Letters to the Editor

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Absence of Usefulness of ABCD Score in the Early Risk of Stroke of Transient Ischemic Attack Patients

To the Editor:

With great interest we read the study of Cucchiara et al.1 about the usefulness of the ABCD score,2 developed by Rothwell et al. A 6-point score derived from the Oxfordshire Community Stroke Project cohort (age ≥60 years=1, blood pressure [systolic >140 mm Hg and/or diastolic ≥90 mm Hg]=1), clinical features [unilateral weakness=2, speech disturbance without weakness=1, other=0], and duration of symptoms in minutes (≥60=2, 10 to 59=1, <10=0; ABCD) was highly predictive of 7-day risk of stroke in the Oxfordshire cohort. In contrast to the Oxfordshire series, the ABCD score is not useful in a North American cohort of transient ischemic attack (TIA) patients. We are pleased to present a study with similar results. We test the ABCD score in 345 consecutive TIA patients attended within 24 hours by the vascular neurologist in the emergency room. Clinical data, symptom duration, neuroimaging and ultrasonographic (carotid and transcranial) findings were prospectively collected within the first 24 hours after symptoms onset. A total of 17 (4.9%) patients had a stroke recurrence within the first 7 days after symptoms onset. Seven of 17 (42.2%) strokes occurred in 124 (35.9%) patients with a score ≥5 or greater, whereas 7-day risk was 4.5% (95% CI, 3.38 to 5.88) in 221 (64.1%) patients with a score <5 (Table). In Cox proportional hazards multivariate analyses in which age, sex, vascular risk factors and variables showing P<0.1 on univariate models were included, only large-artery occlusive disease remained independent predictor for stroke recurrence (hazard ratio 5.88 [95% CI, 2.17 to 15.89; P<0.001]).

After a first TIA up to 20% of patients had a stroke within the next 90 days, and in 50% of them, the stroke recurrence occurs within the first 24 to 72 hours after the event.3–5 Consequently, TIA must be considered a medical emergency. However, only a small number of clinical factors have been found to be weakly associated with an increased risk of stroke after TIA (advanced age, diabetes mellitus, symptoms lasting >10 minutes, weakness and impaired speech) and consequently patients at highest risk of recurrent events cannot be reliably identified.6 We previously demonstrated that TIA patients with moderate to severe intracranial or extracranial stenoses have a higher risk of stroke recurrence7 which may indicate that clinical data are not enough to identify those patients at higher risk.8,9 Moreover, MR diffusion-weighted imaging which assesses the presence or absence of true ischemia could be a useful prognostic method.10 The combination of clinical, radiological and vascular information may improve the predictive accuracy of stroke recurrence risk.10 The routine use of combined carotid/transcranial ultrasound testing performed early will be useful for identifying high risk individuals in order to plan urgent aggressive prevention therapies.

Disclosures

None.

Table: Seven-Day Risk of Stroke Stratified According to ABCD Score

<table>
<thead>
<tr>
<th>ABCD Score</th>
<th>Patients (%)</th>
<th>Events (%)</th>
<th>% Risk (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1</td>
<td>15 (4.4)</td>
<td>1 (5.9)</td>
<td>7.7 (0–21.18)</td>
</tr>
<tr>
<td>2</td>
<td>49 (14.2)</td>
<td>3 (17.6)</td>
<td>6.1 (0–12.8)</td>
</tr>
<tr>
<td>3</td>
<td>55 (15.9)</td>
<td>3 (17.6)</td>
<td>5.5 (0–11.5)</td>
</tr>
<tr>
<td>4</td>
<td>103 (29.9)</td>
<td>3 (17.6)</td>
<td>2.9 (0–6.1)</td>
</tr>
<tr>
<td>5</td>
<td>90 (26.1)</td>
<td>5 (29.4)</td>
<td>5.6 (0–10.4)</td>
</tr>
<tr>
<td>6</td>
<td>33 (9.6)</td>
<td>2 (11.8)</td>
<td>6.1 (0–14.3)</td>
</tr>
<tr>
<td>Total</td>
<td>345</td>
<td>17 (100)</td>
<td>4.9 (2.6–7.2)</td>
</tr>
</tbody>
</table>


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Stroke. 2007;38:855-856; originally published online January 18, 2007; doi: 10.1161/01.STR.0000257306.00512.d3

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