Current guidelines for the management of patients with acute ischemic stroke published by the American Heart Association Stroke Council include specific recommendations for the administration of intravenous recombinant tissue plasminogen activator (rtPA). Despite its effectiveness in improving neurological outcomes, the majority of patients with ischemic stroke are not treated with rtPA, largely because they arrive after the currently approved 3-hour time limit for administration of the medication. One of the potential approaches to increase treatment opportunities has been the designation of a longer time window for treatment.2–4

A recent prospective study, the European Cooperative Acute Stroke Study (ECASS)-3, has provided new data on rtPA (alteplase) treatment in the 3-to-4.5-hour window.5 The SITS-MOST definition at 24 hours after rtPA was 1.7% (95% CI 1.4% to 2.0%; Figure 3 in Wahlgren et al6). The frequency of symptomatic intracerebral hemorrhage per the Cochrane/National Institute of Neurological Disorders and Stroke (NINDS) definition at 24 hours after rtPA was 7.3% (95% CI 6.7% to 7.9%). By comparison, this frequency was slightly less than 8.6% in data taken from a pool of randomized, controlled trials (Figure 2 in Wahlgren et al). For efficacy, the frequency of scores of 0, 1, and 2 on the combined modified Rankin scale at 90 days was 54.8% (95% CI 53.5% to 56.0%) among rtPA patients, which was comparable to the pooled sample.6 These findings appear to confirm the potential safety of rtPA within the 3-hour window in European centers.

In addition, the Safe Implementation of Thrombolysis in Stroke—International Stroke Treatment Registry 3-to-4.5-hour study (SITS-ISTR 3-to-4.5-hour), a post hoc sampling of limited data acquired between December 2002 and November 2007 from the ongoing international registry (SITS-ISTR), compared 11 865 patients treated with rtPA within 3 hours of symptom onset with 664 patients who received treatment within 3 to 4.5 hours.7 Most (72%) of the patients treated after 3 hours were treated between 3 and 3.5 hours. Although there were several weaknesses in that study, no differences between the 3-to-4.5-hour cohort and the <3-hour cohort were apparent with respect to symptomatic intracerebral hemorrhage, mortality, or modified Rankin Scale score of 0 to 2 at 90 days.7 SITS-ISTR is an ongoing registry that includes experience from SITS-MOST, non-European centers, and active studies.

The American Heart Association makes every effort to avoid any actual or potential conflicts of interest that may arise as a result of an outside relationship or a personal, professional, or business interest of a member of the writing panel. Specifically, all members of the writing group are required to complete and submit a Disclosure Questionnaire showing all such relationships that might be perceived as real or potential conflicts of interest.

This advisory was approved by the American Heart Association Science Advisory and Coordinating Committee on April 22, 2009. A copy of the advisory is available at http://www.americanheart.org/presenter.jhtml?identifier=3003999 by selecting either the “topic list” link or the “chronological list” link (No. LS-2097). To purchase additional reprints, call 843-216-2533 or e-mail kelle.ramsay@wolterskluwer.com.

The American Heart Association requests that this document be cited as follows: del Zoppo GJ, Saver JL, Jauch EC, Adams HP Jr; on behalf of the American Heart Association Stroke Council.

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Stroke is available at http://stroke.ahajournals.org

DOI: 10.1161/STROKEAHA.109.192535

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In 2008, ECASS-3, a multicenter, prospective, randomized, placebo-controlled trial that enrolled patients to best medical treatment together with either rtPA (n=418) or placebo (n=403) between 3 and 4.5 hours after symptom onset, was completed. The dosing regimen was 0.9 mg/kg (maximum of 90 mg), with 10% given as an initial bolus and the remainder infused over 1 hour, exactly what is stated in the current guidelines. Initially, the trial restricted enrollment to patients treated within 4 hours of stroke onset, then increased the permitted time window to 4.5 hours (median treatment interval 4 hours). The trial excluded persons older than 80 years, those with a baseline National Institutes of Health Stroke Scale score 25, those taking oral anticoagulants, and those who had the combination of a previous stroke and diabetes mellitus. Otherwise, the exclusion and inclusion criteria for the trial were similar to those contained in the American Heart Association Stroke Council guidelines for treating persons within 3 hours of stroke onset. Ancillary medical care was similar to that included in the current guidelines except that patients were permitted to receive parenteral anticoagulants for prophylaxis of deep vein thrombosis within 24 hours after treatment with rtPA.

Symptomatic intracranial hemorrhage (according to the ECASS-3 definition) was diagnosed in 10 subjects treated with rtPA (2.4%) and 1 subject who had been given placebo (0.2%; odds ratio [OR] 9.85, 95% CI 1.26 to 77.32, P=0.008). Symptomatic intracranial hemorrhage, as defined by the criteria used in the NINDS study, was diagnosed in 33 subjects treated with rtPA (7.9%) and 14 subjects given placebo (3.5%; OR 2.38, 95% CI 1.25 to 4.52, P=0.006). The increased incidence of symptomatic intracranial hemorrhage with the use of thrombolytic agents is consistent with the experience with rtPA in other clinical trials that tested the agent. In ECASS-3, the incidence of intracerebral hemorrhage was not increased greatly despite the parenteral administration of anticoagulants for prevention of deep vein thrombosis within the first 24 hours after rtPA treatment.
The frequency of the primary efficacy outcome in ECASS-3 (defined as modified Rankin Scale score of 0 to 1 at 90 days after treatment) was significantly greater with rtPA (52.4%) than with placebo (45.2%; OR 1.34, 95% CI 1.02 to 1.76; risk ratio 1.16, 95% CI 1.01 to 1.34; \( P = 0.04 \)). The point estimate for the degree of benefit seen in ECASS-3 (OR for global favorable outcome 1.28, 95% CI 1.00 to 1.65) was less than the point estimate of benefit found in the pool of patients enrolled from 0 to 3 hours after stroke symptoms in the NINDS study (OR 1.9, 95% CI 1.2 to 2.9).5,8 and was similar to that in a single pooled analysis of the results of subjects enrolled in the 3-to-4.5-hour window in previous trials of rtPA (OR 1.4).8–13 However, the overlap in CIs limits conclusions about these observations. Global favorable outcome was assessed as a modified Rankin Scale score of 0 to 1, a Barthel Index score \( \geq 95 \), a National Institutes of Health Stroke Scale score of 0 or 1, and a Glasgow Outcome Scale score of 1. In ECASS-3, mortality in the 2 treatment groups did not differ significantly, although it was nominally higher among the subjects treated with placebo.5

The ECASS-3 trial represents an important advance in the treatment of acute ischemic stroke. The results, which are consistent with the results in this time window from previous studies and pooled analyses of previous trials,3,4,11 provide level B evidence that intravenous rtPA can be given safely to carefully selected patients treated 3 to 4.5 hours after stroke and that intravenous rtPA given in this time period can improve outcomes after stroke in a selected group of patients. Confirmation of the ECASS-3 outcome is encouraged.

**Recommendations**

Patients who are eligible for treatment with rtPA within 3 hours of onset of stroke should be treated as recommended in the 2007 guidelines.1 Although a longer time window for treatment with rtPA has been tested formally, delays in evaluation and initiation of therapy should be avoided, because the opportunity for improvement is greater with earlier treatment.

rtPA should be administered to eligible patients who can be treated in the time period of 3 to 4.5 hours after stroke (Class I Recommendation, Level of Evidence B). The eligibility criteria for treatment in this time period are similar to those for persons treated at earlier time periods, with any one of the following additional exclusion criteria: Patients older than 80 years, those taking oral anticoagulants with an international normalized ratio \( \leq 1.7 \), those with a baseline National Institutes of Health Stroke Scale score >25, or those with both a history of stroke and diabetes. Therefore, for the 3-to-4.5-hour window, all patients receiving an oral anticoagulant are excluded regardless of their international normalized ratio. The relative utility of rtPA in this time window compared with other methods of thrombus dissolution or removal has not been established. The efficacy of intravenous treatment with rtPA within 3 to 4.5 hours after stroke in patients with these exclusion criteria is not well established (Class IIb Recommendation, Level of Evidence C) and requires further study.

Ancillary care for patients receiving rtPA at 3 to 4.5 hours after ischemic stroke should be similar to that included in the 2007 American Heart Association Stroke Council Guidelines.1 These recommendations, which are based on peer-reviewed publications, should be reevaluated after the results of regulatory agency review of detailed, nonpublicly available data are known. The recommendations use the American Heart Association’s classification of recommendations and levels of evidence shown in the Table.

**Disclosures**

**Writing Group Disclosures**

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<tr>
<th>Writing Group Member</th>
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*Modest.
†Significant.
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References


Key Words: AHA Scientific Statements | stroke | tissue plasminogen activator | hemorrhage | intracerebral hemorrhage
Expansion of the Time Window for Treatment of Acute Ischemic Stroke With Intravenous Tissue Plasminogen Activator: A Science Advisory From the American Heart Association/American Stroke Association

Gregory J. del Zoppo, Jeffrey L. Saver, Edward C. Jauch and Harold P. Adams, Jr on behalf of the American Heart Association Stroke Council

*Stroke*. 2009;40:2945-2948; originally published online May 28, 2009;
doi: 10.1161/STROKEAHA.109.192535

*Stroke* is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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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/40/8/2945

An erratum has been published regarding this article. Please see the attached page for:
/content/41/9/e562.full.pdf

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In the article by del Zoppo et al, “Expansion of the Time Window for Treatment of Acute Ischemic Stroke With Intravenous Tissue Plasminogen Activator: A Science Advisory From the American Heart Association/American Stroke Association,” which published ahead of print on May 28, 2009, and appeared in the August 2009 issue of the journal, a correction was needed.

On page 2945, a statement of affirmation has been added. It reads, “The American Academy of Neurology affirms the value for this paper as an educational tool for neurologists.”

This correction has been made to the current online version of the article, which is available at http://stroke.ahajournals.org/cgi/content/full/40/8/2945.