Does Ticlopidine Prevent Reversible Cerebrovascular Ischemic Events in Women?

Recently, there has been a greater awareness of gender differences in age-specific stroke mortality and morbidity, risk factor constellations, and treatment outcomes. For example, it is controversial whether aspirin is equally effective in preventing stroke in women and men. However, the primary analysis from the Ticlopidine Aspirin Stroke Study (TASS) found that ticlopidine reduces the risk of subsequent fatal and nonfatal stroke in women and men with an initial reversible cerebrovascular ischemic event or minor stroke. The overall risk reduction for ticlopidine-treated patients was greater than that seen for aspirin-treated patients. This efficacious response in both genders was confirmed by the Canadian American Ticlopidine Study (CATS) and collaborators suggested in their analysis that women benefit most from ticlopidine. But again, this is from the baseline characteristics of TASS. Unfortunately, no analysis was performed, either by Grotta et al or myself, to evaluate separately for women the efficacy of ticlopidine in preventing reversible cerebrovascular ischemic events. It would be interesting to undertake such an evaluation, but one must realize that as we concentrate on smaller and smaller subgroups, the number of events as well as the number of patients involved gets ever smaller, and the power of statistical analysis loses its effectiveness and meaning.

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Improving Stroke Rehabilitation: A Controlled Study

The randomized clinical trial by Kalra and colleagues found a significantly better outcome for stroke patients treated in a stroke unit compared with those in general medical wards. Although baseline characteristics of the patients and total physiotherapy time were similar in the two groups, the authors did not give any information about the physiotherapy staff in the two arms of the trial. It is likely that physiotherapists in the unit dedicated to stroke care were more interested and specialized in stroke rehabilitation than their colleagues in general medical wards. The study was carried out in a district general hospital in Britain. Stroke rehabilitation in the general medical wards of such hospitals makes up only a part of physiotherapists' total workload, with the bulk comprising other activities, such as chest physiotherapy. Furthermore, the seniority of the physiotherapy staff in the two treatment areas was not addressed. Consequently, an equal number of “30-minute therapy units” of stroke rehabilitation delivered by therapists of different experience and seniority cannot be considered as equivalent.

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References

Migraine Equivalent and Hemorrhagic Infarction

The cause of stroke during migraine is unknown. We report here the very rare case of a patient who suffered a hemorrhagic cerebral infarction after scintillating scotoma.

In July 1980, acute left homonymous hemianopia and scintillating scotoma were experienced by a 70-year-old man, who had been suffering recurrent scintillating scotoma without migraine headache twice a month for about 30 years. The visual abnormality lasted approximately 30 minutes, which was longer than usual. He had a sensation of “lightning bolts,” left homonymous hemianopia, and what appeared to be glittering lights. On neuroophthalmologic examination, visual field testing showed left homonymous superior quadrantanopia. Computed tomographic scanning and magnetic resonance imaging showed hemorrhagic infarction in the right occipital lobe. No abnormal findings were detected by electroencephalography. Angiography showed poor filling in the vicinity of the right posterior cerebral artery. The left homonymous hemianopia and scintillating scotoma changed into visual hallucinations. The visual hallucinations suddenly followed the scintillating scotoma, and the lesion was consistent with that of scintillating scotoma. Moreover, the hemorrhagic infarction lesion did not conflict with the focus of the symptom neuroradiologically.

The left homonymous hemianopia and visual hallucinations were thus considered to have a cause-and-effect relationship with the hemorrhagic infarction. Recurrent scintillating scotoma may be produced by a variety of causes. However, the scintillating scotoma and left homonymous hemianopia for 30 years may have been caused by transient ischemic attacks in the right occipital lobe followed by migraine equivalent.

In classical migraine headache, the neurological symptoms of the aura are generally attributed to focal ischemia. Migraine stroke is a complication of this headache. However, the mechanism of cerebral ischemia in migraine remains unknown. No cases of hemorrhagic infarction followed by migraine equivalent have been reported in the literature. This case should thus provide some clarification of the mechanism of cerebral ischemia in migraine.

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Reference

Major Cerebral Vessel Occlusion in SLE Due to Circulating Anticardiolipin Antibodies

Stroke due to major cerebral artery occlusion is a recognized but rare consequence of systemic lupus erythematosus (SLE). There are at least 30 reported cases; in all but one, the SLE was active at the time of the stroke. In that patient, the postulated mechanism was in situ thrombosis due to circulating anticardiolipin (aCL) antibodies, but the specific assay was not performed. We have studied a second such patient with an acute hemispheric stroke and angiographically proven large- vessel occlusion in association with inactive SLE, with aCL antibodies as the presumed mechanism.

At age 22, the patient had acute glomerulonephritis due to SLE. His condition improved, but there was residually elevated serum creatinine (2.8 mg/dL) and proteinuria (500 mg/24 h). He first developed hypertension and had a right frontal headache in June 1993. One month later he suddenly had left hemiplegia. At his local hospital, a brain computed tomographic (CT) scan showed a large superficial and deep infarct in the territory of the upper and lower
Improving stroke rehabilitation: a controlled study.

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Stroke. 1994;25:911-912
doi: 10.1161/01.STR.25.4.911.b

Stroke is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 0039-2499. Online ISSN: 1524-4628

The online version of this article, along with updated information and services, is located on the
World Wide Web at:
http://stroke.ahajournals.org/content/25/4/911.2.citation

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