

The role of Weather Conditions and Normal Level of air Pollution in Appearance of Stroke in the Region of Southeast Europe

Knezović, Marijana; Pintarić, Sanja; Jelavić, Mornar Marko; Bašić Kes, Vanja; Neseck, Višnja; Bogović, Siniša; Cvetković, Bruno; Pintarić, Hrvoje

Source / Izvornik: **Acta Neurologica Belgica, 2018, 118, 267 - 275**

Journal article, Published version

Rad u časopisu, Objavljena verzija rada (izdavačev PDF)

<https://doi.org/10.1007/s13760-018-0885-0>

Permanent link / Trajna poveznica: <https://um.nsk.hr/um:nbn:hr:239:912585>

Rights / Prava: [Attribution 4.0 International](#)

Download date / Datum preuzimanja: **2020-10-20**




Repository / Repozitorij:

[Repository UHC Osijek - Repository University Hospital Centre Osijek](#)



The role of weather conditions and normal level of air pollution in appearance of stroke in the region of Southeast Europe

Marijana Knezovic¹ · Sanja Pintaric² · Marko Mornar Jelavic^{3,4}  · Vanja Basic Kes^{1,3,5} · Visnja Neseck^{5,6} · Sinisa Bogovic⁷ · Bruno Cvetkovic⁸ · Hrvoje Pintaric^{1,3}

Received: 20 December 2017 / Accepted: 21 January 2018 / Published online: 24 February 2018
© Belgian Neurological Society 2018

Abstract

We investigated correlation between the normal level of air pollution, weather conditions and stroke occurrence in the region of Southeast Europe with a humid continental climate. This retrospective study included 1963 patients, 1712 (87.2%) with ischemic (IS) and 251 (12.8%) with hemorrhagic stroke (HS) admitted to emergency department. The number of patients, values of weather condition (meteorological parameters) [air temperature (°C), atmospheric pressure (kPa), relative humidity (%)] and concentrations of air pollutants [particulate matter (PM₁₀), nitrogen dioxide (NO₂), ozone (O₃)], were recorded and evaluated for each season (spring, summer, autumn, winter) during 2 years (July 2008–June 2010). The highest rate of IS was observed during spring (28.9%) ($p = 0.0002$) and HS in winter (33.9%) ($p = 0.0006$). We have found negative Spearman's correlations (after Bonferroni adjustment for the multiple correlations) of the number of males with values of relative humidity (%) (day 0, $\rho = -0.15$), the total number of strokes (day 2, $\rho = -0.12$), females (day 2, $\rho = -0.12$) and IS (day 2, $\rho = -0.13$) with concentrations of PM₁₀ (µg/m³), as well as negative correlations of the number of females (day 2, $\rho = -0.12$) and IS (day 2, $\rho = -0.12$) with concentrations of NO₂ (µg/m³) (for all $p < 0.002$). In winter, the number of HS (day 0, $\rho = 0.25$, $p = 0.001$) positively correlated with concentrations of O₃ (µg/m³). The appearance of stroke has seasonal variations, with the highest rates during spring and winter. Positive correlation between the number of HS and values of O₃ requires an additional reduction of the legally permitted pollutants concentrations.

Keywords Stroke · Ozone · Particular matter · Nitrogen dioxide · Weather conditions

Introduction

Stroke is a major cause of mortality and disability in clinical practice. Its prevalence varies widely across the world, with the highest values in China, while in Europe, the peak prevalence was recorded in the eastern countries. These variations could be explained with genetic, as well as population differences in exposure to traditional cardiovascular risk factors (smoking, alcoholism, hypertension, diabetes, dyslipidemias, and obesity) [1]. Some role in pathogenesis of stroke has external environment, i.e., meteorological parameters and air pollutants, which may help to understand why cerebrovascular events occur at particular time. Studies have reported a seasonal peak of stroke incidence and mortality during winter and spring, and decrease during summer period [2]. A modest rise in serum levels of lipids, glucose, and fibrinogen has been recorded during winter, and reflects the presence of increased prothrombotic and proatherosclerotic factors [3]. Both positive and negative temperature

✉ Marko Mornar Jelavic
mjelavic@yahoo.com

- ¹ University Hospital Center “Sestre milosrdnice”, Zagreb, Croatia
- ² First school of Economics, Zagreb, Croatia
- ³ School of Dental Medicine, University of Zagreb, Zagreb, Croatia
- ⁴ Institute for Cardiovascular Prevention and Rehabilitation, Zagreb, Croatia
- ⁵ School of Medicine, Josip Juraj Strossmayer, University of Osijek, Osijek, Croatia
- ⁶ University Hospital “Sveti Duh”, Zagreb, Croatia
- ⁷ University Hospital Center Osijek, Osijek, Croatia
- ⁸ Teaching Institute of Public Health “dr. Andrija Stampar”, Zagreb, Croatia

ranges have potentially important effects on cardiovascular mortality and morbidity [4–6]. Changes in barometric pressure may increase risk of intracranial hemorrhage [7]. Results of several studies obtained that correlation of stroke incidence with meteorological factors was more apparent in women than in men [2, 8]. It could be explained by less efficient thermoregulatory and sweating mechanisms and greater vascular sensitivity to outdoor temperature among women [9, 10].

Air pollutants are a heterogeneous, complex mixture of gases, liquids, and particulate matter (PM), which are connected with an increased risk of cardiovascular events [11]. Furthermore, several studies have shown air pollution represents a great health risk even in developed countries with legally defined thresholds of air pollution [12–14]. Some studies have found, while the others excluded associations between air pollution and stroke admissions [15, 16].

Taken overall, existing studies lack consistency and further work is needed to clarify the nature of the link between weather, air pollution, and stroke incidence.

The aim of this study was to investigate correlation between the normal level of air pollution, weather conditions and stroke occurrence in the region of Southeast Europe, an area with a humid continental climate.

Patients and methods

Zagreb is the largest city of the Republic of Croatia, placed in Southeast Europe, with 1.2 million inhabitants (20% of the total Croatian population) [17].

We retrospectively analysed daily visits in emergency department (ED) of two hospitals in Zagreb (University Hospital Centre “Sestre milosrdnice” and University Hospital “Sveti Duh”), during a 2-year period (July 2008–June 2010). Only patients with ischemic (IS) or hemorrhagic stroke (HS) as a primary diagnosis and living in Zagreb were included.

According to the Köppen’s meteorological classification, the seasons were grouped as follows: winter = December–February, spring = March–May, summer = June–August, and autumn = September–November [18]. Daily average measures of meteorological parameters [air temperature (°C), atmospheric pressure (kPa), and relative humidity (%)] and air pollutants [PM₁₀, nitrogen dioxide (NO₂), and ozone (O₃)] were collected on the basis of hourly values reported by the Meteorological and Hydrological Service of Croatia and National Monitoring Station Zagreb-1 (Environmental Protection Agency).

Statistical analysis

Qualitative data are presented with absolute number (*N*) and percentage (%). To test the seasonal variations in stroke occurrence, a goodness-of-fit Chi-square test was used to compare the difference between the observed and expected number of strokes. Due to lack of evidence of seasonal distribution of stroke admission rate from the previous studies in our geographical area, the expected number of strokes is based on assumption of a homogeneous distribution of the number of admissions throughout seasons (the expected frequency of patients per seasons was defined as 25% of patients).

Quantitative data are presented with median and corresponding interquartile range; differences between two groups were tested by Mann–Whitney *U* test. Spearman’s Rank-Order Correlation analysis was used to determine the correlation of brain stroke admission rate with meteorological parameters and air pollutants. It was classified by Spearman’s rho values as very weak (0–0.19), weak (0.20–0.39), moderate (0.40–0.59), strong (0.60–0.79), and very strong (0.80–1.0) correlations. The level of statistical significance was set at $p < 0.05$. For the multiple correlations, the statistical significance, after Bonferroni adjustment, was fixed at $p = 0.002$. Processing was done using the MedCalc 17.8.2 (MedCalc Software, Ostend, Belgium).

Results

The median daily values of meteorological parameters varied across seasons, while median concentrations of air pollutants were below the legally defined thresholds (Tables 1, 2). We obtained the following results:

1. Of the total of 1963 patients, there were 251 (12.8%) and 1712 (87.2%) cases with HS and IS, respectively (Fig. 1). Subjects with IS were older than those with HS [median aged 74 (18–104) vs 70 (23–95) years, $p < 0.001$]. The seasonal variation of stroke occurrence was confirmed by Chi-square test. We demonstrated that the peak stroke incidence was in spring ($N = 567$, 28.9%) ($p < 0.0001$). Among the stroke subtypes, the highest IS admission rate was observed in spring ($N = 495$, 28.9%) ($p = 0.0002$), while those with HS had the highest admission rate during winter months ($N = 85$, 33.9%), ($p = 0.0006$). Females (50.0%) were older [median aged 77 (22–104) vs 70 (18–95) years, $p = 0.001$]; we have found no significant gender differences in rates of HS and IS.

Table 1 Average daily values of meteorological parameters during a 2-year study period (July 2008–June 2010)

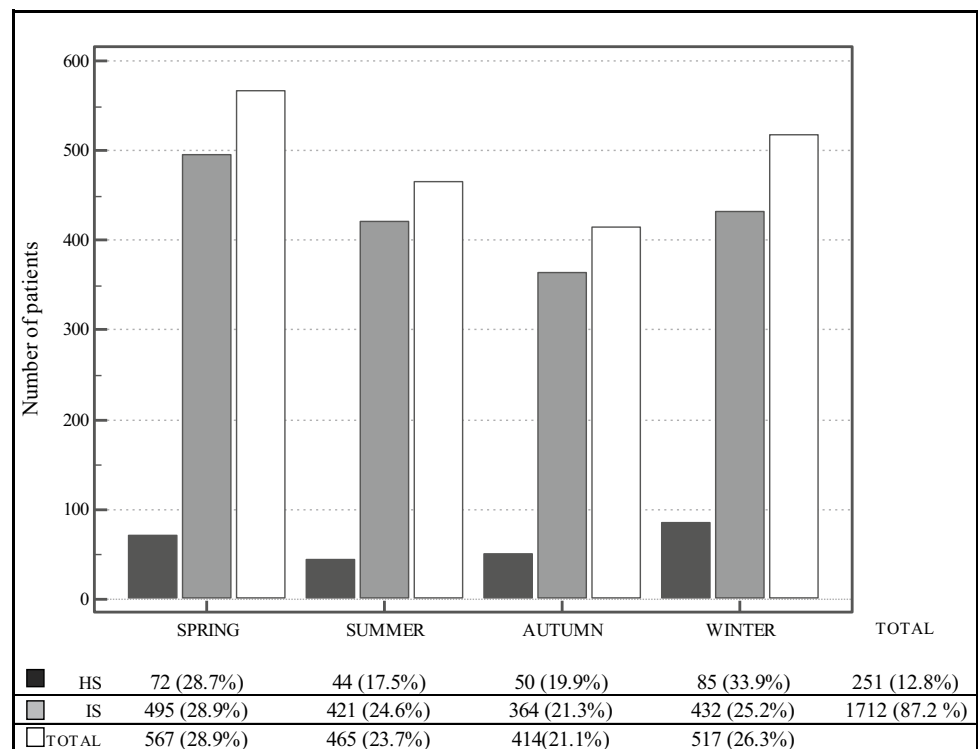
	Days	Temperature (°C) median (range)	Relative humidity (%) median (range)	Air pressure (hPa) median (range)
Total	730	13.4 (– 7.9 to 28.5)	68.9 (37.7 to 95.3)	996 (966 to 1020)
Spring	184	13.8 (– 1.2 to 26.5)	60.7 (37.7 to 91.4)	997 (966 to 1009)
Summer	184	22.5 (13.3 to 28.5)	61.5 (41.0 to 89.5)	996 (984 to 1004)
Autumn	182	13.1 (1.0 to 25.4)	73.5 (44.4 to 95.3)	998 (979 to 1013)
Winter	180	2.6 (– 7.9 to 14.5)	78.9 (43.6 to 94.0)	994 (971 to 1020)
Kruskal–Wallis ANOVA		$p = 0.000$	$p = 0.000$	$p = 0.000$

Statistical significance with $p < 0.05$

Table 2 Average daily values (below legally defined thresholds) of air pollution parameters during a 2-year study period (July 2008–June 2010)

	Days	PM ₁₀ (µg/m ³) median (range)	Days	NO ₂ (µg/m ³) median (range)	Days	O ₃ (µg/m ³) median (range)
Total	720	25.7 (4.6 to 146.6)	692	25.9 (1.7 to 89.7)	646	47.1 (4.7 to 135.4)
Spring	184	22.2 (5.5 to 61.2)	184	24.7 (2.0 to 59.3)	184	56.6 (13.7 to 127.6)
Summer	181	20.4 (5.5 to 83.6)	180	24.2 (5.5 to 41.7)	164	59.4 (16.6 to 135.4)
Autumn	182	31.5 (4.6 to 93.8)	148	30.7 (3.7 to 53.2)	128	36.5 (9.1 to 80.3)
Winter	173	37.1 (9.6 to 146.6)	180	26.8 (1.7 to 89.7)	170	27.5 (4.7 to 70.5)
Kruskal–Wallis ANOVA		$p = 0.000$		$p = 0.000$		$p = 0.001$

Statistical significance with $p < 0.05$

Fig. 1 Number of patients with stroke during a 2-year study period (July 2008–June 2010)

2. As it is presented in Tables 3 and 4, we have found negative correlations of the number of males with values of relative humidity (%) (day 0, $\rho = -0.15$), the total

number of strokes (day 2, $\rho = -0.12$), females (day 2, $\rho = -0.12$) and IS (day 2, $\rho = -0.13$) with concentrations of PM₁₀ (µg/m³), as well as negative correlations

Table 3 Spearman's Rank-Order Correlation analysis (ρ) of meteorological parameters during a 2-year study period (July 2008–June 2010)

	Total	Females	Males	IS	HS
Temperature (°C) day 0					
ρ	– 0.05	– 0.08	– 0.01	– 0.02	– 0.10
95% CI	– 0.12 to 0.02	– 0.15 to – 0.01	– 0.08 to 0.06	– 0.09 to 0.06	– 0.17 to – 0.02
p	0.684	0.034	0.836	0.687	0.011
Days	730	730	730	730	730
Temperature (°C) day 1					
ρ	– 0.07	– 0.09	– 0.02	– 0.03	– 0.09
95% CI	– 0.14 to 0.01	– 0.16 to – 0.02	– 0.09 to 0.05	– 0.11 to 0.04	– 0.16 to – 0.02
p	0.071	0.014	0.625	0.372	0.013
Days	730	730	730	730	730
Temperature (°C) day 2					
ρ	– 0.06	– 0.08	– 0.02	– 0.03	– 0.09
95% CI	– 0.13 to 0.01	– 0.15 to – 0.01	– 0.09 to 0.06	– 0.11 to 0.04	– 0.16 to – 0.02
p	0.085	0.024	0.652	0.360	0.013
Days	730	730	730	730	730
Temperature (°C) day 3					
ρ	– 0.04	– 0.04	– 0.02	– 0.01	– 0.09
95% CI	– 0.11 to 0.03	– 0.12 to 0.03	– 0.10 to 0.05	– 0.08 to 0.07	– 0.16 to – 0.02
p	0.297	0.236	0.588	0.861	0.011
Days	730	730	730	730	730
Relative humidity (%) day 0					
ρ	– 0.10	0.00	– 0.15	– 0.10	– 0.02
95% CI	– 0.17 to – 0.03	– 0.07 to 0.07	– 0.22 to – 0.07	– 0.17 to – 0.03	– 0.09 to 0.05
p	0.010	0.950	0.002	0.010	0.550
Days	730	730	730	730	730
Relative humidity (%) day 1					
ρ	– 0.06	0.02	– 0.10	– 0.07	0.02
95% CI	– 0.13 to 0.01	– 0.05 to 0.09	– 0.17 to – 0.03	– 0.14 to 0.01	– 0.06 to 0.09
p	0.106	0.579	0.010	0.067	0.682
Days	730	730	730	730	730
Relative humidity (%) day 2					
ρ	– 0.02	0.04	– 0.08	– 0.02	0.00
95% CI	– 0.09 to 0.05	– 0.03 to 0.11	– 0.15 to – 0.00	– 0.09 to 0.06	– 0.07 to 0.07
p	0.578	0.280	0.044	0.673	0.960
Days	730	730	730	730	730
Relative humidity (%) day 3					
ρ	– 0.02	0.03	– 0.06	– 0.02	0.00
95% CI	– 0.10 to 0.05	– 0.04 to 0.11	– 0.14 to 0.01	– 0.09 to 0.05	– 0.07 to 0.08
p	0.603	0.366	0.102	0.626	0.909
Days	730	730	730	730	730
Atmospheric pressure (hPa) day 0					
ρ	0.04	0.01	0.06	0.04	0.03
95% CI	– 0.04 to 0.11	– 0.06 to 0.08	– 0.02 to 0.13	– 0.04 to 0.11	– 0.05 to 0.10
p	0.293	0.818	0.119	0.330	0.489
Days	730	730	730	730	730

Table 3 (continued)

	Total	Females	Males	IS	HS
Atmospheric pressure (hPa) day 1					
rho	0.06	− 0.01	0.09	0.06	0.00
95% CI	− 0.01 to 0.13	− 0.08 to 0.07	0.02 to 0.17	− 0.01 to 0.14	− 0.07 to 0.07
<i>p</i>	0.103	0.951	0.013	0.088	0.947
Days	730	730	730	730	730
Atmospheric pressure (hPa) day 2					
rho	0.02	− 0.04	0.07	0.02	0.00
95% CI	− 0.05 to 0.09	− 0.11 to 0.03	− 0.01 to 0.14	− 0.05 to 0.10	− 0.07 to 0.08
<i>p</i>	0.560	0.307	0.078	0.544	0.905
Days	730	730	730	730	730
Atmospheric pressure (hPa) day 3					
rho	− 0.01	− 0.05	0.03	− 0.01	0.00
95% CI	− 0.08 to 0.67	− 0.12 to 0.03	− 0.04 to 0.10	− 0.08 to 0.06	− 0.07 to 0.07
<i>p</i>	0.834	0.216	0.399	0.797	0.984
Days	730	730	730	730	730

Statistical significance after Bonferroni adjustment with $p < 0.002$

HS hemorrhagic stroke, IS ischemic stroke

of the number of females (day 2, rho = − 0.12) and IS (day 2, rho = − 0.12) with concentrations of NO₂ (μg/m³) (for all $p < 0.002$);

- In winter, the number of HS (day 0, rho = 0.25, confidence interval [0.11–0.39], $p = 0.001$) was in positive correlations with concentrations of O₃ (μg/m³) particles.

Discussion

According to our knowledge, this is the first study which investigates the role of weather conditions and air pollution on the appearance of stroke in the region with a humid continental climate. We want to emphasize that concentrations of air pollutants were below legally defined thresholds during the whole study period. Across studies, findings are inconsistent, complex, and often contradictory.

Stroke continues to be a leading cause of morbidity and mortality, with clearly identified physiological and lifestyle risk factors. Weather conditions may also be connected to stroke, and multiple meteorological variables have been examined as possible influences on stroke occurrence [19].

Weather conditions may be involved in several pathophysiological mechanisms, which were not completely explained [19]. For example, high temperature leads to endothelial dysfunction, dehydration, and increased blood viscosity, with consequent higher risk of adverse vascular events. Cerebral ischemia is worsened by elevated body temperature in both laboratory animals and human stroke patients [19]. In addition, as we already mentioned in “Introduction” section, results of several studies

obtained that correlation of stroke incidence with meteorological factors was more apparent in women than in men [2, 8]. It could be explained by less efficient thermoregulatory and sweating mechanisms and greater vascular sensitivity to outdoor temperature among women [9, 10].

Several authors reported every 1 °C increase in mean temperature during the preceding 24 h was associated with a 2.1% rise in hospital admissions for IS [20]. Furthermore, low temperature the day before and at the day of stroke has been found to be a significant risk factor for intracerebral hemorrhage (ICH) [21]. An average 5 °C fall in mean temperature was associated with a 7% elevation in hospital admissions, especially females [8, 22]. Ohwaki et al. reported that days on which hypertensive ICH occurred had significantly lower minimum temperatures compared with the previous day, while the others excluded any influence of temperature on stroke [21–23]. In this study, we also have found no significant correlation between the number of strokes and air temperature.

According to the literature data, the number of patients with stroke positively correlated with atmospheric pressure [23]. Other studies reported risk of IS increased almost fourfold when air pressure fell more than 3 hPa from the previous day, and increased emergency admissions due to ICH were observed for every 1 hPa drop in air pressure from the day prior to the event [23, 24]. Finally, several authors reported no relationship between air pressure and the incidence of particular stroke subtypes [21, 25], which is in consistency with our results.

The third finding was the number of patients (males) negatively correlated with relative humidity. Decreases in humidity on the day of and/or day before stroke have been

Table 4 Spearman's Rank-Order Correlation analysis (*rho*) of air pollution parameters during a 2-year study period (July 2008–June 2010)

	Total	Females	Males	IS	HS
PM₁₀ (µg/m³) day 0					
rho	– 0.02	– 0.05	0.02	– 0.03	0.02
95% CI	– 0.09 to 0.06	– 0.12 to 0.03	– 0.05 to 0.09	– 0.10 to 0.05	– 0.05 to 0.10
<i>p</i>	0.695	0.226	0.549	0.497	0.515
Days	720	720	720	720	720
PM₁₀ (µg/m³) day 1					
rho	– 0.06	– 0.07	– 0.01	– 0.08	0.03
95% CI	– 0.13 to 0.01	– 0.14 to 0.00	– 0.09 to 0.06	– 0.16 to – 0.01	– 0.04 to 0.11
<i>p</i>	0.092	0.063	0.739	0.027	0.369
Days	720	720	720	720	720
PM₁₀ (µg/m³) day 2					
rho	– 0.12	– 0.12	– 0.04	– 0.13	0.00
95% CI	– 0.19 to – 0.05	– 0.19 to – 0.05	– 0.11 to 0.04	– 0.20 to – 0.06	– 0.07 to 0.07
<i>p</i>	0.001	0.001	0.315	0.001	0.995
Days	720	720	720	720	720
PM₁₀ (µg/m³) day 3					
rho	– 0.07	– 0.06	– 0.03	– 0.07	– 0.02
95% CI	– 0.14 to 0.01	– 0.13 to 0.01	– 0.11 to 0.04	– 0.14 to 0.00	– 0.09 to 0.05
<i>p</i>	0.068	0.102	0.376	0.053	0.601
Days	720	720	720	720	720
NO₂ (µg/m³) day 0					
rho	– 0.01	– 0.01	0.01	– 0.01	– 0.01
95% CI	– 0.09 to 0.06	– 0.09 to 0.06	– 0.07 to 0.08	– 0.08 to 0.06	– 0.08 to 0.07
<i>p</i>	0.707	0.760	0.896	0.802	0.814
Days	692	692	692	692	692
NO₂ (µg/m³) day 1					
rho	– 0.06	– 0.07	– 0.01	– 0.07	0.02
95% CI	– 0.13 to 0.01	– 0.14 to 0.00	– 0.09 to 0.06	– 0.15 to 0.00	– 0.05 to 0.10
<i>p</i>	0.110	0.063	0.782	0.050	0.532
Days	694	694	694	694	694
NO₂ (µg/m³) day 2					
rho	– 0.09	– 0.12	0.00	– 0.12	0.05
95% CI	– 0.16 to – 0.01	– 0.19 to – 0.04	– 0.08 to 0.08	– 0.19 to – 0.05	– 0.02 to 0.13
<i>p</i>	0.018	0.002	0.990	0.001	0.170
Days	694	694	694	694	694
NO₂ (µg/m³) day 3					
rho	– 0.04	– 0.04	– 0.02	– 0.06	0.02
95% CI	– 0.11 to 0.03	– 0.11 to 0.04	– 0.09 to 0.05	– 0.13 to 0.02	– 0.05 to 0.10
<i>p</i>	0.303	0.333	0.595	0.139	0.563
Days	694	694	694	694	694
O₃ (µg/m³) day 0					
rho	0.01	– 0.04	0.05	0.00	0.02
95% CI	– 0.07 to 0.08	– 0.12 to 0.04	– 0.03 to 0.13	– 0.08 to 0.08	– 0.06 to 0.10
<i>p</i>	0.836	0.323	0.193	0.991	0.608
Days	646	646	646	646	646

Table 4 (continued)

	Total	Females	Males	IS	HS
O₃ (µg/m³) day 1					
rho	0.04	0.00	0.04	0.04	– 0.02
95% CI	– 0.04 to 0.12	– 0.08 to 0.08	– 0.03 to 0.12	– 0.04 to 0.12	– 0.10 to 0.06
<i>p</i>	0.335	0.967	0.248	0.281	0.654
Days	646	646	646	646	646
O₃ (µg/m³) day 2					
rho	0.03	0.01	0.03	0.06	– 0.07
95% CI	– 0.05 to 0.11	– 0.06 to 0.09	– 0.04 to 0.12	– 0.02 to 0.13	– 0.13 to 0.02
<i>p</i>	0.391	0.753	0.376	0.148	0.155
Days	646	646	646	646	646
O₃ (µg/m³) day 3					
rho	0.06	0.05	0.04	0.07	– 0.01
95% CI	– 0.02 to 0.14	– 0.02 to 0.13	– 0.04 to 0.11	– 0.01 to 0.15	– 0.09 to 0.07
<i>p</i>	0.120	0.166	0.342	0.070	0.769
Days	646	646	646	646	646

Statistical significance after Bonferroni adjustment with $p < 0.002$

HS hemorrhagic stroke, IS ischemic stroke

significantly linked to IS, transient ischemic attack [21] and subarachnoid hemorrhage (SAH) [26]. Another researches have shown no direct relationship between humidity and stroke, including IS [21, 23, 27, 28] and ICH [22, 23, 27, 29].

Chronic inhalation of air pollutants may cause chronic pulmonary and systemic oxidative stress and inflammation, with endothelial dysfunction, vasoconstriction, and atherosclerosis at the vasculature level, and coagulation with thrombosis at the blood tissue level [30]. These processes are critical for the onset of cerebrovascular events, such as stroke, especially IS.

Studies of short-term air pollution exposure (up to lag of 7 days) and hospitalization for any stroke have reported associations between PM₁₀ [31–34], NO₂ [33, 35–37], and O₃ [38–40] and IS. A majority of studies did not observe associations between air pollutants and HS, with a few exceptions [33, 41–44]. A few studies reported stronger associations between O₃ and IS in men than women [38, 39, 45]. Air pollution on warm days was more strongly associated with HS and IS in some countries, and both HS and IS in Taiwan [33, 35, 40].

Shah et al. performed meta-analysis based on 94 studies in 28 countries [46]. They reported HS was less common than IS. In terms of the same day exposures, they found small positive associations between the risk of hospitalization or mortality for stroke and each of PM_{2.5}, PM₁₀, and NO₂. In terms of stroke subtypes, they found positive associations between IS and exposure to PM_{2.5} and NO₂, and between HS and exposure to NO₂.

Butland et al. analysed 1758 incident strokes (1311 were ischemic and 256 were hemorrhagic) [47]. They found no

association between all stroke or IS and the same day exposure to PM_{2.5}, PM₁₀, O₃, and NO₂. For HS, they found a negative association with PM₁₀ suggestive of a 14.6% fall in risk per 10 mg/m³ increase in pollutant.

We have found the values of PM₁₀ and NO₂ negatively correlated with the number of patients (total), females and IS. In winter, the number of HS positively correlated with O₃. For negative correlations between the number of strokes and concentrations of air pollutants, we have no reasonable explanation. These unique or rare findings of our study are similar with previously mentioned investigation of Butland et al., in which authors got unexplained negative association of stroke and PM₁₀ [47].

Some limitations of our study include small number of HS. In addition, our study design did not include other stroke subtypes, because we primarily evaluated stroke admissions from ED medical records, and classification stroke by subtypes requires more specific diagnostic tools that are not obtained in ED.

In conclusion, the appearance of stroke in the region with a humid continental climate has seasonal variations, with the highest prevalence during spring and winter. Positive correlation between the number of HS and values of O₃ (µg/m³) requires an additional reduction of the legally permitted pollutants concentrations. Our results may provide useful data for the future planning of public health measures to minimize the influence of weather conditions and air pollutants on population.

Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical approval All procedures were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. This retrospective study has approval of the appropriate institutional Ethics committee.

Informed consent For this type of study, formal consent is not required.

References

- Thorvaldsen P, Asplund K, Kuulasmaa K et al (1995) Stroke incidence, case-fatality, and mortality in the WHO MONICA Project. *Stroke* 26:361–367
- Turin TC, Kita Y, Murakami Y et al (2008) Higher stroke incidence in the spring season regardless of conventional risk factors: Takashima Stroke Registry, Japan, 1988–2001. *Stroke* 39:745–752
- McArthur K, Dawson J, Walters M (2010) What is it with the weather and stroke? *Expert Rev Neurother* 10:243–249
- Hong Y, Rha J, Lee J et al (2003) Ischemic stroke associated with decrease in temperature. *Epidemiology* 14:473–478
- Feigin V, Nikitin YP, Bots ML et al (2000) A population-based study of the associations of stroke occurrence with weather parameters in Siberia, Russia (1982–92). *Eur J Neurol* 7:171–178
- Berginer VM, Goldsmith J, Batz U et al (1989) Clustering of strokes in association with meteorologic factors in the Negev desert of Israel: 1981–1983. *Stroke* 20:65–69
- Jehle D, Moscatti R, Frye J et al (1994) The incidence of spontaneous subarachnoid hemorrhage with change in barometric pressure. *Am J Emerg Med* 12:90–91
- Matsumoto M, Ishikawa S, Kajii E (2010) Cumulative effects of weather on stroke incidence: a multi-community cohort study in Japan. *J Epidemiol* 20:136–142
- Bittel J, Henane R (1975) Comparison of thermal exchanges in men and women under neutral and hot conditions. *J Physiol* 250:475–489
- Sato F, Matsushita S, Hyodo K et al (2008) Sex difference in peripheral arterial response to cold exposure. *Circ J* 72:1367–1372
- Brunekreef B, Holgate ST (2002) Air pollution and health. *Lancet* 360:1233–1242
- Kraft M, Eikmann T, Kappos A et al (2005) The German view: effects of nitrogen dioxide on human health—derivation of health-related short-term and long-term values. *Int J Hyg Environ Health* 208:305–318
- Samoli E, Aga E, Touloumi G et al (2006) Short-term effects of nitrogen dioxide on mortality: an analysis within the APHEA project. *Eur Respir J* 27:1129–1138
- Wong CM, Ma S, Hedley AJ et al (1999) Does ozone have any effect on daily hospital admissions for circulatory diseases? *J Epidemiol Community Health* 53:580–581
- Villeneuve PJ, Chen L, Stieb D et al (2006) Associations between outdoor air pollution and emergency department visits for stroke in Edmonton, Canada. *Eur J Epidemiol* 21:689–700
- Han M-H, Yi H-J, Ko Y et al (2016) Association between hemorrhagic stroke occurrence and meteorological factors and pollutants. *BMC Neurol* 16:59
- City of Zagreb (2014) Zagreb in brief. The official City of Zagreb website, <http://www.zagreb.hr/default.aspx?id=1125> (accessed 2014)
- Sheth T, Nair C, Muller J et al (1999) Increased winter mortality from acute myocardial infarction and stroke: the effect of age. *J Am Coll Cardiol* 33:1916–1919
- Nocera R, Petrucelli P, Park J et al (2014) Meteorological variables associated with stroke. *Int Sch Res Notices* 2014:597106
- Dawson J, Weir C, Wright F et al (2008) Associations between meteorological variables and acute stroke hospital admissions in the west of Scotland. *Acta Neurol Scand* 117:85–89
- Chang CL, Shipley M, Marmot M et al (2004) Lower ambient temperature was associated with an increased risk of hospitalization for stroke and acute myocardial infarction in young women. *J Clin Epidemiol* 57:749–757
- Ohwaki K, Yano E, Murakami H et al (2004) Meteorological factors and the onset of hypertensive intracerebral hemorrhage. *Int J Biometeorol* 49:86–90
- Jimenez-Conde J, Ois A, Gomis M et al (2008) Weather as a trigger of stroke. Daily meteorological factors and incidence of stroke subtypes. *Cerebrovasc Dis* 26:348–354
- Hori A, Hashizume M, Tsuda Y et al (2012) Effects of weather variability and air pollutants on emergency admissions for cardiovascular and cerebrovascular diseases. *Int J Environ Health Res* 22:416–430
- Houck PD, Lethen JE, Riggs MW et al (2005) Relation of atmospheric pressure changes and the occurrences of acute myocardial infarction and stroke. *Am J Cardiol* 96:45–51
- Lejeune JP, Vinchon M, Amouyel P et al (1994) Association of occurrence of aneurysmal bleeding with meteorologic variations in the north of France. *Stroke* 25:338–341
- Magalhães R, Silva MC, Correia M et al (2011) Are stroke occurrence and outcome related to weather parameters? Results from a population-based study in northern Portugal. *Cerebrovasc Dis* 32:542–551
- Lee HC, Hu CJ, Chen CS et al (2008) Seasonal variation in ischemic stroke incidence and association with climate: a six-year population-based study. *Chronobiol Int* 25:938–949
- Goggins WB, Woo J, Ho S et al (2012) Weather, season, and daily stroke admissions in Hong Kong. *Int J Biometeorol* 56:865–872
- Scheers H, Jacobs L, Casas L et al (2015) Long-term exposure to particulate matter air pollution is a risk factor for stroke: meta-analytical evidence. *Stroke* 46:3058–3066
- Chan CC, Chuang KJ, Chien LC et al (2006) Urban air pollution and emergency admissions for cerebrovascular diseases in Taipei, Taiwan. *Eur Heart J* 27:1238–1244
- Corea F, Silvestrelli G, Baccarelli A et al (2012) Airborne pollutants and lacunar stroke: a case cross-over analysis on stroke unit admissions. *Neurol Int* 4:e11
- Tsai SS, Goggins WB, Chiu HF et al (2003) Evidence for an association between air pollution and daily stroke admissions in Kaohsiung, Taiwan. *Stroke* 34:2612–2616
- Wellenius GA, Schwartz J, Mittleman MA (2005) Air pollution and hospital admissions for ischemic and hemorrhagic stroke among medicare beneficiaries. *Stroke* 36:2549–2553
- Ballester F, Tenias JM, Perez-Hoyos S (2001) Air pollution and emergency hospital admissions for cardiovascular diseases in Valencia, Spain. *J Epidemiol Community Health* 55:57–65
- Villeneuve PJ, Johnson JY, Pasichnyk D et al (2012) Short-term effects of ambient air pollution on stroke: who is most vulnerable? *Sci Total Environ* 430:193–201
- Wellenius GA, Burger MR, Coull BA et al (2012) Ambient air pollution and the risk of acute ischemic stroke. *Arch Intern Med* 172:229–234

38. Xu X, Sun Y, Ha S et al (2013) Association between ozone exposure and onset of stroke in Allegheny county, Pennsylvania, USA, 1994–2000. *Neuroepidemiology* 41:2–6
39. Henrotin JB, Besancenot JP, Bejot Y et al (2007) Short-term effects of ozone air pollution on ischaemic stroke occurrence: a case-crossover analysis from a 10-year population-based study in Dijon, France. *Occup Environ Med* 64:439–445
40. Henrotin JB, Zeller M, Lorgis L et al (2010) Evidence of the role of short-term exposure to ozone on ischaemic cerebral and cardiac events: the dijon vascular project (diva). *Heart* 96:1990–1996
41. Turin TC, Kita Y, Rumana N et al (2012) Short-term exposure to air pollution and incidence of stroke and acute myocardial infarction in a Japanese population. *Neuroepidemiology* 38:84–92
42. Villeneuve PJ, Chen L, Stieb D et al (2006) Associations between outdoor air pollution and emergency department visits for stroke in Edmonton, Canada. *Eur J Epidemiol* 21:689–700
43. Yang CY, Chen YS, Chiu HF et al (2005) Effects of asian dust storm events on daily stroke admissions in taipei, taiwan. *Environ Res* 99:79–84
44. Yamazaki S, Nitta H, Ono M et al (2007) Intracerebral haemorrhage associated with hourly concentration of ambient particulate matter: case-crossover analysis. *Occup Environ Med* 64:17–24
45. Bedada GB, Smith CJ, Tyrrell PJ et al (2012) Short-term effects of ambient particulates and gaseous pollutants on the incidence of transient ischaemic attack and minor stroke: a case crossover study. *Environ Health* 11:77
46. Shah AS, Lee KK, McAllister DA et al (2015) Short term exposure to air pollution and stroke: systematic review and meta-analysis. *BMJ* 350:h1295
47. Butland BK, Atkinson RW, Crichton S et al (2017) Air pollution and the incidence of ischaemic and haemorrhagic stroke in the South London Stroke Register: a case-cross-over analysis. *J Epidemiol Community Health* 71:707–712