Transesophageal Echocardiography Is Superior to Transthoracic Echocardiography in Management of Patients of Any Age With Transient Ischemic Attack or Stroke

Sebastiaan F.T.M. de Bruijn, MD, PhD; Willem R.P. Agema, MD, PhD; Gert Jan Lammers, MD, PhD; Ernst E. van der Wall, MD, PhD; Ron Wolterbeek; Eduard R. Holman, MD, PhD; Edward L.E.M. Bollen, MD, PhD; Jeroen J. Bax, MD, PhD

Background and Purpose—The merits of transthoracic echocardiography (TTE) and transesophageal echocardiography (TEE) in the management of transient ischemic attack (TIA) and stroke patients remain a matter of debate.

Methods—Two hundred and thirty-one consecutive patients with a recent TIA or stroke for which no definite cause and indication for anticoagulation was assessed after standardized work-up underwent TTE and TEE. Echocardiographic findings were categorized into minor and major risk factors.

Results—A potential cardiac source of embolism was detected in 55% (127/231) of the patients by echocardiography, in 39% (90/231) only identified on TEE. Major risk factors, with an absolute indication for oral anticoagulation, were detected in 20% (46/231) of the patients, in 16% (38/231) of all patients identified on TEE only. A thrombus in the left atrial appendage was the most common major risk factor (38 patients, 16%). The presence of major risk factors was independent of age ($\chi^2=1.48; P=0.224$). The difference in proportions of cardiac sources detected in favor of TEE was highly significant in both patients ≤45 years of age (10/39, $P=0.002$) and in those >45 years of age (80/192; $P<0.004$).

Conclusions—TEE proved superior to TTE for identification of a cardiac embolic source in patients with TIA or stroke without pre-existent indication or contraindication for anticoagulation. In patients with normal TTE, a cardiac source of embolism was detected by TEE in ≈40% of patients, independent of age. More than 1 of 8 patients of any age with normal TTE revealed a major cardiac risk factor on TEE, in whom anticoagulation is warranted. (Stroke. 2006;37:2531-2534.)

Key Words: anticoagulation • echocardiography • stroke • TIA

It has been estimated that cardiogenic emboli are a source of transient ischemic attack (TIA) or stroke in 20% to 40% of all cases.1 Recently, transesophageal echocardiography (TEE) has been proven superior to transthoracic echocardiography (TTE) for the detection of potential sources of cardiac embolism in patients with previous stroke.2 The diagnostic yield of TEE for the detection of a cardiac source of embolism is estimated between 40% and 60%.3,4 However, the precise relative merits of TEE and TTE in the management of TIA and stroke patients remain a matter of debate.5,6 In clinical practice, TTE is still the first choice technique in patients with stroke, particularly in patients over 45 years of age. In these patients, TEE is frequently not performed when TTE does not reveal abnormalities.

In the current prospective study, the relative merits of TTE and TEE to identify a potential cardiac source of embolism were compared in patients with a TIA or stroke without a definite cause after the standardized work-up, and without clear indication or contraindication for anticoagulation. In particular, the additional value of TEE in the patients above 45 years of age, in whom TEE is still far from routine procedure, was evaluated. In addition, emphasis was placed on therapeutic consequences, ie, the indication for anticoagulation, based on the results of TEE and TTE in patients with TIA or stroke of all ages.

Methods

From January 2002 to March 2004, 231 consecutive patients, both from the clinics and the outpatient clinic, were prospectively enrolled. Eligible patients had a recent TIA or stroke, for which no definite cause and indication for anticoagulation was assessed after standardized diagnostic work-up (12-lead ECG, carotid ultrasound if applicable, routine blood tests with hematology included). We included strokes of all subtypes, both from the anterior and the posterior circulation. Patients with a pre-existing indication or contraindication to anticoagulation were excluded.

All patients underwent TTE, directly followed by TEE, which were performed by experienced sonographers (W.R.P.A., E.R.H., J.J.B.) according to a predefined protocol. For TTE, patients were imaged in the left lateral decubitus position using a commercially available system.

Received April 6, 2006; accepted June 27, 2006.


Correspondence to S.F.T.M. de Bruijn, Leiden University Medical Centre and Haga Hospital, The Hague, The Netherlands. E-mail s.debruijn@hagaziektenhuis.nl

© 2006 American Heart Association, Inc.

Stroke is available at http://www.strokeaha.org

DOI: 10.1161/01.STR.0000241064.46659.69

2531
TABLE 1. Potential Cardiac Sources of Embolism in 231 TIA or Stroke Patients Assessed by TTE or TEE

<table>
<thead>
<tr>
<th>Potential Cardiac Source</th>
<th>TTE</th>
<th>TEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major risk factor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LA cavity thrombus</td>
<td>0</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>LA appendage thrombus</td>
<td>1 (1%)</td>
<td>38 (16%)</td>
</tr>
<tr>
<td>LV thrombus</td>
<td>2 (1%)</td>
<td>*</td>
</tr>
<tr>
<td>Aortic thrombus</td>
<td>0</td>
<td>*</td>
</tr>
<tr>
<td>Dilated cardiomyopathy (LVEF &lt; 35%)</td>
<td>5 (2%)</td>
<td>*</td>
</tr>
<tr>
<td>Mitral valve stenosis</td>
<td>0</td>
<td>*</td>
</tr>
<tr>
<td>Minor risk factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mitral valve prolapse</td>
<td>4 (2%)</td>
<td>*</td>
</tr>
<tr>
<td>Mitral annular calcification</td>
<td>4 (2%)</td>
<td>*</td>
</tr>
<tr>
<td>Calcified aortic stenosis</td>
<td>8 (3%)</td>
<td>*</td>
</tr>
<tr>
<td>Patent foramen ovale</td>
<td>3 (1%)</td>
<td>12 (5%)</td>
</tr>
<tr>
<td>Spontaneous echo contrast</td>
<td>2 (1%)</td>
<td>5 (2%)</td>
</tr>
<tr>
<td>Atrial septal aneurysm</td>
<td>5 (2%)</td>
<td>8 (3%)</td>
</tr>
<tr>
<td>LV aneurysm</td>
<td>1 (1%)</td>
<td>*</td>
</tr>
<tr>
<td>Aortic aneurysm</td>
<td>0</td>
<td>*</td>
</tr>
<tr>
<td>False tendon</td>
<td>0</td>
<td>*</td>
</tr>
<tr>
<td>Aortic plaques</td>
<td>1 (1%)</td>
<td>69 (30%)</td>
</tr>
<tr>
<td>Other</td>
<td>2 (1%)</td>
<td>*</td>
</tr>
</tbody>
</table>

LA indicates left atrium; LV, left ventricular; LVEF, left ventricular ejection fraction.

Percentages below 0.5% are rounded off upwards to 1%.

*Identical values.

Results

All results are summarized in Tables 1 and 2. A potential cardiac source of embolism was detected in 55% (127/231) of the patients by echocardiography. In 39% (90/231) a potential cardiac source was only identified on TEE.

Major risk factors, with an absolute indication for oral anticoagulation, were detected in 20% of the patients (46/231), and 16% (38/231) of them were only identified on TEE. A thrombus in the left atrial appendage was the most commonly observed major cardiac risk factor, occurring in 16% (38/231). Of note, left atrial appendage thrombi were virtually never adequately detected on TTE.

The presence of major and minor risk factors was independent of age (Table 2; major risk factors, χ² = 1.48; P = 0.224). Eighty-three percent (192/231) of the patients were > 45 years old. In these patients echocardiography (TTE or TEE) revealed a potential cardiac source of embolism in 59% (114/192) of the patients. TTE identified a cardiac source in 18% (34/192) of the patients, with 4% (8/192) having a major risk factor and an indication for anticoagulation therapy. TEE confirmed the potential cardiac source in these 34 patients, but also detected a potential source in 80 additional patients (80/192, 35%). In these 114 patients, a major risk factor was present in 36% (41/114), 21% (41/192) of all patients above 45 years of age, with an indication for anticoagulation therapy. In 80% (33/41) of these patients, the indication for anticoagulation therapy was based on the TEE results only.

A total of 39 (17%) patients were ≤ 45 years of age. In this patient category echocardiography (TTE or TEE) detected a potential cardiac source of embolism in 33% (13/39) of these patients. TTE identified a potential cardiac source in 8% (3/39), with none of them having a major risk factor. A
potential cardiac source on TEE was observed in 13 of 39 (33%) patients, confirming the 3 patients already identified on TTE. In these 13 patients, a major risk factor was present in 38% (5/13). In all of these 5 patients the indication for anticoagulation therapy was based on the TEE results only.

The analysis of agreement between the 2 methods in detecting a cardiac source resulted in a k of 0.286 for patients ≤45 years of age, thus showing fair agreement and a k of 0.450 in those >45 years which is considered moderate.10

The difference in proportions of cardiac sources detected in favor of TEE was highly significant in patients ≤45 years of age, as well as in those over 45 years of age (10/39; P=0.002 and 80/192; P<0.004 respectively, McNemar test). The relative merit of TEE in the detection of major risk factors was comparable between younger (≤45 years, 13% major risk factors on TEE) and older (>45 years, 17% major risk factors on TEE; χ²=0.45; P=0.45) patients.

### Discussion

The findings in the current study can be summarized as follows. TEE proved superior to TTE for the identification of a cardiac source of embolism in this unselected series of patients with TIA or stroke without pre-existent indication or contraindication for anticoagulation. In TIA or stroke patients with a normal TTE, a cardiac source of embolism was yet detected by TEE in ≈40% of patients, independent of age. More than 1 of 8 patients of any age with a normal TTE revealed a major cardiac risk factor on TEE, for whom anticoagulation therapy is recommended.

Identification of a cardiac source of embolism in patients with previous TIA/stroke is important because it influences future therapeutic management. Indeed, as outlined above, TEE was superior in detecting “major cardiac risk factors”, in particular the detection of a thrombus in the left atrial appendage. This is important because these findings have therapeutic implications (ie, anticoagulation therapy). In patients with major cardiac risk factors (thrombi in the left atrium, left atrial appendage and left ventricle, dilated cardiomyopathy) anticoagulation therapy is generally recommended.2,13,14 Anticoagulation is probably even more warranted after a thromboembolic event like a TIA or stroke, although there is no evidence at this time from randomized-controlled trials. Recruitment for these trials would probably also be difficult because large numbers of stroke patients are needed. In addition, many neurologists are likely to be reluctant to put patients with a major cardiac source, like a left atrial thrombus, after a TIA or stroke on aspirin (instead of anticoagulants).

In an earlier study TEE did not find any patient with left atrial thrombus in all 236 patients with stroke and other suspected embolic events with a normal TTE.15 Therefore, TTE was considered sufficient as a screening tool in stroke patients, especially in the older population. Clearly, in our study TEE showed superiority over TTE in detection of left atrial thrombus in stroke patients of all ages. The reason for this discrepancy is unknown, but based on the present results we do not consider TTE alone a valid screening tool to rule out a potential cardiac source, left atrial thrombus included.

Other studies have also demonstrated that TEE is superior to TTE for the assessment of possible sources of cardiac embolism, including intracardiac thrombi, patent foramen ovale, atrial septal aneurysm and slow left atrial flow.3,16

The diagnostic superiority of TEE was also demonstrated in an unselected series of 457 patients with previous TIA or stroke.3 In that series, TEE or TTE detected a potential cardiac source in 57% of patients. TEE appeared superior in the detection of some major risk factors (including left atrial appendage thrombus and aortic thrombus), and was reported to “change or confirm appropriateness of management” in 9% of all 457 patients. The current findings are in line with these results because a potential cardiac source of embolism was detected by echocardiography in 55% of patients. However, TEE changed therapy in a slightly higher percentage of patients in the current study. This difference may be related to differences in study populations.

The issue of age is an important one in the discussion on whether TTE or TEE should be used in patients with previous TIA or stroke. Sorescu et al demonstrated that older age (>60 years) was one of the strongest, independent risk factors for the presence of thrombus in the left atrial appendage and spontaneous echo contrast on echocardiography.6 In the current study, it was demonstrated that relative merit of TEE in the detection of major risk factors was comparable between younger and older patients.

In particular, in the present series, 96% of the TTEs in patients >45 years of age failed to identify a major risk factor, whereas TEE demonstrated a major risk factor in 17% (n=32 patients). These patients would have been incorrectly denied anticoagulation therapy if only TTE was used. Thus, the current observations support the additional value of TEE in both younger and older patients.

For many cardiac risk factors, referred to as “minor risk factors”, the optimal choice of therapy is not clear. At present, there is not enough evidence in the literature to recommend anticoagulation therapy over aspirin in patients with minor risk factors, and therefore TEE does not provide therapeutic gain in terms of medical treatment.

In patients with a pre-existing indication or contraindication to anticoagulation therapy, screening for cardiac sources of emboli is generally not considered useful, in terms of therapeutic consequences.2 These patients were, however, excluded in the present study. Still, it could be argued that detection of any cardiac source of embolism is helpful in understanding the underlying pathophysiological mechanism of stroke in an individual patient. Some cardiac abnormalities detected may also influence clinical decisions beyond medical therapy (eg, patent foramen ovale, which could be considered for device closure therapy).17

In conclusion, the current results demonstrate the relative merit of TEE over TTE in patients with previous TIA or stroke. The findings support the routine use of TEE in all patients with TIA or stroke of unknown origin.

### Disclosures

None.
References

Transesophageal Echocardiography Is Superior to Transthoracic Echocardiography in Management of Patients of Any Age With Transient Ischemic Attack or Stroke

Sebastiaan F.T.M. de Bruijn, Willem R.P. Agema, Gert Jan Lammers, Ernst E. van der Wall, Ron Wolterbeek, Eduard R. Holman, Edward L.E.M. Bollen and Jeroen J. Bax

*Stroke*. 2006;37:2531-2534; originally published online August 31, 2006;
doi: 10.1161/01.STR.0000241064.46659.69

*Stroke* is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2006 American Heart Association, Inc. All rights reserved.
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/37/10/2531

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in *Stroke* can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to *Stroke* is online at:
http://stroke.ahajournals.org/subscriptions/