which induce inflammatory responses in vascular endothelial cells and indirectly stimulate macrophage infiltration in atherosclerotic vessels (9). Furthermore, hyperuricemia promotes platelet adhesiveness and damage to vascular smooth muscle cell and endothelia, contributing to the pathology of cerebrovascular events (10). Our aim in this study was to investigate the effect of high uric acid levels on atherosclerotic intracranial/extracranial artery stenosis and AF, and to determine whether high serum uric acid levels were an independent risk factor in acute ischemic stroke.

Weir et al. found an association between poor prognosis and moderate-severe disability and hyperuricemia in their study conducted on 2498 patients with acute stroke who were evaluated within the first 24 hours after stroke and the 90th day of stroke. In addition, hyperuricemia was found to be a risk factor for developing major vascular events in the same study (11). Neogi et al. found a significant relationship between higher serum uric acid levels and carotid atherosclerotic plaques in males. In that study, the authors also suggested that hyperuricemia accelerated the pro-inflammatory process, existed in large amount within the vascular atherosclerotic plaques, and induced pro-inflammatory processes in smooth muscle cells (12-15). In recent experimental studies, hyperuricemia was found to induce endothelial dysfunction and increase local oxidant formation, monocyte chemoattractant protein-1, interleukin (IL)-1-beta, IL-6, and systemic inflammatory mediators such as tumor necrosis factor (TNF)-alpha in the blood circulation (16-21). In our study, high SUA levels were found in atherosclerosis of the extracranial portion of the anterior circulation. Patients with higher uric acid levels had severe stenosis both in the anterior and posterior circulation.

In a study conducted in 237 patients in 2013, serum uric acid levels were found to be high in all types of stroke, but were the highest in the PACI group (22). In our study, SUA levels were highest in the LACI and PACI groups, respectively.

The relationship between serum uric acid and the effect of sex after acute ischemic stroke has yet to be explored. The biologic mechanisms underlying such sex specificity remains unclear. It is known that there is a sex difference in uric acid levels; women usually have lower uric acid levels than men (23). Several previous studies demonstrated that higher uric acid levels were significantly related with the development of HT and metabolic syndrome in women than in men. In the China Antihypertensive Trail in Acute Ischemic Stroke (CATIS) trial, Chen et al. found that elevated serum UA was positively associated with better prognosis in men, but not in women (24-26). In our study we found a relation between high uric acid levels in moderate and severe stenosis of the extracranial portion of the posterior circulation in women.

Tamariz et al. examined the relationship between SUA levels with AF in the Atherosclerosis Risk in Communities Study (ARIC) study, the hypothesis was that high SUA levels would be indicative of AF (27). Animal studies have also shown that atrial electrical remodeling is enabled with oxidative stress (28,29). The hypothesis of the Kuwabara et al. was that hyperuricemia induced the electrical remodeling process by affecting ion channel expression in atrial myocytes, and the authors thus examined whether it caused AF. In their study, uric acid levels above 8 mg/dL were shown to be independent predictors of AF. In the study group, the prevalence of AF was significantly lower in individuals using uric acid-lowering agents (30). In our study, AF was detected in 36 of 174 patients and elevation of uric acid was observed in 14 of these patients. There was no statistically significant difference between serum uric acid levels and AF; no statistically significant correlation was found between AF and atherosclerotic intracranial artery stenosis. We only found a correlation between AF and extracranial atherosclerosis of the anterior circulation as contour irregularity and moderate stenosis (*p*=0.05).

The current literature does not support the treatment of asymptomatic hyperuricemia, even among subjects at high cardiovascular risk. The usefulness of reducing SUA with xanthine oxidase inhibitors in the setting of ischemic stroke and other acute illnesses still requires further evaluation with appropriately designed randomized controlled trials (31).

Our study is one of the few studies that is mostly based on SUA levels and intracranial-extracranial arteriostenosis location. As a conclusion, in the present study, we found that LACI and PACI were the most frequent lesion locations for patients with high uric acid levels. According to our results, female patients have elevated uric acid levels in moderate and severe stenosis of extracranial portion of posterior circulation. So it has to be taken in consideration for woman with extracranial posterior circulation stenosis who has a high serum uric acid level.

The limitation of our study is the small number of patients. It is possible that a significant relationship between high uric acid levels and atherosclerotic intracranial- extracranial artery stenosis and AF could have been shown with larger groups.

**Conflict of interest**

No conflict of interest was declared by the authors.

**REFERENCES**

1. Chin JH, Vora N. The global burden of neurologic diseases. Neurology 2014; 22; 83(4):349–351.
2. Iranmanesh F, Sheykholeslami NZ, Gadari F, Ahmady J. Acute ischemic non- embolic stroke and serum level of uric acid. Iran J Neurol. 2012;11(1):1-5.
3. Sautin Y, Johnson R. Uric acid: The oxidant-antioxidant paradox. Nucleosides Nucleotides Nucleic Acids. 2008; 27 (6):608-619.
4. So A, Thorens B. Uric acid transport and disease. J Clin Invest. 2010;120:1791-9.
5. J Lin SD, Tsai DH, Hsu SR. Association between serum uric acid level and components of the metabolic syndrome. Chin Med Assoc. 2006;69:512-6.
6. Yang XL, Kim Y, Kim TJ, Jung S, Kim CK, Lee SH. Association of serum uric acid and cardioembolic stroke in patients with acute ischemic stroke. J Neurol Sci. 2016; 370:57–62.
7. Nakagawa T, Hu H, Zharikov S, Tuttle KR, Short RA, Glushakova O, et al. A causal role for uric acid in fructose- induced metabolic syndrome. Am J Physiol Renal Physiol. 2006;290:F625-31.
8. Mazzali M, Hughes J, Kim YG, Jefferson JA, Kang DH, Gordon KL, et al. Elevated uric acid increases blood pressure in the rat by a novel crystal-independent mechanism. Hypertension. 2001;38:1101-6.
9. Dimitroula HV, Hatzitolios AI, Karvounis HI. The role of uric acid in stroke: the issue remains unresolved. Neurologist. 2008;14:238–242.
10. Ginsberg MH, Kozin F, O'Malley M, McCarty DJ. Release of platelet constituents by monosodium urate crystals. J Clin Invest. 1977;60:999-1007.
11. Weir CJ, Muir SW, Walters MR, Lees KR. Serum urate as an independent predictor of poor outcome and future vascular events after acute stroke. Stroke. 2003;34:1951-6.
12. Neogi T, Ellison RC, Hunt S, Terkeltaub R, Felson DT, Zhang Y. Serum uric acid is associated with carotid plaques: The National Heart, Lung, and Blood Institute Family Heart Study. J Rheumatol. 2009; 36:378-384.
13. Tavil Y, Kaya MG, Oktar SO, Sen N, Okyay K, Yazici HU, et al. Uric acid level and its association with carotid intima-media thickness in patients with hypertension. Atherosclerosis 2008;197: 159-63.
14. Kawamoto R, Tomita H, Oka Y, Kodama A, Ohtsuka N, Kamitani A. Association between uric acid and carotid athherosclerosis in elderly persons. Intern Med 2005;44:787-93.
15. Iribarren C, Folsom AR, Eckfeldt JH, McGovern PJ, Nieto FJ. Correlates of uric acid and its association with asymptomatic carotid atherosclerosis: the ARIC Study. Atherosclerosis Risk in Communities. Ann Epidemiol. 1996;6:331-40.
16. Kim SY, Guevara JP, Kim KM, Choi HK, Heitjan DF, Albert DA. Hyperuricemia and risk of stroke: A systematic Review and meta-analysis. Arthritis Rheum. 2009;15;61:885-92.
17. Kang DH, Nakagawa T, Feng L, Watanabe S, Han L, Mazzali M, et al. A role for uric in the progressions of renal disease. J Am Soc Nephrol.2002 ;13 : 2888-2897
18. Johnson RJ, Kang DH, Feig D, Kivlighn S, Kanellis S, Watanabe S, et al. Is there a pathogenetic role for uric acid in hypertension and cardiovascular and renal disease? Hypertension. 2003;41:1183-1189
19. Kanellis J, Feig D, Johnson R. Does asymptomatic hyperuricaemia contribute to the development of renal and cardiovascular disease? An old controversy renewed. Nephrology (Carlton). 2004;9:394-399.
20. Kang D, Han L, Ouyang X, Kahn AM, Kanellis J, Li P, et al·. Uric acid causes vascular smooth muscle cell proliferation by entering cells via a functional urate transporter. Am J Nephrol. 2005;25:425-433.
21. Rao G, Corson M, Berk M. Uric acid stimulates vascular smooth cell proliferation by increasing platelet-derived growth factor A-chain expression. J Bio Chem. 1991;266:8604-8608.
22. Kamisli O, Gonullu S, Kamisli S, Kaplan Y, Ozcan A. The evaluation of serum uric acid levels in the ischemic stroke subtypes. Turkish Journal of Cerebrovascular Disease. 2013;19:7-10.
23. Chen LH, Zhong C, Xu T, Xu T, Peng Y, Wang A, et al. Sex-specific association between uric acid and outcomes after acute ischemic stroke: A Prospective Study from CATIS Trial. Nature. Scientific Reports. 2016; 6: 3835.
24. Kivity S, Kopel E, Maor E, Abu-Bachar F, Segev S, Sidi Y, et al. Association of serum uric acid and cardiovascular disease in healthy adults. Am J Cardiol 2013;111: 1146–51.
25. Zhang, W, Sun K, Yang Y, Zhang H, Hu FB, Hui R. Plasma uric acid and hypertension in a Chinese community: prospective study and metaanalysis. Clin Chem. 2009; 55:2026–34.
26. Babio N, Martinez-Gonzalez MA, Estruch R, Warnberg J, Recondo J, Ortega-Calvo M, et al. Associations between serum uric acid concentrations and metabolic syndrome and its components in the PREDIMED study. Nutr Metab Cardiovasc Di. 2014; 25:173–80.
27. Tamariz L, Agarwal S, Soliman EZ, Chamberlain AM, Prineas R, Folsom AR, et al. Association of serum uric acid with incident atrial fibrillation. J Am Cardiol.2011; 108(9):1272-1276.
28. Carness CA, Chung MK, Nakayama T, Nakayama H, Baliga RS, Piao S, et al. Ascorbate attenuates atrial pacing-induced peroxinitrite formation and electrical remodeling and decreases the incidence of postopreative atrical fibrillation. Circ Res.2001;89:E 32-8D.
29. Korantzopoulos P, Kolettis TM, Galaris D, Goudevenos JA. The role of oxidative stress in the pathogenesis and perpetuation of atrial fibrillation. Int J Cardiol. 2007;115:135-143.
30. Kuwabara M, Niwa K, Niinuma H. Hyperuricemia is an independent risk factor of atrial fibrillation due to electrical remodeling through activation of uric acid transporter. Arrhythmias: 2013; Volume 59, Issue 13.
31. Pasina L, Brucato AL, Djade CD, Di Corato P, Ghidoni S, Tetramanti M, et al. Inappropriate prescription of allopurinol and febuxostat and risk of adverse events in the elderly: results from the REPOSI registry. Eur J Clin Pharmacol 2014;70:1495-503.