Cochrane Corner

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Sanchi for Acute Ischemic Stroke

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Currently, very few drugs are supported for routine use for acute ischemic stroke. Sanchi may be a potential remedy, which acts through several mechanisms. We aimed to assess the efficacy and safety of sanchi for acute ischemic stroke within 30 days of onset.

Methods

A comprehensive data search was performed according to the search strategy of the Cochrane Collaboration Stroke Review Group. Only randomized, controlled clinical trials were eligible for inclusion. The interventions were sanchi compared with placebo or no treatment, whereas equal cointerventions were allowed. Two review authors independently extracted data and assessed trial quality.

Results

Eight trials involving 660 participants were included. Seven of the 8 studies were of poor quality. Follow-up time was less than 1 month in 6 trials. Only 2 trials provided data for the number of participants who were dead or dependent at the end of 28 days of treatment, indicating a significantly lower rate of death and dependency in the sanchi group than in the control group (relative risk, 0.63; 95% CI, 0.45 to 0.88). One trial reported higher Barthel Index scores in the sanchi group. Pooled analysis of 7 trials indicated that sanchi might improve neurological deficit more than control with a significant difference (relative risk, 0.29; 95% CI, 0.18 to 0.47). Few adverse events were reported. Data were limited in respect of stroke recurrence and quality of life.

Conclusions

Implications for Practice

The effect of treatment with sanchi is implausibly large in our review, but the methodology of the studies is poor (the trials were either not double-blind or not balanced for prognostic factors) and the results are hardly credible. There is no clear evidence to suggest benefit of sanchi in acute ischemic stroke.

Figure. Comparison: Sanchi vs control. Outcome: Proportion of patients with no improvement of neurological deficit (different constituents).

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Implications for Research
There is a need for more randomized clinical trials with high methodological quality, large numbers of participants, and good reporting to provide stronger evidence. In particular, such trials should assure adequate randomization and allocation concealment, blinding of participants, drug providers and outcome assessors, good reporting of methodology, and losses of participants using intention-to-treat analysis. In addition, they should have appropriate control interventions using placebo or no treatment. No confounded medicine should be added to the treatment intervention. Cointervention should be concordant in the 2 groups in a trial. Basic drug therapy for ischemic stroke such as aspirin may be given to both groups. Follow-up should be longer. Functional outcome such as death or dependency at the end of follow-up over 2 months should be measured as the primary outcome. Sample size should be large enough to provide adequate statistical power. Finally, we recommend all clinical trials are appropriately registered before they start, for example, on the Chinese Clinical Trial Register’s web site.

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Disclosures
None.

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