Hypertension is a well-known risk factor for cerebrovascular disease, stroke, and vascular dementia. It has been associated with silent brain injury, including gray matter atrophy, silent infarcts, microbleeds, and white matter damage. Individuals with an apoE-ε4 allele may be particularly susceptible to adverse effects of hypertension.2,3

Middle age is an important period for emergence of hypertension; yet, few studies have focused solely on this age range when examining hypertension effects on cerebral white matter microstructure. This is an important limitation because hypertension may have different effects in younger than older adults.4

In addition, because hypertension is associated with increased mortality, hypertension effects may be underestimated in studies of older adults because of survival bias, or results may be confounded by latent neurodegenerative pathology. Diffusion-weighted neuroimaging enables quantification of the degree and direction of water molecule motion within tissue. It is a sensitive method for detecting differences in white matter microstructure as a function of injury or illness5,6 and has been used to investigate effects of hypertension in older adults.7,8 For example, in a large study (n=4532) of adults aged 46 to 100 years (mean, 63.8), severe, but not moderate, hypertension was associated with reduced fractional anisotropy (FA) or increased mean diffusivity (MD) in numerous white matter tracts.9 No significant main effects of apoE-ε4 were observed, but this study did not examine whether hypertension effects differed by apoE-ε4 status. Although several studies have looked at main effects of the ε4 allele on diffusion metrics, with mixed results,10–12 none have examined whether hypertension effects differ by apoE-ε4 status.

In one of the few studies focused on younger adults (aged, 19–63 years; mean, 39.2 years) increased systolic blood pressure (SBP) was associated with altered diffusion in several tracts, even though high BPs were mainly at prehypertensive or mild hypertensive levels.13 This suggests that white matter microstructure may already be affected early in the course of the disease.

If white matter changes are an early occurrence in hypertension, it might be expected that severity of effects would be...
larger in those with longer duration hypertension. This has not been found consistently for macroscopic white matter lesions, however, and effects of duration of hypertension on white matter microstructure have not been assessed in middle-aged adults. Similarly, few studies have looked at whether adequate BP control may mitigate effects of hypertension on white matter microstructure.\(^5\,6\)

To address these gaps in the literature, we examined participants of the Vietnam Era Twin Study of Aging (VETSA), a longitudinal study of cognitive and brain aging beginning in midlife.\(^6\,13\) We hypothesized that, in middle-aged adults, long-duration hypertension is associated with altered white matter microstructure relative to normotensive individuals, with greater adverse effects in ε4 carriers than in noncarriers. In secondary analyses, we explored whether hypertension of more recent onset is also associated with significant white matter alterations and whether white matter microstructure differs between hypertensive individuals with controlled and uncontrolled BP.

**Methods**

**Participants**

Participants in the parent VETSA cohort were recruited from the Vietnam Era Twin Registry, a nationally distributed sample of male–male twin pairs who served in the United States military at some point between 1965 and 1975.\(^6\) Participants are similar in health and lifestyle characteristics to American men in their age range.\(^6\) Although all VETSA participants are veterans, most (>80%) did not experience combat situations. Of the 409 VETSA participants who underwent clinical assessment at wave 1 and brain magnetic resonance imaging 5.6 years later, during wave 2, 9 individuals were excluded because of missing apoE data, 63 because of missing or poor quality magnetic resonance imaging data, and 21 because of the use of antihypertensive medications for reasons other than BP control. The final sample comprised 316 participants aged 61.8 (±2.58; range, 56.7–65.6) years at wave 2. Participants were predominantly white (88.9%), with an average education of 13.9 (SD, 2.0) years.

The study was conducted under local institutional review board supervision at the participating institutions, and all participants provided signed informed consent.

**Hypertensive Status**

At both waves, SBP and diastolic BP were measured as the average of 2 AM and 2 PM seated BP readings by trained observers with an electronic sphygmomanometer (Omron Model HEM-757/Wave 1; Lifesource Model UA-789 AC/Wave 2). Participants rested for 5 minutes before the first reading in each set, wearing a BP cuff on their right arm with their arm resting on a table. Participants rested for 1 minute between the paired readings.

Participants were classified as having hypertension based on SBP ≥140 mmHg, diastolic BP ≥90 mmHg, or self-report of a physician diagnosis. Normotensive individuals did not meet hypertension criteria at either wave 1 or wave 2 (n=101; 32.0%). Participants who met hypertension criteria at wave 1 were classified as having longer duration hypertension (n=173; 54.7%), those who met hypertension criteria at wave 2 but not at wave 1 were classified as having shorter duration hypertension (n=42; 13.3%).

To examine differences related to BP control, individuals who met hypertension criteria at wave 2 were categorized into controlled (SBP<140 mmHg and diastolic BP <90 mmHg at wave 2; n=142), and uncontrolled (n=73) hypertension groups.

**Clinical and Lifestyle Covariates**

During wave 2, height and weight were measured, and body mass index (BMI) was calculated. Diabetes mellitus status was ascertained from self-report of a doctor’s diagnosis or reported use of a diabetes mellitus–related medication. Following laboratory protocols, fasting morning blood samples were centrifuged after allowing 30 to 45 minutes for the sample to clot. Low- and high-density lipoprotein cholesterol and triglycerides were assayed as a part of a lipid panel via spectrophotometry. C-reactive protein (CRP) levels were assessed with nephelometry. Assays were conducted by Quest Diagnostics Inc/Nichols Institute, San Juan Capistrano, California. CRP values of ≥10 were assumed to reflect acute infection and these cases (n=8) were excluded from analyses that included CRP. CRP, cholesterol, and triglyceride levels were log-transformed before analyses.

Smoking, alcohol, and medication use were assessed at wave 2 as part of a structured medical history interview. Individuals were categorized into nonsmokers, former smokers, or current smokers, and into nondrinkers, moderate drinkers (≤2 drinks/d), or heavy drinkers (>2 drinks/d) based on reported use during the previous 2 weeks.

**apoE Genotype**

Methods for apoE genotyping were previously described.\(^20\) Participants were separated into apoE-ε4 carriers if they had at least 1 copy of the ε4 allele (25.3%) or noncarriers (74.7%).

**Image Acquisition and Processing**

T₁-weighted and diffusion-weighted images were obtained using standardized protocols on 3T scanners at 2 sites. Image acquisition and processing methods are detailed in the online-only Data Supplement. Diffusion metrics, including FA, a scalar value of the degree of anisotropic/directional diffusion within the voxel; MD, the average diffusion in all directions; longitudinal diffusivity, the average diffusion along the primary axis of diffusion; and transverse diffusivity (TD), the average diffusion along the 2 nonprimary axes, were derived from each fiber tract region of interest using a probabilistic diffusion tensor atlas of fiber tract locations and orientations (AtlasTrack\(^1\)). We averaged diffusion metrics from homologous tracts in left and right hemispheres and examined 9 major tracts previously shown to be affected by hypertension\(^11\,12\): the uncinate fasciculus (UF), inferior fronto-occipital fasciculus (IFOF), inferior and superior lateral fasciculi (ILF), anterior thalamic radiations, cingulum portion of the cingulate bundle (CeC), the corticospinal tract, and forceps minor and forceps major (the anterior and posterior portions of the corpus callosum). Locations of these tracts are shown in Figure S1 in the online-only Data Supplement.

**Statistical Analysis**

Diffusion metrics were submitted to linear mixed-effect models (Proc Mixed SAS, version 9.4). Base models included fixed effects of site (scanner) and age at wave 2. A family ID variable was included in all models as a random effect to control for nonindependence of twin data. To test our primary hypothesis, we examined whether diffusion metrics differed between normotensive individuals and those with longer duration hypertension as a function of apoE-ε4 status. Base models included fixed effects of hypertension and apoE-ε4 status, as well as an interaction term between hypertension and apoE-ε4. In separate models, we adjusted for covariates that differed between normotensive and hypertensive individuals at P<0.10: education level, BMI, low-density lipoprotein, CRP, diabetes mellitus, statin use, and alcohol use.

In exploratory analyses, we examined differences in diffusion metrics related to relative duration of hypertension and to control of hypertension. In these analyses, there were too few ε4 carriers in relevant subgroups to meaningfully assess differential effects of apoE. Base models included age, site, and family ID; secondary models adjusted for the covariates described above.

**Results**

Table 1 shows the demographic and clinical characteristics of normotensive individuals and those with longer duration hypertension, by apoE-ε4 status. Normotensives had lower...
BMI, lower CRP levels, were less likely to have diabetes mellitus, less likely to take statin medication, and had higher low-density lipoprotein levels than those with hypertension. There were no significant effects of apoE or interactions between hypertension and apoE on any clinical or demographic variable.

Table 2 shows the main effects of hypertension and the interaction of hypertension with apoE for the 4 diffusion metrics within the 9 tracts. In base models, hypertension was associated with significantly lower FA or increased diffusivity in all tracts except the CgC and forceps major. MD and TD were more often affected than longitudinal diffusivity.

Significant interactions between apoE-ε4 and hypertension were found for the UF, IFOF, and ILF; hypertension was associated with significantly lower FA or higher MD or TD among ε4 carriers only.

With adjustment for potentially confounding covariates, the apoE–hypertension interaction remained significant for FA, MD, TD in the UF and TD in the IFOF (Figure 1). Main effects of hypertension on diffusion metrics in the UF, IFOF, ILF, superior lateral fasciculi, anterior thalamic radiation, and forceps minor remained significant with adjustment for covariates (Table 2).

**Hypertension Duration**

Characteristics of normotensive individuals and those with shorter or longer duration hypertension are shown in Table S1. There were no significant differences between the 2 hypertensive groups on any demographic or clinical measure.

Mixed-effects models showed significant effects of hypertension on FA, MD, and TD in the UF, ILF, superior lateral fasciculi, anterior thalamic radiation, and forceps minor remained significant with adjustment for covariates (Table 2).

### Controlled Versus Uncontrolled Hypertension

Characteristics of hypertensive individuals who achieved good BP control and those who did not are shown in Table S3. The 2 treatment groups did not differ in age, proportion of apoE-ε4 carriers, high-density lipoprotein, triglyceride levels, or smoking. The controlled hypertension group had a higher proportion of individuals with diabetes mellitus (22.5% versus 9.6%), a higher proportion of individuals on statin medication, and lower low-density lipoprotein levels than the uncontrolled hypertension group. The uncontrolled hypertension group had higher BMI, SBP, and diastolic BP and consumed more alcohol than the controlled hypertension group. Less than half of those in the uncontrolled hypertensive group were taking antihypertensive medications (47.9%).

Mixed-effects models showed significant effects of hypertension on diffusion metrics in the UF, ILF, superior lateral fasciculi, and anterior thalamic radiation (Table S4). Pairwise comparisons revealed significant differences between normotensives and those with hypertension, but no significant differences on any measure between the controlled and uncontrolled hypertension groups were observed (Figure 2; Figure S2). Controlling for additional covariates did not materially affect the findings.

### Discussion

We examined the association of hypertension with tract-specific diffusion metrics in a relatively large cohort of...
Hypertension was associated with altered diffusion properties in several tracts. Alterations included lower FA and higher MD or TD, with few effects on longitudinal diffusivity. (2) The apoE-ε4 allele was associated with increased susceptibility to the effects of hypertension in the UF and IFOF. (3) Longer duration of hypertension was not associated with greater white matter microstructural differences than hypertension of more recent onset. (4) White matter microstructural alterations were observed in both controlled and uncontrolled hypertension groups. These findings suggest that hypertension-related alterations in white matter microstructure occur early in the course of the disease and may persist despite adequate BP control.

Of the 9 tracts examined, all but the forceps major and CgC showed associations with hypertension. Some studies have suggested that anterior white matter may be more susceptible to hypertension than posterior white matter.22 Our finding of significant effects in anterior but not in posterior corpus callosum is consistent with this, but we also observed significant effects in more centrally or posteriorly situated tracts, as have others.7–9 This suggests that hypertension has widespread effects on brain white matter. Previous findings...
that alterations in white matter diffusion metrics are associated with decreased cognitive performance suggest that these changes are not benign.\(^7,23,24\)

Negative effects of hypertension were greater in apoE-\(\varepsilon_4\) carriers than in noncarriers in the UF, which connects orbitofrontal regions to anterior temporal and limbic regions, and the IFOF, which connects frontal regions to occipital regions. This is consistent with previous findings in healthy adults of greater susceptibility of frontal regions than other brain regions to apoE-\(\varepsilon_4\).\(^{20}\) It is also consistent with previous findings that apoE-\(\varepsilon_4\) confers greater vulnerability to effects of hypertension on cognition\(^3,25\) and white matter lesions.\(^2\)

Hypertension was associated with decreased FA and increased MD, with TD more often affected than longitudinal diffusivity. Animal studies suggest that such a pattern is consistent with myelin damage.\(^{26}\) However, mechanisms by which hypertension affects brain white matter are varied and complex.\(^1,27,28\) Chronic hypertension is associated with vascular remodeling and reduced vascular reserve, which may lead to ischemia. Hypertension also interferes with perivascular lymphatic drainage and increases blood–brain permeability, resulting in fluid accumulation that may be toxic to cells.\(^{28}\) Both tissue damage and fluid accumulation will alter diffusion. Thus, the complexity of fiber projections in the human brain and the multitude of factors that can affect diffusion preclude inference of the neurobiological basis of the observed differences.\(^{29,30}\)

Longer duration of hypertension was not associated with greater white matter differences. Few studies have looked at effects of hypertension duration on white matter microstructure. In a 10-year follow-up of much older adults (mean, 83 years at imaging) high and variable BP was associated with strongest detrimental effects on white matter measures.\(^{10}\) Macroscopic white matter lesions did not differ between individuals with recent onset hypertension and those with 3- or 6-year hypertension in a study of adults aged 55 to 72 years at entry.\(^{11}\) In a study of adults aged 60 to 90 (mean, 72) years at entry, 20-year, but not 5-year, duration of hypertension was associated with increased odds of white matter lesions, but only among individuals with onset of hypertension before middle age.\(^2\) With longer follow-up, effects of longer duration of hypertension may become detectable in our sample. In addition, our shorter duration hypertensive group was relatively small, perhaps precluding detection of subtle differences related to hypertension duration.

The lack of significant differences in diffusion properties between those with controlled and uncontrolled hypertension is consistent with the interpretation that microstructural damage to white matter tracts occurs relatively early in the course of the disease and suggests that this damage may not be easily reversible. A previous study (aged, 50–85 years; mean, 66 years) also found significantly lower FA in both adequately and inadequately treated hypertensive groups relative to normotensives.\(^8\)

The current study has several limitations. The cohort is restricted to men, and largely white; thus, results may not generalize to women, other races, or ethnicities. Image analyses were cross-sectional; longitudinal imaging studies are needed to confirm the time course of microstructural changes in relation to the onset of hypertension and impact of treatment over time. Finally, the low number of \(\varepsilon_4\) carriers in shorter duration and uncontrolled hypertension subgroups limited our ability to determine whether hypertension duration or treatment interacts with this genetic risk factor.

**Figure 2.** Transverse diffusivity (TD) in the uncinate fasciculus (UF; A) and superior lateral fasciculus (SLF; B) by relative duration of hypertension and by control of hypertension (UF C and SLF D). Means are adjusted for age and scanner site. *\(P<0.05\), ** \(P<0.01\) for differences of the hypertensive subgroup relative to normotensives; the longer and shorter duration hypertension groups did not significantly differ from each other, or did the controlled and uncontrolled hypertension groups.
Study strengths include the large number of men representative of the general population in health and lifestyle characteristics, and the narrow age range centered at middle age. This minimizes differential survival effects and potential confounding because of latent neurodegenerative pathology. We were also able to control for numerous cardiovascular and behavioral risk factors. That significant differences remained between hypertensive and normotensive individuals after covariate adjustment indicates that the effects on white matter were not because of differences in education, age, BMI, diabetes mellitus, inflammation, lipid levels, statin therapy, or alcohol use.

Perspectives

This study demonstrates that hypertension is associated with significant microstructural differences in cerebral white matter in middle-aged men, and that apoE-ε4 carriers may show greater vulnerability to hypertension than noncarriers. Hypertension-related differences seem to occur early in the course of hypertension and are apparent even in those with adequately controlled hypertension. This suggests that prevention, rather than management, of hypertension may be vital to preserving brain health in aging.

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Disclosures

L.K. McEvoy has stock options in CorTechs Laboratories, Inc. A.M. Dale is a founder of and holds equity in CorTechs Laboratories, Inc, and serves on its Scientific Advisory Board. He is a member of the Scientific Advisory Board of Human Longevity, Inc and receives funding through research agreements with General Electric Healthcare and Medtronic, Inc. The terms of these arrangements have been reviewed and approved by University of California, San Diego in accordance with its conflict of interest policies. The other authors report no conflicts.

References

What Is New?

• In middle-aged men, hypertension, whether controlled or uncontrolled, was associated with reduction of white matter microstructural organization in many major white matter tracts.
• Similar effects were observed in individuals with recent onset (within 6 years) and those with longer duration hypertension.
• Individuals with a copy of the apoE-ε 4 allele, a genetic risk factor for Alzheimer disease, showed greater hypertension-related differences than those without the genetic risk factor.

What Is Relevant?

• Hypertension seems to have adverse effects on the brain early in the course of the disease; these effects may be difficult to reverse with blood pressure management.

Summary

Hypertension is associated with adverse effects on multiple major white matter tracts. Because these effects appear early in the course of the disease and are apparent even those who achieve good blood pressure control, prevention—rather than management—of hypertension may be critical for preserved brain health in aging.

Hypertension-Related Alterations in White Matter Microstructure Detectable in Middle Age

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HYPERTENSION-RELATED ALTERATIONS IN WHITE MATTER MICROSTRUCTURE
DETECTABLE IN MIDDLE AGE

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METHODS

Image Acquisition

Images were acquired at two sites, University of California, San Diego (UCSD) and Massachusetts General Hospital (MGH). At UCSD, images were acquired with a GE 3T Discovery 750× scanner (GE Healthcare, Waukesha, WI, USA) with an eight-channel phased array head coil. The imaging protocol included a sagittal 3D fast spoiled gradient echo (FSPGR) T1-weighted volume optimized for maximum gray/white matter contrast (TE = 3.164 msec, TR = 8.084 msec, TI = 600 msec, flip angle = 8°, pixel bandwidth= 244.141, FOV = 24 cm, frequency = 256, phase = 192, slices = 172, slice thickness = 1.2 mm), and a diffusion-weighted scan with 51 diffusion directions, b value = 1000 s/mm2, integrated with a pair of b = 0 images with opposite phase-encode polarity, TR = 9700 msec, TE 80-84 msec, pixel bandwidth 3906.25.

At MGH, images were acquired with a Siemens Tim Trio, (Siemens USA, Washington, D.C.) with a 32 channel head coil. The imaging protocol included a 3D magnetization-prepared rapid gradient-echo (MPRAGE) T1-weighted volume optimized for maximum gray/white matter contrast (TE = 4.33 msec, TR = 2170 msec, TI = 1100 msec, flip angle = 7°, pixel bandwidth= 140, slices = 160, slice thickness = 1.2 mm), and diffusion-weighted scans including two separate b=0 images with opposite phase-encode polarity, followed by two scans with 30 diffusion directions, b value = 1000 s/mm2 (and one b=0 image), TR = 9500 msec, TE 94 msec, pixel bandwidth 1371.

Image Processing

All imaging processing was performed at UCSD, using procedures that have been previously described in detail1-3. Briefly, the T1-weighted volume was automatically corrected for spatial distortion due to gradient nonlinearity4 and B1 field inhomogeneity5. Automated volumetric segmentation methods available in the FreeSurfer software suite6 were used to define grey matter, white matter and cerebral spinal fluid (CSF), and used to constrain fiber tracts as described below.

Diffusion weighted images were corrected for eddy current distortions7, head motion8, B0 distortions (using the reversing gradient method)9, and gradient nonlinearity distortions8, and then registered to the T1-weighted structural image using mutual information10 after pre-registration using atlas images for each modality. Diffusion images were then rigidly resampled into a standard orientation with 2 mm isotropic resolution. Cubic interpolation was used for all resampling steps. Conventional DTI methods were used to model the diffusion tensor as an ellipsoid where eigenvalues \( \lambda_1, \lambda_2, \text{and} \lambda_3 \) define the three primary axes11-14. Average fractional anisotropy (FA), a scalar value of the degree of anisotropic/directional diffusion within the voxel; mean diffusivity (MD), the average diffusion of all directions; longitudinal diffusivity (LD), the average diffusion along the primary axis and transverse diffusivity (TD), the average diffusion along the two non-primary axes, were calculated. Diffusion metrics for selected fiber tracts were derived using a probabilistic atlas of fiber tract locations and orientations (AtlasTrack8). T1-weighted images were used to nonlinarly register the brain to a common space, and diffusion tensor orientation estimates were compared to the AtlasTrack atlas to obtain a map of the relative probability that a voxel belonged to a particular fiber.
given the location and similarity of diffusion orientations. These probability values were used to calculate weighted averages of the diffusion measures for each fiber tract. A fiber probability threshold of 0.08 was used to ensure that voxels with very low probability of belonging to a given fiber did not contribute to average values. This threshold value was previously found to provide optimal correspondence in fiber tract volumes between atlas-derived and manually-selected fiber tract ROIs. Results of FreeSurfer’s automated brain segmentation were used to identify and exclude voxels in fiber tract regions of interest that were primarily gray matter or CSF. Left and right hemisphere metrics from homologous tracts were averaged. The nine tracts analyzed here (uncinate fasciculus, UF, inferior frontotemporal occipital fasciculus, IFOF, the inferior and superior lateral fasciculi, ILF and SLF, the cingulum portion of the cingulum bundle, CgC, anterior thalamic radiations, ATR, corticospinal tract, CST, forceps minor and forceps major) were chosen a priori based on prior findings of associations with hypertension 15-17. The anatomical locations of the nine fiber tracks are illustrated in Figure S1.

REFERENCES

Table S1. Demographic and clinical characteristics at Wave 2 of normotensive individuals and individuals with recent-onset or longer duration hypertension. Values are mean (standard deviations) unless otherwise specified.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Normotensive (n=101)</th>
<th>Shorter-Duration Hypertension (n=42)</th>
<th>Longer-Duration Hypertension (n=173)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, yrs</td>
<td>61.8 (2.6)</td>
<td>61.3 (2.7)</td>
<td>61.9 (2.5)</td>
<td>0.12</td>
</tr>
<tr>
<td>Education, yrs</td>
<td>14.2 (2.3)</td>
<td>13.7 (2.2)</td>
<td>13.7 (1.8)</td>
<td>0.11</td>
</tr>
<tr>
<td>BMI kg/m²</td>
<td>27.3 (4.5)</td>
<td>28.5 (4.9)</td>
<td>29.5 (3.9)</td>
<td>&lt;0.001†</td>
</tr>
<tr>
<td>Systolic BP, mmHg</td>
<td>119.2 (9.2)</td>
<td>130.8 (15.0)</td>
<td>133.0 (17.7)</td>
<td>&lt;0.001†</td>
</tr>
<tr>
<td>Diastolic BP mmHg</td>
<td>74.4 (6.8)</td>
<td>79.7 (9.7)</td>
<td>80.9 (9.8)</td>
<td>&lt;0.001†</td>
</tr>
<tr>
<td>*log triglycerides, mg/dL</td>
<td>4.65 (0.58)</td>
<td>4.72 (0.58)</td>
<td>4.77 (0.50)</td>
<td>0.239</td>
</tr>
<tr>
<td>*log HDL, mg/dL</td>
<td>3.92 (0.26)</td>
<td>3.83 (0.24)</td>
<td>3.86 (0.31)</td>
<td>0.138</td>
</tr>
<tr>
<td>*log LDL, mg/dL</td>
<td>4.74 (0.34)</td>
<td>4.57 (0.31)</td>
<td>4.60 (0.32)</td>
<td>0.001†</td>
</tr>
<tr>
<td>*log CRP</td>
<td>0.02 (1.03)</td>
<td>0.62 (1.10)</td>
<td>0.51 (1.01)</td>
<td>&lt;0.001†</td>
</tr>
<tr>
<td>APOE ε4+ (%)</td>
<td>26.7</td>
<td>33.3</td>
<td>22.5</td>
<td>0.327</td>
</tr>
<tr>
<td>HTN Meds (%)</td>
<td>0</td>
<td>59.5</td>
<td>72.3</td>
<td>&lt;0.001†</td>
</tr>
<tr>
<td>Statins (%)</td>
<td>23.8</td>
<td>40.5</td>
<td>42.2</td>
<td>0.007†</td>
</tr>
<tr>
<td>Diabetes (%)</td>
<td>5</td>
<td>23.8</td>
<td>16.8</td>
<td>0.003†</td>
</tr>
<tr>
<td>Smoking (% current/former)</td>
<td>21.8 / 33.7</td>
<td>26.2 / 40.5</td>
<td>17.9 / 37.6</td>
<td>0.587</td>
</tr>
<tr>
<td>Alcohol (% moderate/ heavy)</td>
<td>53.5 / 6.9</td>
<td>59.5 / 9.5</td>
<td>50.0 / 18.0</td>
<td>0.083</td>
</tr>
</tbody>
</table>

* Lipid and CRP data were missing for a small number of participants. N’s for triglyceride and LDL data for the 3 groups were 94, 40, and 160; N’s for HDL were 95, 40, 161; N’s for CRP were 97, 42, and 166.
† the longer-duration hypertensive group differed significantly from the normotensive group.
‡ the normotensive group differed from the two hypertensive groups, who did not differ from each other.
Table S2. F and p values of the differences in tract-specific diffusion measures between normotensive, and those with shorter or longer duration hypertension, controlling for age, scanner site, and non-independence of twin data.

<table>
<thead>
<tr>
<th>Fiber Track</th>
<th>FA</th>
<th>MD</th>
<th>TD</th>
<th>LD</th>
</tr>
</thead>
<tbody>
<tr>
<td>UF</td>
<td>3.72; 0.028</td>
<td>8.17; &lt;.001</td>
<td>7.13; 0.001</td>
<td>4.70; 0.011</td>
</tr>
<tr>
<td>IFOF</td>
<td>2.76; 0.068</td>
<td>2.77; 0.068</td>
<td>3.05; 0.052</td>
<td>1.55; 0.217</td>
</tr>
<tr>
<td>ILF</td>
<td>2.53; 0.085</td>
<td><strong>3.28; 0.042</strong></td>
<td><strong>3.71; 0.028</strong></td>
<td>1.63 0.200</td>
</tr>
<tr>
<td>SLF</td>
<td><strong>5.44; 0.006</strong></td>
<td><strong>6.13; 0.003</strong></td>
<td><strong>6.83; 0.002</strong></td>
<td>2.15 0.122</td>
</tr>
<tr>
<td>CgC</td>
<td>1.91; 0.154</td>
<td>1.19; 0.310</td>
<td>1.32; 0.271</td>
<td>0.32; 0.726</td>
</tr>
<tr>
<td>ATR</td>
<td><strong>4.65; 0.012</strong></td>
<td><strong>4.49; 0.014</strong></td>
<td><strong>4.98; 0.009</strong></td>
<td>2.74 0.070</td>
</tr>
<tr>
<td>FMin</td>
<td>1.85; 0.163</td>
<td>1.54; 0.220</td>
<td>1.57; 0.213</td>
<td>1.39 0.254</td>
</tr>
<tr>
<td>FMaj</td>
<td>1.11; 0.333</td>
<td>0.82; 0.443</td>
<td>0.88; 0.417</td>
<td>0.36 0.701</td>
</tr>
<tr>
<td>CST</td>
<td>0.76; 0.471</td>
<td>0.81; 0.447</td>
<td>0.89; 0.414</td>
<td>1.18 0.310</td>
</tr>
</tbody>
</table>

Values are from base models which corrected for age, scanner site and non-independence of twin data; p values < .05 are shown in bold; underlined values remained significant after adjustment, in separate models, for education level, alcohol use, BMI, diabetes, CRP levels, LDL levels, and statin use.

FA indicates fractional anisotropy; MD, mean diffusivity; TD, transverse diffusivity; LD, longitudinal diffusivity; htnt hypertension; UF, uncinate fasciculi; IFOF, inferior fronto-occipital fasciculi; ILF, the inferior lateral fasciculi; SLF, the superior lateral fasciculi; ATR, anterior thalamic radiations; CgC, cingulum portion of the cingulate bundle; Fmin, forceps minor; Fmaj, forceps major, and CST, corticospinal tract.
Table S3. Demographic and clinical characteristics of normotensive individuals and those with controlled and uncontrolled hypertension. Values shown are mean (standard deviation) unless otherwise specified.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Normotensive (n=101)</th>
<th>Controlled Hypertension (n=142)</th>
<th>Uncontrolled Hypertension (n=73)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, yrs</td>
<td>61.8 (2.6)</td>
<td>61.2 (2.5)</td>
<td>61.4 (2.6)</td>
<td>0.254</td>
</tr>
<tr>
<td>Education, yrs</td>
<td>14.2 (2.3)</td>
<td>13.6 (1.9)</td>
<td>13.9 (1.9)</td>
<td>0.062</td>
</tr>
<tr>
<td>BMI kg/m²</td>
<td>27.3 (4.5)</td>
<td>28.8 (4.2)</td>
<td>30.4 (3.96)</td>
<td>&lt;0.001†</td>
</tr>
<tr>
<td>Systolic BP, mmHg</td>
<td>119.2 (9.2)</td>
<td>123.1 (10.0)</td>
<td>150.9 (12.8)</td>
<td>&lt;0.001†</td>
</tr>
<tr>
<td>Diastolic BP mmHg</td>
<td>74.4 (6.8)</td>
<td>76.0 (7.0)</td>
<td>89.8 (8.0)</td>
<td>&lt;0.001‡</td>
</tr>
<tr>
<td>*log Triglycerides, mg/dL</td>
<td>4.65 (0.58)</td>
<td>4.73 (0.46)</td>
<td>4.83 (0.62)</td>
<td>0.129</td>
</tr>
<tr>
<td>*log HDL, mg/dL</td>
<td>3.9 (0.26)</td>
<td>3.9 (0.3)</td>
<td>3.8 (0.3)</td>
<td>0.147</td>
</tr>
<tr>
<td>*log LDL, mg/dL</td>
<td>4.74 (0.034)</td>
<td>4.55 (0.028)</td>
<td>4.67 (0.040)</td>
<td>&lt;0.001§</td>
</tr>
<tr>
<td>*log CRP</td>
<td>-0.01 (0.98)</td>
<td>0.41 (0.98)</td>
<td>0.55 (0.92)</td>
<td>&lt;0.001‖</td>
</tr>
<tr>
<td>APOE e4+ (%)</td>
<td>73.3 / 26.7</td>
<td>73.2 / 26.8</td>
<td>79.5 / 20.5</td>
<td>0.565</td>
</tr>
<tr>
<td>HTN Meds (%)</td>
<td>0</td>
<td>81</td>
<td>47.9</td>
<td>&lt;0.001†</td>
</tr>
<tr>
<td>Statins (%)</td>
<td>23.8</td>
<td>51.4</td>
<td>23.3</td>
<td>&lt;0.001§</td>
</tr>
<tr>
<td>Diabetes (%)</td>
<td>5</td>
<td>22.5</td>
<td>9.6</td>
<td>&lt;0.001§</td>
</tr>
<tr>
<td>Smoking (%current/former)</td>
<td>21.8 / 33.7</td>
<td>20.4 / 36.6</td>
<td>17.8 / 41.1</td>
<td>0.896</td>
</tr>
<tr>
<td>Alcohol (% moderate/heavy)</td>
<td>53.5 / 6.9</td>
<td>51.8 / 13.5</td>
<td>52.1 / 21.9</td>
<td>0.050‡</td>
</tr>
</tbody>
</table>

For abbreviations, see footnote to Table S2.

* Lipid and CRP data were missing for a small number of participants. The N’s for triglycerides for the 3 groups were 94,133,67; N’s for LDL were 92, 128, 64; for HDL were 95, 134, and 67; and for CRP were 96, 132, and 69.

† all 3 groups differed significantly from each other

‡ the uncontrolled hypertensive group differed from controlled hypertensive and normotensive groups, who did not differ from each other.

§ the controlled hypertensive group differed from significantly from normotensive and uncontrolled hypertensive groups, who did not differ from each other.

‖ the normotensive group differed from the hypertensive groups, who did not differ from each other.
**Table S4.** F and p values of the differences in tract-specific diffusion measures between normotensive, controlled and uncontrolled hypertension, controlling for age, scanner site, and non-independence of twin data.

<table>
<thead>
<tr>
<th>Fiber Track</th>
<th>FA</th>
<th>MD</th>
<th>TD</th>
<th>LD</th>
</tr>
</thead>
<tbody>
<tr>
<td>UF</td>
<td>3.09; 0.050</td>
<td>8.06; &lt;0.001</td>
<td>6.65; 0.002</td>
<td>4.81; 0.010</td>
</tr>
<tr>
<td>IFOF</td>
<td>2.80; 0.066</td>
<td>2.76; 0.068</td>
<td>3.05; 0.052</td>
<td>1.74; 0.181</td>
</tr>
<tr>
<td>ILF</td>
<td>2.04; 0.135</td>
<td><strong>3.39; 0.038</strong></td>
<td><strong>3.53; 0.033</strong></td>
<td>2.06 0.134</td>
</tr>
<tr>
<td>SLF</td>
<td><strong>5.55; 0.005</strong></td>
<td><strong>6.69; 0.002</strong></td>
<td><strong>7.32; 0.001</strong></td>
<td>2.63 0.077</td>
</tr>
<tr>
<td>CgC</td>
<td>1.73; 0.182</td>
<td>1.19; 0.310</td>
<td>1.18; 0.311</td>
<td>0.59; 0.558</td>
</tr>
<tr>
<td>ATR</td>
<td><strong>4.01; 0.021</strong></td>
<td><strong>4.55; 0.013</strong></td>
<td><strong>4.87; 0.010</strong></td>
<td><strong>3.20; 0.045</strong></td>
</tr>
<tr>
<td>Forceps Min</td>
<td>1.75; 0.179</td>
<td>0.72; 0.488</td>
<td>1.14; 0.323</td>
<td>0.09; 0.914</td>
</tr>
<tr>
<td>Forceps Maj</td>
<td>1.09; 0.341</td>
<td>0.93; 0.398</td>
<td>0.90; 0.411</td>
<td>0.91; 0.406</td>
</tr>
<tr>
<td>CST</td>
<td>1.36; 0.260</td>
<td>0.92; 0.400</td>
<td>1.33; 0.269</td>
<td>0.23; 0.791</td>
</tr>
</tbody>
</table>

Values are from base models which corrected for age, scanner site and non-independence of twin data; p values < .05 are shown in bold; underlined values remained significant with separate adjustment for potentially related variables, including education level, alcohol use, BMI, diabetes, CRP level, LDL level, and use of statins.

For abbreviations, see footnote to Table S2.
Figure S1. Diagrammatic representation of the anatomical location of the nine fiber tracts examined in this study. View of the tracts from the right side is superimposed on a sagittal brain image (left), view of the tracts from above is superimposed on a horizontal brain image (right). The forceps minor contains commissural fibers connecting homologous regions in left and right frontal lobes; the forceps major contains commissural fibers connecting left and right occipital regions. The corticospinal tract (CST) contains fibers that project from motor cortex to the spinal cord. The anterior thalamic radiations (ATR) connect the thalamus to the frontal lobes. The cingulum portion of the cingulate bundle (CgC) connects anterior and posterior cingulate regions. The superior lateral fasciculus (SLF) connects dorsolateral prefrontal areas to supplementary motor areas, superior temporal areas and occipital cortex. The uncinate fasciculus (UF) connects orbitofrontal cortex to temporopolar and limbic regions. The inferior fronto-occipital fasciculus (IFOF) is a long-range cortical association fiber pathway that connects frontal to occipital cortices. The inferior lateral fasciculus (ILF) connects anterior temporal regions with occipital areas.
Figure S2. Transverse diffusivity of the nine tracts for normotensive individuals (Normo) and those with longer or shorter duration hypertension. * p < .05. ** p < .01 for the comparison of the hypertension subgroup with the normotensive group, from the pairwise comparisons within the base model, which controlled for age, scanner site and non-independence of twin data. Longer and shorter duration hypertensive groups did not differ from each other for any measure. For tract abbreviations, see Figure S1.
Figure S3. Transverse diffusivity of the nine tracts for normotensive individuals (Normo) and those with controlled or uncontrolled hypertension. * p < .05. ** p < .01 for the comparison of the hypertensive subgroup with the normotensive group, from the pairwise comparisons within the base model, which controlled for age, scanner site and non-independence of twin data. Controlled and uncontrolled hypertensive groups did not differ from each other for any measure. For tract abbreviations, see Figure S1.