Safety and Effectiveness of Endovascular Therapy After 8 Hours of Acute Ischemic Stroke Onset and Wake-Up Strokes

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Background and Purpose—This is a retrospective review of patients who underwent endovascular recanalization ≥8 hours after acute ischemic stroke symptom onset, including wake-up strokes, between June 2005 and June 2008.

Methods—Thirty patients with a premorbid modified Rankin score ≤1 and NIHSS between 5 and 22 were included. All had admission CT, CTA, and CT perfusion scans to evaluate for salvageable brain tissue. Recanalization effectiveness was assessed by angiograms obtained within 30 hours after intervention. Patient, treatment characteristics, and immediate and 3-month outcomes were analyzed.

Results—Mean NIHSS at presentation was 13 (median=12). Mean interval between time last-seen well and angiogram was 12.75 hours (median=10). Twenty-six patients (86.7%) presented with complete-to-near-complete vessel occlusion (thrombolysis in myocardial infarction [TIMI] 0/1); 4 had partial vessel occlusion (TIMI 2). Interventions included intra-arterial pharmacological thrombolysis (n=10), mechanical thrombectomy (n=21; Merci, 16; intracranial stent, 9; extracranial stent, 3), angioplasty (n=14; intracranial, 11; extracranial, 3). Nine patients received GPIIb/IIIa inhibitors (eptifibatide); all received heparin. Partial-to-complete recanalization (TIMI 2/3) was achieved in 20 patients (66.7%). Procedure-related complications included vascular perforations (n=3) and femoral access site complication (n=1). One patient had an embolic anterior cerebral artery infarct during intervention; another had progression of brain stem infarct. Symptomatic intracerebral hemorrhage occurred in 3 patients (10%), with 2 being primarily subarachnoid in location. Total in-hospital mortality including procedural mortality, disease progression, or other comorbidities was 23.3% (n=7). Mean discharge NIHSS was 9.5, representing an overall NIHSS 3-point improvement. Overall, mean modified Rankin score at death or last follow-up (mean=10.6 months) was 4.2. At 3 months, total mortality was 33.3% (n=10), 20% had modified Rankin score ≤2, and 33% had modified Rankin score ≤3. Among survivors, mean modified Rankin score at 3-month follow-up was 3.

Conclusion—Our data show that delayed endovascular revascularization of carefully selected patients is safe, effective, and improves clinical outcome. *(Stroke. 2009;40:3269-3274.)*

Key Words: acute ischemic stroke ■ endovascular therapy ■ outcomes ■ recanalization ■ revascularization time window ■ wake-up strokes

Approximately 395,000 strokes occur in the US annually, of which ≈85% are ischemic.1 The only US FDA-approved medical therapy for acute stroke to date is intravenous tissue plasminogen activator (t-PA) administered within 3 hours of symptom onset.2 However, <5% of patients with acute ischemic stroke in the US receive t-PA, primarily because of a delay in hospital presentation.3 To increase the proportion of acute stroke patients who receive treatment, efforts are ongoing to try to expand the time window for reperfusion therapy beyond 3 hours. These efforts include the development of novel thrombolytic agents,4 mechanical thrombectomy,5 self-expanding stents,6 and use of advanced imaging techniques.7,8 There is increasing evidence that identification of potentially salvageable brain tissue with advanced MR and CT imaging may allow the selection of patients who can be effectively and safely treated with intravenous thrombolysis for up to 9 hours after ictus.9-16

Approximately 16% to 28% of ischemic stroke patients awaken with their deficits.17,18 In these wake-up strokes (WUS), the onset of symptoms is defined as the “time last-seen well” (TLSW). Because this is the time the patient went to sleep, unfortunately, these patients are usually placed outside the window for thrombolysis or ineligible for entry into reperfusion clinical trials. Barreto et al19 reported that patients with WUS have better outcomes when they are treated. There was no significant difference between WUS
patients and patients treated within 3 hours by intravenous thrombolysis when time of stroke onset was known. Reestablishment of flow to perfuse salvageable brain tissues has been shown to significantly reduce the morbidity and mortality of ischemic stroke.11 Endovascular techniques to recanalize occluded vessels have overcome some of the limitations of systemic intravenous thrombolysis, such as narrow therapeutic window, poor recanalization rates, high hemorrhage rates, and inability to visualize treatment effectiveness immediately.4,21 In this report, we describe our center’s experience using various endovascular therapies to treat ischemic stroke at least 8 hours after stroke symptom onset and including WUS.

Materials and Methods

A retrospective review was conducted of a prospectively collected registry of acute ischemic stroke patients undergoing endovascular treatment at a single high-volume stroke center (Millard Fillmore Gates Hospital) between June 2005 and June 2008. Data for the consecutive series of patients who had an angiogram with intent-to-treat at least 8 hours after the time when they were last known to be normal (TLSW) were collected and analyzed. Our Institutional Review Board approved this study.

Patient Selection

All patients who had witnessed or nonwitnessed (including WUS) strokes with TLSW between 7 and 23 hours (treatment initiation between 8 and 24 hours) and had a premorbid modified Rankin score (mRS) score of 0 to 1 and NIHSS between 5 and 22 were included in this study. All patients had cranial CT, CTA, and CT perfusion scans on admission. After the diagnosis of ischemic stroke caused by vessel occlusion had been made and the presence of an intracranial hemorrhage had been excluded by noncontrast CT imaging, CT perfusion scans were analyzed to evaluate for salvageable brain tissue. Endovascular therapy was only implemented on those patients in whom CT perfusion volume maps demonstrated the presence of clinically significant salvageable brain tissue as compared with established core infarct (less than one-third of the middle cerebral artery territory) that was at high risk for hemorrhagic conversion (ASPECTS ≥7) as demonstrated by CT perfusion cerebral blood volume maps. Cause of ischemic stroke was determined by a complete neurological–neuroimaging evaluation, including diagnostic angiography, noninvasive imaging, telemetry, and 2-dimensional echocardiography.

CT Perfusion Protocol

Our CT perfusion protocol starts with an axial noncontrast cranial CT scan. If hemorrhage was present, the protocol was aborted and these patients were not included in this review. Most perfusion scans were performed on the Toshiba Aquilion 64-slice CT scanner (Toshiba American Medical Systems, Inc). Maps obtained by the Toshiba Aquilion 64 were generated using both Gaussian Fit and single value deconvolution methods using Vitrea software (Vital Images), yielding the additional perfusion parameters that were also analyzed by Gaussian fit and single value deconvolution, as well as the newest single value deconvolution plus algorithm, using Vitrea software, yielding the additional perfusion parameters of mean time to peak and a delay map. Patients were chosen for treatment using the same criteria as that for the Aquilion 64 with the additional requirement for preserved volume on the single value deconvolution plus maps. This helped in identifying patients with decreased cerebral blood flow in the same hemisphere if there was a coexisting ipsilateral carotid stenosis.

Treatment Protocol

Endovascular therapy was commonly performed under conscious sedation with a rigid easily detachable headholder, thereby allowing safe road mapping, adequate imaging, and continuous monitoring of the patient’s neurological examination. General anesthesia was used only in cases of large dominant hemisphere strokes or for uncooperative patients. Antiplautelet therapy was instituted or continued on all patients within the first 24 hours. All patients receiving stents were given a loading dose of clopidogrel on the angiogram table via a nasogastric feeding tube. Mechanical revascularization methods were the primary choice in these patients because the use of thrombolitics at a delayed time window increases the risk of hemorrhage. Intra-arterial (IA) pharmacological thrombolysis (t-PA) was used only when the clot was not accessible with available devices or as an adjunct to mechanical strategies. An IA GP IIb/IIIa inhibitor (eptifibatide) was used if thrombus formation was noticed after recanalization. All patients were monitored in a neurosurgical intensive care unit for at least the first 24 hours after intervention. All patients received a postintervention noncontrast cranial CT scan and CT perfusion imaging and CTA on the day after the intervention.

Data Collected

Data collected were patient characteristics (age, sex, comorbid conditions, antithrombotic agent intake, presentation NIHSS score, TLSW); treatment characteristics (angiography-catheterization time, occlusion site, occlusion grade [TIMI grading]; recanalization time [time interval between catheterization and revascularization]), type of intervention, adjunctive heparinization, procedural complications, extent of recanalization (TIMI); immediate posttreatment outcome (symptomatic intracerebral hemorrhage, presence of parenchymal hemorrhage [ECASS II grading],23 subarachnoid hemorrhage, discharge NIHSS score, discharge destination, hospital stay, morbidity, and mortality); and 3-month follow-up data (mRS, mortality [evaluated by the interventionist and NIHSS-certified members of his team]).

Results

Patient Characteristics

Thirty patients who presented with acute ischemic stroke at least 8 hours after the TLSW (including WUS) were selected for endovascular revascularization after clinical assessment and imaging. There were 17 men and 13 women, with a mean age of 72 years (range, 24–91 years), who presented with a mean NIHSS of 13 (median, 12; range, 5–22). Twenty-seven patients had anterior-circulation ischemia and 3 had posterior-circulation ischemia. Stroke risk factors included hypertension in 21 patients (70%), smoking in 11 (36.6%), hyperlipidemia in 10 (33.3%), atrial fibrillation in 13 (43.3%), diabetes mellitus in 10 (33.3%), previous stroke in 2 (6.6%; 1 ipsilateral), transient ischemic attacks in 2 (6.6%; both ipsilateral), transient ischemic attacks in 2 (6.6%; both ipsilateral), myocardial infarction in 3 (10%), and hypercoagulable state in 3 (10%). Nine patients (30%) had concomitant coronary artery disease, 2 (6.6%) had cardiomyopathy, and 7 (23.3%) had cardiac valvulopathy. At presentation, 11 patients (36.6%) were using aspirin, 4 were using clopidogrel (13.3%), 7 (23.3%) each were using warfarin and a statin, and 1 was using aspirin/extended-release dipryidamole. Overall, 19 (63.3%) patients were receiving some form of antiplatelet or anticoagulant therapy at presentation. The etiology for ischemic stroke was determined to be arterioen-
bolic in 7 patients (23.3%), cardioembolic in 13 (43.3%), left-to-right cardiac shunt in 1, and unknown in 9 (30%). Occlusion sites were cervical ICA in 2 patients, petrous ICA in 2, intracranial ICA in 4, proximal M1 in 7, distal M1 in 13, M2 in 7, vertebrabasilar junction to superior cerebellar artery in 2, superior cerebellar artery to basilar artery bifurcation in 2, A1 in 1, and A2 in 1. Eight patients had multiple intracranial occlusions (ICA terminus, A1, and M1-3; M1 and M2-5), and 1 patient had tandem cerebral ICA and intracranial M1 occlusions. Twenty-six of 30 patients (86.7%) presented with complete to near-complete vessel occlusion (TIMI 0/1); 4 patients presented with partial vessel occlusion (TIMI 2).

**Treatment Characteristics**

Mean interval between TLSW and angiography-catheterization time was 12.75 hours (median, 10 hours; range, 8–27.5 hours). Mean time from emergency department door to angiography-catheterization time was 3.5 hours (median, 3 minutes; range, 0.25–8.0 hours). Interventions included IA pharmacological thrombolysis in 10 patients (8 alone; 2 in combination with mechanical measures), mechanical thrombectomy in 21 patients (Merci [Concentric Medical], 16; intracranial stent, 9; extracranial stent, 3), and balloon angioplasty in 14 (intracranial, 11; extracranial, 3). A total of 9 patients received IA (8 patients) or intravenous (6 patients) eptifibatide in combination with endovascular therapy. Heprin was used in all patients to an activated coagulation time measured at 250 seconds.

Partial-to-complete recanalization (TIMI grade 2/3) was achieved in 20 of 30 patients (66.7%). The mean time to recanalization from angiography-catheterization time was 87 minutes (median, 83 minutes; range, 30 minutes to 4 hours). Procedure-related complications included vascular perforations in 3 patients and a femoral access site complication in 1.

One patient required a craniotomy because of inability to open the initial middle cerebral artery M1 occlusion (with subsequent hemispheric infarct, edema, and impending herniation from mass effect); 1 patient had an anterior cerebral artery (ACA) infarct attributable to embolus during intervention, despite attempting IA thrombolysis and IA eptifibatide for the embolus; and another had progression of brain stem infarct and underwent percutaneous endoscopic gastrostomy placement.

**Immediate Posttreatment Outcomes**

Postprocedure hemorrhage (subarachnoid hemorrhage or ICH) was radiologically detected in 9 patients (33.3%). Eight (26.7%) patients had subarachnoid hemorrhages and 8 had parenchymal hemorrhages (HI 1-3, HI 2-1, PH 1-3, PH 2-1 [ECASS II13 grades]). Symptomatic intracerebral hemorrhage was present in 3 patients (10%), with 2 of these being primarily subarachnoid in location (and 1 being a PH2). Of these, all 3 had Merci clot retrieval, stents placed, and IA t-PA; 1 had additional balloon angioplasty; and 1 had intravenous bolus eptifibatide. Four patients (13.3%) were discharged home, 15 (50%) were discharged to rehabilitation (acute and subacute), and 4 (13.3%) were sent to chronic care facilities. The total in-hospital mortality rate including procedural mortality, progression of disease, or other comorbidities was 23.3% (7 patients). Mean discharge NIHSS was 9.5, representing an overall NIHSS improvement of 3.5 points.

**Three-Month Outcomes**

At 3 months, total mortality rate was 33.3% (10 patients). Overall, mean mRS at death or last follow up (mean, 10.6 months) was 4.2. Twenty-percent (6 patients) had good outcomes (mRS ≤2) and 33% (10 patients) had acceptable outcomes (mRS ≤3). Among survivors, mean mRS at the time of the 3-month follow up was 3.

**Discussion**

Until the recent publication of ECASS III,15 there had been no level 1 evidence in the form of a randomized controlled trial with primary clinical outcome measures for intravenous t-PA (or, indeed, clot retrieval) beyond 3 hours. The results of this trial have extended the time window to 4.5 hours for intravenous t-PA.15 Furthermore, there is strong evidence for IA thrombolysis in middle cerebral artery occlusion up to 6 hours, based on the PROACT II results.24 The pooled analysis by Hacke et al25 demonstrates a treatment effect up to 4.5 hours, and the meta-analysis by Wardlaw et al26 demonstrates a treatment effect up to 6 hours, thus formally providing level 1 evidence (meta-analysis of randomized controlled trials), even in patients selected by “only” noncontrast CT. There is increasing evidence that identification of potentially salvageable brain tissue with advanced MR and CT imaging may allow selection of patients who can be effectively and safely treated with intravenous thrombolysis for up to 9 hours after ictus.9–16 Although MR imaging-based perfusion imaging is a useful imaging modality for determining salvageable tissue, CT perfusion has been shown to be comparable27,28 and is widely available. In this study, we used CT perfusion images to define the core and penumbra in acute ischemic stroke.

The Table compares our study to the NINDS Recombinant t-PA Stroke Study,2 prominent studies of endovascular treatments for acute ischemic stroke,5,24–29 and the recently published DIAS-2 study because the time window in this study was up to 9 hours and the investigators used MR imaging to assess salvageable brain tissue for treatment selection.16 Our recanalization rate of 66.7% was comparable to previous series using endovascular interventions for opening up acutely occluded vessels. The use of GP IIb/IIIa inhibitors changes the prothrombotic–antithrombotic balance in the intracranial vessels, thus probably facilitating and maintaining recanalization.30,31 The rates of complications, symptomatic intracerebral hemorrhage, and mortality at 3 months are comparable to previous studies in which patients were treated within a shorter duration after stroke onset.

All 3 patients with posterior circulation ischemia had basilar artery occlusions and were selected for intervention based on CT perfusion imaging. They presented with NIHSS scores of 18, 5, and 18 with TLSW–angiography-catheterization time of 19.5, 19, and 9.5 hours, respectively. Merci device was used in the first patient, but we were not able to reopen the vessel and there was a perforation with subarachnoid hemorrhage. The second patient had TIMI 3 flow after Merci, IA t-PA, and IA eptifibatide. The third patient had...
Revascularization strategy

<table>
<thead>
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<th>Strategy</th>
<th>NINDS 2</th>
<th>DIAS-2 3</th>
<th>PROACT I 4</th>
<th>PROACT II 5</th>
<th>Multi MERCI 6</th>
<th>Our Study</th>
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<td>IV desmoteplase</td>
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<td>3–9 hours MR perfusion</td>
<td>6 hours</td>
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<td>8 hours</td>
<td>8–27.5 hours (including WUS)</td>
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<td>Primary end points</td>
<td>Part 1: 4-point NIHSS improvement or resolution of deficit within 24 hours; Part 2: BI, mRS, GOS, NIHSS at 3 mon</td>
<td>NIHSS, BI, mRS at 90 days, infarct volume</td>
<td>Recanalization at 2 hours. NIHSS, mRS, BI at 7, 30, and 90 days; SICH</td>
<td>mRS &lt;2 at 90 days</td>
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<td>NIHSS at discharge, recanalization rate, complications, SICH</td>
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<td>Secondary end points</td>
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<td>Not mentioned</td>
<td>MCA recanalization, SICH, mortality</td>
<td>mRS and mortality at 90 days</td>
<td>mRS at 3 mon and mortality</td>
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<td>NIHSS</td>
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<td>NIHSS improvement</td>
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<td>mRS &lt;2 or &lt;1 at 3 mon</td>
<td>14 to 8</td>
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<td>Mortality at 3 mon</td>
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<td>30.8%*</td>
<td>40%</td>
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<td>Mortality at 3 mon</td>
<td>17%</td>
<td>21%</td>
<td>26.9%</td>
<td>26%</td>
<td>26%</td>
<td>33.3%</td>
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**Table. Comparison of Our Study With Previous Acute Ischemic Stroke Studies**

BI indicates Barthel Index; DIAS-2, Desmoteplase in Acute Ischemic Stroke-2; GOS, Glasgow Outcome Scale; GP, glycoprotein; IA, intraarterial; IV, intravenous; MCA, middle cerebral artery; MERCI, Mechanical Embolus Removal in Cerebral Ischemia; MR, magnetic resonance; NA, not available; NIHSS, National Institutes of Health Stroke Scale; NINDS, National Institute of Neurological Disorders and Stroke Recombinant Tissue Plasminogen Activator Stroke Study; PROACT, Prolyse in Acute Cerebral Thromboembolism; SICH, symptomatic intracranial hemorrhage; UK, urokinase.

TIMI 2 flow after Wingspan stent (Boston Scientific) placement. The first 2 patients did not recover from their original insult and died within 30 days. The third patient had a brain stem infarct, underwent percutaneous endoscopic gastroscopy placement for swallowing difficulty, but did not survive for 1 month after the intervention. The third patient did not have an obvious perforation during angiography after Merci retrieval, but the postprocedure CT scan showed a subarachnoid hemorrhage that was suggestive of a perforation. The patient was managed conservatively and had mRS of 2 at the 3-month follow-up evaluation.

Only 20% and 33% of patients in our series had favorable and acceptable outcomes, respectively, at 3 months. These rates are lower than those in previous studies (Table). Differences can be explained by the decrease in the ability to salvage brain tissue as the time window from insult to treatment increases. Nevertheless, in our series, there was an improvement of 3.5 points in NIHSS overall attributable to treatment, and 33% of patients had an acceptable outcome with comparable morbidity and mortality. The addition of neuroprotectants may further improve the outcomes in this group of patients, and this needs to be studied in the future.32–35 Janjua et al36 used clinical diffusion mismatch criteria (patients with NIHSS >8 with limited abnormality on DWI imaging) to evaluate the benefit of endovascular interventions in 11 patients with large vessel occlusion presenting >8 hours after stroke symptom onset. At 1 week after treatment, 72% of the total and 100% of successfully revascularized patients in their study had a decrease of >4 points in NIHSS score. The DAWN trial37 is an ongoing multicenter trial designed to study safety and efficacy of endovascular treatment in MR or CT perfusion-selected patients with acute ischemic stroke attributable to a proximal large-vessel anterior circulation occlusion (eg, ICA and/or middle cerebral artery M1 segment) who present “beyond the typical therapeutic window” >8 hours (including “wake-up”) events. The main hypothesis of this trial is that MR or CT perfusion-based endovascular treatment in wake-up and late-presenting stroke patients is at least as safe and effective as standard endovascular treatment performed within 8 hours of symptoms onset and leads to improved outcomes when compared to best medical treatment. The results of this trial may provide more evidence of the benefits of treatment in this group of patients.

**Conclusions**

Our study sheds light on the safety, effectiveness, and feasibility of endovascular therapy for patients presenting after 8 hours of stroke symptom onset and WUS. The recanalization rate with endovascular therapy is superior to that reported using intravenous t-PA, whereas the rate of symptomatic intracerebral hemorrhage is low. There is a moderate improvement in outcome at 3 months in these
patients when they are carefully selected with perfusion imaging, without an increase in morbidity or mortality. Prospective randomized controlled trials are needed to assess the role of endovascular intervention after 8 hours of stroke symptom onset and WUS.

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Disclosures
Dr Hopkins has an ownership interest in AccessClosure, Boston Scientific, Micrus, and Square One, Inc. (<$10 000 each); and serves as a consultant to/member of the advisory board for Abbott, AccessClosure, Bard, Boston Scientific, Cordis, and Micrus (<$10 000 each). Dr Levy receives research support (grant support, other research support (devices), and honoraria from Boston Scientific (<$10 000) and research support from Micrus Endovascular (<$10 000); and receives compensation for work performed as a consultant to/Micrus Endovascular (<$10 000). Dr Siddiqui has received a research grant from the University at Buffalo (<$10 000); is a consultant to Codman/Cordis, Concentric Medical, ev3, Micrus Endovascular, and Neurecor (<$10 000 each); serves on the speakers’ bureaus for Cordis and Genentech (<$10 000 each); and has received honoraria from Genentech, Neurecor, an American Association of Neurological Surgeons’ course, an Emergency Medicine Conference, and from Cordis for training other neurointerventionists (<$10 000 each). Dr Ionita, Dr Natarajan, and Dr Snyder have nothing to disclose.

References


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