Table S1: Relation of RLS to hypertension, cardiovascular disease and stroke. Summary of study characteristics and findings.

First Author, Year, Country	Study Population	Condition (Ascertainment)	RLS/PLMS Definition Used	Reported Association			Additional Comment
				HTN	CVD	Stroke[#]	
Van Den Eeden, 2015,[2] USA	473 358 person-year follow-up (mean follow-up time: 3.91 years); subjects were subclasified in primary vs secondary RLS (7621 primary RLS and 4507 secondary RLS)	Outcomes and covariates derived from the electronic clinical databases at KPNC. ICD9 codes were used: CAD (International Classification of Diseases, Ninth Revision [ICD-9] 410, and 413, or a coronary revascularizatio n procedure); CVD (CAD plus ischemic stroke [ICD-9 434], or transient ischemic attack [ICD-9 435]); and hypertension (ICD-9 401)	RLS assessment: RLS was identified and classified using a complex algorithm which incorporates record diagnoses of RLS, survey data from the California Men's Health Study, and clinical expert evaluation of a sample of electronic medical records. Secondary RLS: If the initial RLS diagnosis was made within 2 years of a diagnosis commonly known to cause secondary RLS such as anemia, pregnancy, or chronic renal failure (or renal dialysis). Primary RLS: Absence of above conditions associated with	Secondary RLS was associated with hypertension (aHR=1.28; 95%CI, 1.18–1.40) compared to just a mild increased risk in primary RLS was (aHR 1.19; 95%CI, 1.12–1.25). The association of hypertension in secondary RLS moves to a null value when this group and its comparison group were matched for baseline comorbidities (anemia, renal disease, pregnancy).	Secondary RLS group showed increased risk of incident CVD (HR= 1.33; 95%CI, 1.21–1.46) as well as incident CAD (HR= 1.40; 95%CI, 1.25–1.56). The associations of CVD and CAD in secondary RLS move to a null value when this group and its comparison group were matched for baseline comorbidities (anemia, renal disease, pregnancy). No significant increased risk of incident CAD or CVD was found in the primary RLS group.		HR for CAD and CVD was adjusted for age, race, sex, smoking, diabetes, BMI, hypertension, hypertension treatment, hyperlipidemia and hyperlipidemia treatment. For hypertension the HR was adjusted for age, race, sex, smoking, diabetes, BMI, hyperlipidemia and hyperlipidemia treatment.

Winter, 2013,[3] USA	N= 22786 Mmen in the US Physicians' Health Studies I and II	Self-reported vascular risk factors. Prevalent major cardiovascular disease, stroke, and myocardial infarction, were confirmed by medical record review.	RLS assessment: Self-reported symptoms using minimal diagnostic criteria combined in 3 questions.	NS	There was a negative association of RLS and prevalent myocardial infarction (OR = 0.73; 95%CI = 0.55-0.97).	RLS was positively associated with stroke (OR = 1.40; 95% CI 1.05-1.86).	For hypertension, multivariable models include all vascular risk factors and were adjusted for age, and randomized aspirin assignments. Prevalent cardiovascular events adjusted for age, randomized aspirin assignments, parental history of myocardial infarction, history of hypertension, history of diabetes, history of hypercholesterolemia, alcohol consumption, BMI, exercise, smoking, and history of depression;
Winter, 2013,[4] USA	N= 30262 Female health professionals (participants in the Women's Health Study [WHS])	Cardiovascular disease events were self-reported and confirmed by medical record review. Major cardiovascular disease defined as a combined end-point of either non-fatal myocardial infarction or non-fatal stroke.	RLS assessment: Self-reported symptoms using minimal diagnostic criteria combined in 3 questions.	NS	After exclusion of secondary RLS cases, no association was found between RLS and prevalent cardiovascular disease (major cardiovascular disease, myocardial infarction, or subjects who underwent coronary revascularization.	NS	For hypertension, multivariable models include all vascular risk factors and were adjusted for age, randomized aspirin assignment, postmenopausal status, postmenopausal hormone use, oral contraceptive use. For prevalent CVD events multivariable models were adjusted for age, randomized aspirin assignment, parental history of myocardial infarction, history of diabetes, BMI, smoking status, alcohol consumption, history of hypertension, exercise, hypercholesterolemia, history of depression, postmenopausal hormone use, postmenopausal

							status and oral contraceptive use
Koo, 2011,[5] USA	N= 2911 Elderly men from the Outcomes of Sleep Disorders in Older Men (MrOS) Sleep Study cohort ; Age: 76.4 ±5.5 y; over 4-y follow up period (range, 9 days to 5.4 y).	Cardiovascular events were surveyed with postcard and/or phone contact every 4 months. Relevant medical records and supporting documentation were obtained if needed, or next to kin were interviewed.	PLMS assessment: In-home polysomnogram (PSG). PLMI was categorized in 'roughly tertiles': PLMI <5, 5 to <30, and ≥30.	NS	No association of PLMS with CAD, CHD. Note: A weak association of PLM arousal index ≥5/h was found with all-cause cardiovascular disease (HR= 1.26; 95%CI, 1.01–1.57; *p* trend 0.0402).	NS	For hypertension, OR was adjusted for clinic site, age, BMI, race, depression, prevalent diabetes, smoking, alcohol use, physical activity, antidepressant use, benzodiazepine use, and AHI. For incident cardiovascular disease HR was adjusted for the same variables as above + hypertension.
Ferri, 2016,[8] Italy and USA	N=171 3 groups: Patients with RLS symptoms less than 10 y (n = 53, 42 females and 11 males, mean age 53.7 ± 11.8 y). Patient with RLS symptoms for more than 10 y (n = 44, 30 females and 14 males, mean age 54.8 ± 14.4 y). Control patients (n = 74, 53 females and 21 males, mean age 53.3 ± 13.36 y).	Silent cerebral small vessel disease (SVD) was evaluated with MRI	RLS assessment: IRLSSG criteria used; history and physical (including neurological) examination by a physician experienced in the diagnosis of RLS; for RLS duration the patient were classified as having RLS >10 y vs <10 y.			Patient with RLS duration > 10 y had SVD area and volume significantly higher compared to both controls and RLS patients < 10 y disease duration. SVD area and volume were not different between controls and RLS patients with <10 y disease duration.	
Ohayon, 2002,[19]	N=18980; Age: 15- 100 y old;	Self-reported heart disease	RLS assessment: RLS assessed by	Hypertension was associated with	Heart disease was associated with		OR adjusted for age, sex, daytime work, BMI,

UK, Germany, Spain, Portugal, Italy	51.3% women	and HTN	telephonic interview using minimal but old RLS criteria. RLS: ICSD 90	RLS (OR 1.36; 95% CI 1.14-1.61; P < 0.001).	RLS (OR 1.41; 95% CI 1.06-1.88; P < 0.05).	blood pressure, musculoskeletal or heart disease, physical activity, snoring, obstructive sleep apnea, cataplexy, coffee or alcohol consumption, smoking, life stress, hypnotics use, and mental disorders.
Winkelman, 2006,[20] USA	N= 2821 Subjects from the Wisconsin Sleep Cohort; mean age: 53 ± 8 y (range 40–75 y)	Self-reported cardiovascular disease and HTN.	RLS assessment: the "urge to move legs, when sitting or lying down, relieved by movement, with uncomfortable feelings in the legs and sleep disruption required"; Sx more than once per week.	NS	Patients with daily RLS symptoms had increased prevalence of cardiovascular disease compared with those without RLS symptoms (OR = 2.58; 95%CI, 1.38-4.84).	OR adjusted for age, sex, body mass index, current smoking, sleep-disordered breathing treatment, diabetes, and snoring.
Winkelman, 2008,[21] USA	N= 3433 Subjects from the Sleep Heart Health Study (SHHS); Mean age: 67.9 y (range: 44-98 y); Female: 54.6%	CAD/CVD: Self-reported HTN: BP was measured in the SHHS; anti-HTN medication use	RLS assessment: IRLSSG criteria Severity assessed: Sx occurred >15 days/month	NS	Increased prevalence of CAD (OR= 2.05; 95%CI, 1.38 to 3.04) and CVD (OR= 2.07; 95%CI, 1.43 to 3.00). Stronger correlation with symptoms frequency ≥ 16 times/month and more severe RLS symptoms. Association was lost in less severe RLS subjects.	OR adjusted for age, sex, race, presence of hypertension, diabetes, smoking history and cholesterol levels.
Li, 2012,[22] USA	N= 70977 Women free of coronary heart	Self-reported CHD event (fatal/non-fatal MI).	RLS assessment: Physician-diagnosed RLS was collected via		Women with RLS≥3 y were found to have more non-fatal	Adjusted for age, ethnicity, smoking status, major chronic disease, alcohol drinking, BMI,

	disease (CHD) and stroke at baseline from the Nurses' Health Study; Mean age: 67 y; follow-up period: 6 y	Information confirmed through review of medical records.	questionnaires. RLS duration assessment: ≥3 y vs <3 y		myocardial infarction (HR= 1.80; 95%CI 1.07-3.01). No statistically significant results found for fatal CHD (HR = 1.49; 95%CI 0.55-4.04).		physical activity, diet quality as assessed by the alterative healthy eating index, menopause status, sleep characteristics, medication and hormones use at baseline, and other variables.
Molnar, 2015,[23] USA	N= 7392 US Veterans patients; Mean age: 59.9 ± 14.3 y; 93% male; 50% RLS positive (incident); Median follow up: 8.1 y	Incident CHD assessed with ICD-9-CM or CPT code for acute MI, coronary artery bypass grafting or percutaneous angioplasty; stroke assessed by ICD-9-CM codes for ischemic stroke.	RLS assessment: Identified using ICD9 diagnostic codes.		Incident RLS was associated with incident CHD (HR 3.97; CI 95% 3.26-4.84).	Incident RLS was associated with incident stroke (HR 3.89; CI 95% 3.07-4.94).	A propensity-matched cohort was created. Multiple variables were used in the logistic regression model to create the propensity score: age, gender, race/ethnicity, income, marital status, baseline eGFR, comorbidities (DM, HTN, cardiovascular diseases, heart failure, CVA, PAD, lung diseases, dementia, RA, malignancy, HIV, depression, presence of OSA, PLMS and BIM). Similar results after adjusting for insomnia.
Wesstrom, 2008,[24] Sweden	N= 3516 Swedish women: Age range: 18-64 y; response rate 70.3%	Self-reported 'heart problems' and HTN using one yes/no question.	RLS assessment: Mailed questionnaires for the 4 IRLSSG criteria.	NS	RLS patients had more co-morbid ‘heart disease” (adjusted OR= 2.13; 95%CI, 1.18-3.86).		OR adjusted for age, smoking, alcohol and coffee consumption and use of sleeping pills
Phillips, 2006,[25] USA	N= 1,506 Subjects from the National Sleep Foundation (NSF) Sleep in America 2005; Mean age: 49 y;	Self-reported physician diagnosis of heart disease or high BP via telephonic interview.	RLS assessment: Two questions telephonic interview: 1.“How often did you have unpleasant feelings in your legs like	There was more RLS in hypertensive patients ($P < 0.05$).	NS		Adjusted for age, gender, and an existing diagnosis of a sleep disorder.

	51.5% women		creepy, crawly or tingly feelings at night with an urge to move when you lie down to sleep?" 2. "Would you say these feelings in your legs are worse, about the same as, or better at night or in the evening compared to other times of day?" Severity assessed: Sx ≥1 time/wk and worse at night.				
Elwood, 2006,[26] UK	N= 1986 Men who completed questionnaires in the Caerphilly cohort in UK; Age range: 55-59 y; Follow up period: 10 y	Self-reported vascular events, review of hospital and general practitioner notes; ECG and BP measurement.	RLS assessment: Self-administered questionnaire (Wisconsin sleep questionnaire). Subjects were asked for 'restless legs or bothersome twitches'. Symptoms frequency ≥ 1-2 x/wk were included.	NS	NS	RLS patient had a small but significant higher incidence of stroke (OR 1.67; CI 95% 1.07 -2.60; P = .024).	OR adjusted for age, social class, smoking, alcohol consumption, BMI, and neck circumference.
Batool-Anwar, 2011,[35] USA	N= 65544 Women who participated in the Nurses' Health Study II; Age range: 41-58 y	Self-reported hypertension and BP.	RLS assessment: Self-administered questionnaire based on the IRLSSG criteria.	RLS group had more prevalent hypertension than those without RLS (OR 1.20; 95% CI: 1.10-1.30; P<0.0001). Severity of RLS correlated with higher odds of hypertension, i.e. RLS symptoms 5 to 14 times per			OR adjusted for age, race, BMI, physical activity, menopausal status, smoking, use of analgesics, intake of alcohol, caffeine, folate, and iron levels.

				month (aOR of 1.06; 95%CI, 0.94-1.18) vs RLS symptoms ≥15 times per month (aOR= 1.41;95%CI, 1.24-1.61).	
Shi, 2015, [36] China	N=2941 Adult patients from a rural community in Shanghai; 50% women; Age: ≥18 y; Mean age for the no-RLS group was 59.1±16.0 and for RLS group 43.3±15.4; RLS cases: 41; RLS prevalence: 1.4%	Hypertension assessed by self-reported physician-diagnosed hypertension.	RLS assessment: 4-item IRLSSG screening questionnaire, followed by a telephonic interview by a sleep specialist to rule out mimics of RLS.	Hypertension was associated with RLS (OR = 4.10; 95% CI: 1.88–8.92; P<0.001). When compared by gender, hypertension was a risk factor for RLS in males but not in females.	Multivariate logistic regression analysis was used to detect the risk factors associated with RLS (models were adjusted for demographic factors, life styles, and medical histories).
Pennestri, 2013, [37] Canada	N=28 14 RLS subjects (6 men, 8 women; 47.6±11.8 y), and 14 healthy subjects (6 men, 8 women; 46.6±9.7 y) matched for age and gender	Blood pressure measured beat-to-beat continuously during one night PSG; SBP and DBP were measured for 10 beats before and 15 beats after onset of PLMS with and without microarousals.	RLS assessment: IRLSSG criteria used, subjects were examined face-to-face, selected patient must have PLMI >5, mimickers were excluded.	Both groups (PLMS in healthy subjects and PLMS with RLS) showed significant increase of HR, systolic and diastolic BP during PLMS. Above variables were more pronounced in subjects with RLS compared to the healthy group.	Note: The aim of the study was to compare BP changes in PLMS in patient with RLS vs healthy controls.
Espinar-Sierra, 1997, [38] Spain	N=91 Patients from a hypertension clinic; Mean	Hypertension classified according to the WHO criteria, third revision.	PLMS assessment: PSG was performed; an old version of PLMS definition was used	The prevalence of PLMS in hypertension type I and type II (combined) was	Adjustments were made for age, sex, apnea severity and anti-hypertensive medications.

	age: 49 y; Age range: 20-76 y; 50.5% women		(Bixler et al. 1982: PLMS were considered to be present if either the criteria for nocturnal myoclonic activity (NMA) or nocturnal myoclonus (NM) were met).	13% compared with a prevalence of 36% in hypertension type III.	Note: The sample was relatively small, with 9 patients in the type I and II hypertension group, and 9 patients in the type III hypertension group.
Wing, 2010, [39] China	N= 314 Children of an ongoing epidemiologic project in Hong Kong; Mean age 10.4 y; 38% girls; 17 children had PLMS	Hypertension defined as a mean SBP or DBP > 95th percentile; prehypertensive if mean SBP or DBP > 90th percentile compared to reference values. Ambulatory BP was monitored using a validated oscillometric monitor; measured hourly during nighttime and every 30 minutes during daytime.	PLMS assessment: PLMS defined as PLMI ≥ 5/hr. Specific RLS symptoms were not addressed.	Children with PLMS had higher risk for elevated nocturnal diastolic BP (aOR= 4.83; 95%CI, 1.66-14.07) and systolic BP (aOR= 6.25; 95%CI, 1.87-20.88) compared with those without PLMS. There was an increased trend for diastolic non-dippers, and for higher daytime systolic and diastolic BP in children with PLMS.	Aim: To analyzed the association of PLMS and hypertension OR adjusted for age, gender, risk for OSA, and birth history. Notes: Non-dipper was defined as nocturnal BP dipping of less than 10% The mean nocturnal BP did not differ between children with and without PLMS.
De Vito, 2014, [40] USA	N= 42,728 female participants from the Nurses' Health Study II; Mean age: 45 y; N=12,812 male participants from the Health	Hypertension reported by physicians at baseline and every 2 y; then participants were asked to report their systolic BP.	RLS assessment: Subjects meeting the IRLSSG criteria and symptoms occurring ≥5 times/month.	NS	Adjustments made for age, ethnicity, smoking, physical activity, use of antidepressant, and other covariates Aim: To analyze prospectively if hypertension is associated with increased risk

	Professionals Follow-up Study; Mean age: 65 y Participants were free of RLS at baseline. Follow-up: 2002-2008 for men, 2005-2009 for women					of developing RLS.
Högl, 2005, [41] Italy	N= 701 Subjects form the general population; Age range: 50 to 89 y	Blood pressure ≥ 140/90 or the use of hypertensive drugs	RLS assessment: IRLSSG criteria and clinical examination.	NS		OR adjusted for age and sex
Giannini, 2014, [42] Italy	N=1709 On-going adult population-based study performed in Northern Italy; 57.5% were women; Mean age 46.3 ± 16.3 y	Self-reported hypertension or anti-hypertensive medication use	RLS assessment: IRLSSG diagnostic criteria in a face-to-face interview.	NS		OR adjusted for age, sex, diabetes mellitus, history of myocardial infarction, raised blood lipids, and BMI.
Benediktsdottir, 2010, [43] Iceland and Sweden	N=1344 Rrandom sample drawn from National Registries of Iceland and Sweden ; Age ≥ 40-y	Self-report of doctor-diagnosed hype rtension and anti-hypertensive medication use	RLS assessment: IRLSSG criteria questionnaire and interview.	NS	NS	Adjusted for center, age, sex and smoking history
Rothdach, 2000, [44] Germany	N= 369 Elder participants; Mean age: 72.7 y; 47.3% female	Self-reported history of hypertension	RLS assessment: IRLSSG criteria used; face-to-face interviews by two RLS-trained physicians	The RLS group had significantly lower hypertension compared to the group without		Limitation: This relatively small study included 36 RLS patients. Only 2 of them reported hypertension.

				RLS (5.6% vs 23.4%; P = 0.04).		
Scofield, 2008,[45] USA	N = 592 Mean age: 41.9 ± 12.6 y; 52.9% women; 31.5% African American	Self-reported hypertension	PLMS assessment: PSG was performed, standardized criteria used; PLMS defined as PLMI >15/hr.	NS		This study was not designed specifically to address the association of HTN and PLMS.
Schuiling, 2005,[68] Netherlands	N=83 Post-subarachnoid hemorrhage survivals patients at one or more year after hemorrhage; Mean age: 53.3 y; 70% women	Non-traumatic SAH assessed by extravasated blood in the basal cisterns on computed tomography (CT) or, if CT was negative, xanthochromia in the cerebrospinal fluid.	RLS assessment: Initial questionnaire screening for sleep disorders, followed by 48-hour PSG at home (N=20) in those with severe scores for insomnia and excessive daytime sleepiness. RLS/periodic limb movement disorder (PLMD) was defined based on a PLMI >10/h plus a history of RLS.		RLS/PLMD was found in 25% (5 out 20) of patients with reported severe sleep disturbance and previous subarachnoid hemorrhage.	The study was limited by small sample and the absence of a control group (only 5 patients with RLS/PLMD).
Lee, 2009,[69] South Korea	N= 137 Patients with acute ischemic stroke, free of RLS at baseline; Mean age: 63.9 ± 11.9 y; Age range: 30–86 y; 46% women	Ischemic stroke assessed by brain magnetic resonance imaging (MRI).	RLS assessment: IRLSSG criteria		Incidence of post-stroke RLS was 12.4% (17 patients). Six-teen out of 17 strokes were subcortical strokes: 10 located in the basal ganglia/corona radiata, 4 in the pons, and 3 in other areas.	Note: Only patients reporting RLS symptoms within one month-post stroke were included.
Gupta, 2015, [70] India	N= 346 Consecutive patients with a	Brain CT/MRI findings supporting clinical	RLS assessment: A diagnosis by IRRLSG criteria made only if there		The prevalence of RLS among patients with stroke was	

	first-ever ischemic or hemorrhagic stroke (up to four weeks from ictus); prospective study conducted over a 3-year period.	diagnosis of stroke	was agreement between independent blinded evaluation by two experienced sleep physicians ; clinical evaluation was carried out through a pre-structured sleep questionnaire; PSG was performed.	10.1% (35 patients); more than 80% were subcortical in nature (16 hemorrhagic and 13 ischemic strokes). RLS symptoms were present on average for 60 ± 40 months before stroke.	
Medeiros, 2011, [71] Brasil	N= 96 Subjects with acute ischemic stroke; Mean age: 64.0 ± 8.9; 38.5% women; RLS prevalence: 12.5%; 51 patients without and 11 with RLS completed the longitudinal evaluation; follow-up at 3 and 12 months.	Stroke outcome estimated by the Barthel Index and the modified Rankin Scale.	RLS assessment: IRLSSG criteria	Stroke outcomes at 3 and 12 months were worse in the RLS patients ($p<0.05$).	Adjusted for diabetes and BMI. Note: The study was limited due to a small number of subjects (only 11 RLS patients). In addition, at baseline RLS patients had more severe stroke by Barthel Index and mRS.
Walters, 2010, [72] Germany	N= 267 26 RLS cases and 241 controls from the population based MEMO-Study.	Clinical stroke, silent infarction, subcortical lesions and cortical atrophy were visually assessed with brain MRI.	RLS assessment: IRLSSG criteria and standardized neurological examination	NS	Age, sex and co-morbidities were taken into account in a logistic regression model.
Park, 2012, [73] South Korea	N= 102 38 idiopathic RLS (iRLS) patients; Mean	Carotid intima-media thickness (IMT) was measured by high-resolution	RLS assessment: IRLSSG criteria Patients with secondary RLS	Idiopathic RLS patients showed significantly lower mean IMT ($p < 0.05$),	Univariate and multivariate analyses included age, sex, hypertension, diabetes, hypercholesterolemia,

	age: 59.0 ± 16.2 y; 55.2% women, and 64 controls; Mean Age 58.9 ± 12.9 y; 54.6% women	B-mode ultrasound.	associated with iron deficiency, renal failure, or pregnancy were excluded; also patients with PLMS or iRLS with PLMS were excluded.	compared with controls. The authors concluded that iRLS patients had a low risk of atherosclerotic progression.	and current cigarette smoking status.
Benbir, 2012, [74] Turkey	N=70 35 consecutive patients with acute ischemic supratentorial stroke; Mean age: 68.1 ±9.9 y; 37.1% women. 35 age-and sex-matched healthy controls; Mean age: 65.7 ±10.1 y, 31.4% women	Brain MRI confirmed stroke	PLMS assessment: Overnight PSG performed, AASM scoring criteria used; PLMS defined as PLMI>15/hr; subjects were prospectively investigated for PLMS within 1 week of stroke onset.	Px with supratentorial stroke had more PLMS compared with healthy controls (54.3% vs 17.1%, respectively; P = 0.038).	No associations were found in terms of stroke localization and PLMS, PLMI or RLS. Most patients had PLMS contralateral to the stroke.
Coelho, 2010,[75] Canada	N= 80 Patients attending the Sunnybrook Hospital Sleep Laboratory between 2004 and 2009; 40 stroke patients (Age: 63.3 ± 1.9 y; 30% women) and 40 controls matched for age, sex, and confound comorbidities	Self-reported history of stroke; medical and PSG record review.	PLMS assessment: Overnight PSG was performed, AASM scoring criteria used. PLMS defined as PLMI>5/hr.	The prevalence of PLMs in stroke patients was 47% compared with 12.5% in control subjects (P < 0.001). The average PLMS index in stroke was 11.7 ± 3.4 compared with 1.9 ± 0.7 in the control group (p= 0.006).	The aim of the study was to assess the frequency of PLMS in patients with a history of stroke. Note: The timing of PLMS symptoms onset in relation to stroke were missing, and no details about the location of the strokes were provided.

	(Age: 63.4 ± 1.7 y; 30% women).

Abbreviations: aOR = adjusted Odds Ratio; BMI = body mass index; CAD = coronary artery disease; CHD = coronary heart disease; CVD = cardiovascular disease; DBP = diastolic blood pressure; ECG = electrocardiogram; HTN = hypertension; IMT = intima-media thickness; ICSD = International Classification of Sleep Disorders; IRLSSG = International Restless Legs Syndrome Study Group; KPNC = Kaiser Permanente Northern California; NS = no significant (value); OR = Odds ratio; Px = patient(s); PLMD = periodic limb movements in sleep; RLS = restless legs syndrome; SBP = systolic blood pressure; Sx = symptoms; wk = week.

[#]Case reports of RLS/PLMS associated with stroke were not included in this table.