Resolution of Intraventricular Hemorrhage Varies by Ventricular Region and Dose of Intraventricular Thrombolytic

The Clot Lysis: Evaluating Accelerated Resolution of IVH (CLEAR IVH) Program

Alastair J.S. Webb, BMBCh; Natalie L. Ullman, BS; Sarah Mann, MD; John Muschelli, ScM; Issam A. Awad, MD; Daniel F. Hanley, MD

Background and Purpose—The Clot Lysis: Evaluating Accelerated Resolution of IVH (CLEAR IVH) program is assessing the efficacy of intraventricular recombinant tissue-type plasminogen activator (rtPA) for spontaneous intraventricular hemorrhage (IVH). This subanalysis assesses the effect of dose of rtPA by region on clearance of IVH.

Methods—Sixty-four patients within 12 to 24 hours of spontaneous IVH were randomized to placebo or 0.3 mg, 1 mg, or 3 mg of rtPA twice daily through an extraventricular drain. Twelve subregions of the ventricles were scored from 0 to 4. Effect of dose on IVH clearance to 50% of baseline score was compared by survival analysis for all regions combined and by subregion. Models including ventricular region, dose, and baseline score were compared by Cox proportional hazards.

Results—IVH score reduced faster across all regions with increasing rtPA dose (clearance to 50%: log-rank P<0.0001; placebo—11.43 days, 95% CI, 5.68–17.18; 0.3 mg—3.19 days, 1.00–5.38; 1 mg—3.54 days, 0.45–6.64; 3 mg—2.59 days, 1.72–3.46). In the combined models, dose and baseline score were independently associated with reduction in IVH score, which was quickest in the midline ventricles, then the anterior half of the lateral ventricles and slowest in the posterior half of the lateral ventricles (clearance to 50%: P<0.0001; rtPA dose: hazard ratio, 1.47, 1.30–1.67; midline versus anterolateral hazard ratio, 1.71, 1.08–2.71; midline versus posterolateral hazard ratio, 4.05, 2.46–6.65; baseline score hazard ratio, 0.96, 0.91–1.01) with a significant interaction between dose and ventricular region (P=0.005).

Conclusions—rtPA accelerates resolution of IVH. This effect is dose-dependent, is greatest in the midline ventricles, and least in the posterolateral ventricles.

Clinical Trial Registration—URL: www.clinicaltrials.gov. Unique identifier: NCT00650858. (Stroke. 2012;43:1666-1668.)

Key Words: intraventricular hemorrhage ■ randomized controlled trials ■ thrombolysis

Intraventricular hemorrhage (IVH) complicates 40% of intracerebral hemorrhage1 and increases mortality2 due to larger associated intracerebral hemorrhage and occlusion of the third and fourth ventricles. However, normalization of intracranial pressure does not reverse the neurological deficit,3 probably because of direct toxicity of blood products.4 Recombinant tissue-type plasminogen activator (rtPA) increases resolution of IVH,5–8 reducing intracranial pressure, duration of cerebrospinal fluid diversion, and direct neural injury. The clinical efficacy of rtPA is being assessed in the The Clot Lysis: Evaluating Accelerated Resolution (CLEAR) III trial. This analysis of the safety8 and dose-finding phases of the Clot Lysis: Evaluating Accelerated Resolution of IVH (CLEAR IVH) program assesses the effect of rtPA dose according to ventricular region (online-only Supplemental Data).

Methods

CLEAR-IVH safety recruited 48 patients aged 18 to 75 years old, who had at least 1 CT scan after insertion of an extraventricular drain (EVD) and started treatment within 12 to 24 hours of a spontaneous IVH.8 They received 3 mg intraventricular rtPA or placebo twice daily, after which the EVD was clamped for 1 hour. Patients underwent daily CT scans until treatment was completed and a follow-up scan between 28 and 32 days. In CLEAR-IVH dose-finding Phase 1, 16 patients were randomized to 0.3 mg or 1 mg rtPA according to the same protocol. The second phase of this study was excluded due to a different dosing schedule.

Received January 16, 2012; final revision received January 25, 2012; accepted January 27, 2012.

From the Department of Clinical Neurosciences (A.J.S.W.), University of Oxford, UK; the Division of Brain Injury Outcomes (N.L.U., S.M., J.M., D.F.H.), Johns Hopkins Medical Institutions, Baltimore, MD; and the Department of Surgery (Neurosurgery; I.A.A.), University of Chicago, Chicago, IL.

The online-only Data Supplement is available with this article at http://stroke.ahajournals.org/lookup/suppl/doi:10.1161/STROKEAHA.111.650523/-/DC1.

Correspondence to Daniel F. Hanley, MD, Division of Brain Injury Outcomes, Johns Hopkins Medical Institutions, 1550 Orleans Street 3M53-South, Baltimore, MD 21231. E-mail dhanley@jhmi.edu

© 2012 American Heart Association, Inc.

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

DOI: 10.1161/STROKEAHA.111.650523

1666
The modified Graeb scale\(^9\) divided the lateral ventricles into anterior (anterolateral) and posterior halves (posterolateral), the third ventricle into anterior and posterior halves, and the fourth ventricle into superior and inferior halves (Supplemental Figure III). “Ipsilateral” or “contralateral” ventricles were defined relative to catheter-assisted rtPA administration, because the impact of IVH and intracerebral hemorrhage laterality has been reported elsewhere.\(^10\)

The region and drug dose. Sensitivity analyses excluded patients who were censored within 7 days or excluded the placebo group. Dose and region independently determined t50 (Cox proportional hazards: P<0.0001; dose–effect: per 1 mg rtPA: hazard ratio [HR], 1.47; 1.30–1.67; P<0.0001; location–effect: midline versus anterolateral HR, 1.71; 1.08–2.71; P=0.022; midline versus posterolateral HR, 4.05, 2.46–6.65, P<0.0001; baseline score HR, 0.96, 0.91–1.01, P=0.0097; Figure 2) with a greater dose–effect in the midline ventricles (dose–region interaction: P=0.005). Sensitivity analyses showed the same result (excluding 10 censored patients: rtPA: HR, 1.46, 1.29–1.66; versus anterolateral HR, 1.59, 0.98–2.57, versus posterolateral HR, 3.57, 2.14–5.99; excluding placebo: rtPA: HR, 1.27, 1.06–1.65; versus anterolateral HR, 1.16, 0.64–2.08, versus posterolateral HR, 3.70, 2.02–6.85).

**Discussion**

IVH cleared quickest in the midline ventricles, even with placebo, probably due to a higher turnover of cerebrospinal fluid. This regional difference was greater with rtPA, probably due to greater drug exposure with greater proximity of IVH to the EVD. Once the midline ventricles were open, rtPA was diverted away from the posterolateral ventricles, potentially limiting the effectiveness of intraventricular rtPA in regions distant to the EVD.

This development of the Graeb score\(^9\) assesses ventricular obstruction by region, does not overweight the midline ventricles, is simple to perform, and is strongly correlated with changes in blood volume. However, the dose–effect in the midline ventricles was not seen in another study looking at dose of intraventricular fibrinolysis,\(^11\) although this non-randomized study only compared 2 doses of rtPA with a

---

**Results**

Patient characteristics have been reported previously.\(^8\) There was high interobserver agreement scoring the 12 ventricular subregions (κ=0.607; 95% CI, 0.59–0.62; P<0.0001) and categorizing each ventricle into quartiles (κ=0.732; 0.70–0.76). Change in baseline score and IVH volume were highly correlated (r²=0.651, 0.640, and 0.628; P<0.0001).

Median time to reduction in the total score decreased with increasing drug dose (log-rank: t50, P=0.001, t75 P<0.001, t50 P<0.001, t25 P=0.003) and was most different for placebo versus 3 mg (t50, Placebo—11.43 days, 95% CI, 5.68–17.18; 0.3 mg—3.19 days, 1.00–5.38; 1 mg—3.54 days, 0.45–6.64; 3 mg—2.59 days, 1.72–3.46). With placebo, IVH resolved quickest in the midline ventricles with no difference amongst anterior and posterolateral ventricles. With rtPA, IVH resolution was dose-dependent, quickest in the midline ventricles (Figure 1), next quickest in the anterolateral ventricles, and slowest, with no dose–effect, in the posterolateral ventricles (Table).

### Table. Baseline Characteristics and Median Time to ≤50% of the Baseline Score According to Ventricular Region and Drug Dose

<table>
<thead>
<tr>
<th>Region</th>
<th>Dose, mg</th>
<th>Placebo (n=22)</th>
<th>0.3 (n=8)</th>
<th>1 (n=8)</th>
<th>3 (n=26)</th>
<th>All (n=64)</th>
<th>Dose P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midline</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=62)</td>
<td></td>
<td>4.96</td>
<td>2.47</td>
<td>2.15</td>
<td>1.37</td>
<td>2.76</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(3.82–6.11)</td>
<td>(0.42–4.52)</td>
<td>(0.97–3.33)</td>
<td>(0.88–1.87)</td>
<td>(1.79–3.73)</td>
<td></td>
</tr>
<tr>
<td>Anterolateral</td>
<td></td>
<td>9.22</td>
<td>2.72</td>
<td>3.00</td>
<td>2.02</td>
<td>3.40</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>(n=64)</td>
<td></td>
<td>(4.17–14.3)</td>
<td>(1.72–3.72)</td>
<td>(0.00–6.72)</td>
<td>(1.28–2.76)</td>
<td>(2.27–4.53)</td>
<td></td>
</tr>
<tr>
<td>Posterolateral</td>
<td></td>
<td>11.2</td>
<td>2.47</td>
<td>5.23</td>
<td>7.79</td>
<td>8.30</td>
<td>0.199</td>
</tr>
<tr>
<td>(n=64)</td>
<td></td>
<td>(7.11–15.3)</td>
<td>(0.00–7.99)</td>
<td>(0.00–27.1)</td>
<td>(1.03–14.6)</td>
<td>(5.44–11.2)</td>
<td></td>
</tr>
<tr>
<td>Region p</td>
<td></td>
<td>0.048</td>
<td>0.448</td>
<td>0.009</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
<td></td>
</tr>
</tbody>
</table>

P values are from log-rank tests.
poorer temporal resolution of CT scans. This analysis only assessed the regional dose-dependence of IVH clearance because the safety aspects of intraventricular rtPA have already been reported, but it provides a method for analyzing the region-dependent effect of rtPA on clinical outcomes in future trials such as CLEAR III. However, future studies will be needed to address dose-safety and whether distribution or severity of IVH should determine EVD location or rtPA dose.

In conclusion, rtPA administered through an EVD increases resolution of IVH in a dose-dependent fashion and has a greater effect on the midline ventricles and anterolateral sections of the lateral ventricles than the posterolateral ventricles. It is likely to increase the rate of resolution of obstructive hydrocephalus but has a less significant effect on blood in the posterolateral ventricles.

Acknowledgments

We sincerely thank all trial participants, their families, and colleagues, particularly Joseph Broderick and Robert Wityk. We gratefully acknowledge the contributions of Karen Lane for article preparation and Tim Morgan for data collection oversight.

Sources of Funding

The IVH Thrombolysis Trial was supported by the Office of Orphan Products Development, Food and Drug Administration (FD-R-001693 and FD-R 002018). Dr Hanley receives National Institutes of Health grants U01NS062851 and R01NS046309, Eleanor Naylor Dana Charitable Trust grant 272-2007, Jeffry, Harriet Legum Endowment, and materials grants from Genentech. Dr Webb receives a Medical Research Council Training Fellowship.

Disclosures

Johns Hopkins has applied for a use-patent and Genentech has licensed this patent for rtPA use.

References

Resolution of Intraventricular Hemorrhage Varies by Ventricular Region and Dose of Intraventricular Thrombolytic: The Clot Lysis: Evaluating Accelerated Resolution of IVH (CLEAR IVH) Program

Alastair J.S. Webb, Natalie L. Ullman, Sarah Mann, John Muschelli, Issam A. Awad and Daniel F. Hanley

Stroke. 2012;43:1666-1668; originally published online April 3, 2012; doi: 10.1161/STROKEAHA.112.650523

Stroke is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2012 American Heart Association, Inc. All rights reserved.
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/43/6/1666

Data Supplement (unedited) at:
http://stroke.ahajournals.org/content/suppl/2012/04/03/STROKEAHA.112.650523.DC1

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Stroke can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Stroke is online at:
http://stroke.ahajournals.org//subscriptions/
Resolution of intraventricular hemorrhage varies by ventricular region and dose of intraventricular thrombolytic: the CLEAR-IVH Program

Alastair JS Webb*, Natalie L Ullman†, Sarah Mann†, John Muschelli, Issam A Awad≠, Daniel F Hanley†

* Department of Clinical Neurology, University of Oxford, UK
† Division of Brain Injury Outcomes, Johns Hopkins Medical Institutions, MD, USA
≠ Department of Surgery (Neurosurgery), University of Chicago Medical Centre, MC, USA

Corresponding author:
Professor Daniel Hanley
Division of Brain Injury Outcomes
Johns Hopkins Medical Institutions
1550 Orleans Street 3M53-South
Baltimore, MD
USA
Tel: 410-614-6996
Fax: 410-502-7869
The CLEAR IVH Program

**rtPA Safety Study:**
To assess the safety of intraventricular rtPA

- 48 patients with spontaneous IVH randomised to placebo or 3mg of rtPA
- Demonstrated efficacy of rtPA in reducing volume of intraventricular blood, but small increase in bleeding complications

Safety of intraventricular rtPA demonstrated

**Dose-Finding Study (CLEAR IVH A):**
To determine the optimal dose of rtPA

- 16 patients with spontaneous IVH randomised to 0.3mg or 1mg of rtPA twice a day
- Demonstrated a dose–effect across all 4 doses, particularly in the 3rd and 4th ventricles

Dose selected for further trials: 1mg

**Dose-Ranging Study (CLEAR IVH B):**
To determine the optimal dose interval & assess 180 day

- 36 patients with spontaneous IVH randomised to 1mg of rtPA given every 8 hours
- Results: 50% of subjects achieved mRS 0-3 at 180 days

Dosing interval determined for Phase 3 trial

**Phase 3 trial CLEAR III:**
To determine the clinical efficacy of rtPA

- 500 patients with spontaneous IVH randomised to placebo or 1mg of rtPA every 8 hours
- Currently recruiting

**Supplemental Figure 1. The CLEAR IVH Program.** The current analysis includes studies in which rtPA was only administered twice daily to allow reliable comparison of doses, being the Safety and Dose-finding stages.
Supplemental Figure 2. Consort Flow Diagram for the Safety and Dose-Finding Phases of the CLEAR IVH Program.
Supplemental figure 3. Diagram of the ventricular system used for the scoring of intraventricular hemorrhage. The ventricles are divided into twelve subregions, each of which is independently scored 0-4. The anterior region of each lateral ventricle was defined as the ventricular space anterior to the posterior margin of the head of the caudate nucleus in any CT slice. The posterior region was defined as the ventricular space posterior to the posterior margin of the septum pellucidum, including the atrium of the ventricle but excluding the temporal horn. The remaining lateral ventricles were bisected along a line between the external auditory meati. The third ventricle was divided into an anterior and a posterior segment along a coronal plane bisecting the ventricle on the slice with the greatest representation of the third ventricle. The fourth ventricle was divided into superior and inferior halves by division of the number of slices in which the fourth ventricle was visible. The proportion of each subregion that was filled with blood was estimated visually, taking into account all slices which showed each region. Each subregion was scored: 0='No blood', 1='<25%', 2 = '25-50%', 3 = '>50%', 4 = 'Full of blood'.

The anterior region of each lateral ventricle was defined as the ventricular space anterior to the posterior margin of the head of the caudate nucleus in any CT slice. The posterior region was defined as the ventricular space posterior to the posterior margin of the septum pellucidum, including the atrium of the ventricle but excluding the temporal horn. The remaining lateral ventricles were bisected along a line between the external auditory meati. The third ventricle was divided into an anterior and a posterior segment along a coronal plane bisecting the ventricle on the slice with the greatest representation of the third ventricle. The fourth ventricle was divided into superior and inferior halves by division of the number of slices in which the fourth ventricle was visible. The proportion of each subregion that was filled with blood was estimated visually, taking into account all slices which showed each region. Each subregion was scored: 0='No blood', 1='<25%', 2 = '25-50%', 3 = '>50%', 4 = 'Full of blood'.

The anterior region of each lateral ventricle was defined as the ventricular space anterior to the posterior margin of the head of the caudate nucleus in any CT slice. The posterior region was defined as the ventricular space posterior to the posterior margin of the septum pellucidum, including the atrium of the ventricle but excluding the temporal horn. The remaining lateral ventricles were bisected along a line between the external auditory meati. The third ventricle was divided into an anterior and a posterior segment along a coronal plane bisecting the ventricle on the slice with the greatest representation of the third ventricle. The fourth ventricle was divided into superior and inferior halves by division of the number of slices in which the fourth ventricle was visible. The proportion of each subregion that was filled with blood was estimated visually, taking into account all slices which showed each region. Each subregion was scored: 0='No blood', 1='<25%', 2 = '25-50%', 3 = '>50%', 4 = 'Full of blood'.

The anterior region of each lateral ventricle was defined as the ventricular space anterior to the posterior margin of the head of the caudate nucleus in any CT slice. The posterior region was defined as the ventricular space posterior to the posterior margin of the septum pellucidum, including the atrium of the ventricle but excluding the temporal horn. The remaining lateral ventricles were bisected along a line between the external auditory meati. The third ventricle was divided into an anterior and a posterior segment along a coronal plane bisecting the ventricle on the slice with the greatest representation of the third ventricle. The fourth ventricle was divided into superior and inferior halves by division of the number of slices in which the fourth ventricle was visible. The proportion of each subregion that was filled with blood was estimated visually, taking into account all slices which showed each region. Each subregion was scored: 0='No blood', 1='<25%', 2 = '25-50%', 3 = '>50%', 4 = 'Full of blood'.

The anterior region of each lateral ventricle was defined as the ventricular space anterior to the posterior margin of the head of the caudate nucleus in any CT slice. The posterior region was defined as the ventricular space posterior to the posterior margin of the septum pellucidum, including the atrium of the ventricle but excluding the temporal horn. The remaining lateral ventricles were bisected along a line between the external auditory meati. The third ventricle was divided into an anterior and a posterior segment along a coronal plane bisecting the ventricle on the slice with the greatest representation of the third ventricle. The fourth ventricle was divided into superior and inferior halves by division of the number of slices in which the fourth ventricle was visible. The proportion of each subregion that was filled with blood was estimated visually, taking into account all slices which showed each region. Each subregion was scored: 0='No blood', 1='<25%', 2 = '25-50%', 3 = '>50%', 4 = 'Full of blood'.
Supplemental figure 4. Correlation between the change in total score across all ventricular regions and change in the volume of IVH. Score and volume are expressed as a percentage of the same value on the stability CT for that patient ($r^2=0.63$ $p<0.0001$).