Validation of a Prognostic Subarachnoid Hemorrhage Grading Scale Derived Directly From the Glasgow Coma Scale

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Background and Purpose—A new Glasgow Coma Scale-based scale has been developed to predict patient outcome in subarachnoid hemorrhage by calculating cut-off points by which 2 consecutive categories corresponded to a statistically significant different outcome. We assessed the external validity of this Prognosis on Admission of Aneurysmal Subarachnoid Hemorrhage (PAASH) scale and compared it to the commonly used World Federation of Neurological Surgeons scale.

Methods—From our database of subarachnoid hemorrhage patients we retrieved data on all patients admitted between November 2000 and March 2006. By means of logistic regression, we calculated OR with corresponding 95% CI for poor outcome at 3 months for each category in comparison with the lowest category of both scales. Areas under the curve of the corresponding receiver operator characteristic curve were calculated.

Results—We included 537 patients. For the PAASH scale, OR ranged from 3.9 (95% CI, 2.4 to 6.2) to 84 (95% CI, 25 to 287) and increased more evenly than for the World Federation of Neurological Surgeons (WFNS) scale, with OR ranging from 2.3 (95% CI, 1.3 to 4.1) to 69 (95% CI, 31 to 157). Areas under the curve were 0.81 (95% CI, 0.77 to 0.84) for the PAASH and 0.82 (95% CI, 0.79 to 0.86) for the WFNS scale.

Conclusion—Both PAASH and WFNS scales have a good discriminatory ability for patient prognosis. Because the OR of the PAASH increase more gradually, it is slightly preferable to the WFNS scale. (Stroke. 2008;39:1347-1348.)

Key Words: outcome ■ prognosis ■ subarachnoid hemorrhage
determine the discriminatory ability of both scales. Age and the Hijdra score, dichotomized on the median, were added to the logistic regression model.

**Results**

In total 632 patients were admitted within 4 days during the study period. For 76 patients outcome was known only at discharge and not at 3 months. For 10 patients the GCS on admission was not documented. Nine patients could not be categorized because of dysphasia or intubation.

Baseline characteristics for the 537 included patients are shown in Table 1. For the PAASH scale, OR for poor outcome increased more evenly than for the WFNS scale (Table 2). The areas under the curve of the receiver operator characteristic curves were similar for the PAASH (0.81; 95% CI, 0.77 to 0.84) and the WFNS scale (0.82; 95% CI, 0.78 to 0.86). The areas under the curve did not change substantially when the Hijdra score or age were added to the logistic regression model.

**Discussion**

Our study shows that both the PAASH and WFNS scale have a good discriminatory ability with regard to patient prognosis. However, OR increased more gradually in the PAASH scale and areas under the curve were similar for both scales.

Predicting outcome of aneurysmal SAH remains a problematic issue. The clinical condition can vary during the acute phase, and complications occurring during the clinical course can influence outcome. Thus, a scale applied on admission will never give a 100% perfect prediction of outcome. Nevertheless, grading patients with SAH on admission is important for clinical and research purposes. The PAASH scale has a good internal and external validity regarding to clinical outcome. Moreover, in our study population, <2% could not be classified because of early intubation, which means that the PAASH scale can be applied in almost all patients with SAH.

To date, there is no universally accepted scale to assess the clinical condition on admission. Both the Hunt and Hess scale and the WFNS scale are widely used in clinical practice and in research reports. Because the interobserver agreement for the Hunt and Hess scale is poor, clinicians using this scale should be advised to use another scale. For these clinicians switching to the PAASH grading scale seems the best choice. Of course it would be better if one scale is used worldwide. Because the PAASH scale is very easy to apply, and based solely on the GCS, which has a much better interobserver agreement, we propose using this scale instead of the other scales in use today.

In conclusion, both the WFNS and PAASH scales have a good prognostic value for patient outcome. However, the PAASH scale shows a more gradual increase of OR in ascending categories. Based on the results of our study, we think the PAASH scale is slightly preferable over the WFNS scale.

**Disclosures**

None.

**References**

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