Earlier Blood Pressure-Lowering and Greater Attenuation of Hematoma Growth in Acute Intracerebral Hemorrhage

INTERACT Pilot Phase

Hisatomi Arima, MD; Yining Huang, MD; Ji Guang Wang, MD; Emma Heeley, PhD; Candice Delcourt, MD; Mark Parsons, MD; Qiang Li, BSc; Bruce Neal, MD; John Chalmers, MD; Craig Anderson, MD; for the INTERACT1 Investigators*

Background and Purpose—The INTEnsive blood pressure Reduction in Acute Cerebral hemorrhage Trial (INTERACT) pilot study showed that early intensive blood pressure-lowering can attenuate hematoma growth in acute intracerebral hemorrhage. The present analysis aimed to determine the treatment effects on hematoma growth by time from intracerebral hemorrhage onset to randomization.

Methods—Patients (N=404) with acute intracerebral hemorrhage and elevated systolic blood pressure were randomly assigned to intensive or guideline-based blood pressure management. Baseline and repeat CT (24 and 72 hours) were performed and changes in hematoma volume were assessed using generalized estimating equations.

Results—Among 296 patients with all 3 CT scans available for analysis, reductions in proportional hematoma growth produced by randomized intensive blood pressure-lowering treatment over 72 hours decreased progressively with delays in initiation of study treatment: 22%, 17%, 9%, and 3% for quartile groups defined by time from onset to randomization of \(<2.9, 2.9\) to \(3.6, 3.7\) to \(4.8\), and \(\geq4.9\) hours, respectively (\(P\) trend=0.001). There were also smaller absolute reductions in hematoma growth with delays in initiation of study treatment (6.5 mL, 3.3 mL, 0.9 mL, and 0.6 mL), although the trend did not reach statistical significance (\(P\) trend=0.12).

Conclusions—Earlier initiation of intensive blood pressure-lowering treatment is likely to provide greater protection against hematoma growth in acute intracerebral hemorrhage.

Clinical Trial Registration Information—http://www.clinicaltrials.gov, NCT002226096.

(Stroke. 2012;43:2236-2238.)

Key Words: blood pressure-lowering ■ clinical trials ■ INTERACT ■ intracerebral hemorrhage ■ time

Hematoma growth is a strong predictor of death and dependency after intracerebral hemorrhage (ICH),\(^1\)\(^\sim\)\(^3\) and accordingly, treatment approaches to attenuate hematoma growth (eg, hemostatic treatment\(^4\) and intensive blood pressure [BP]-lowering\(^5\),6) may improve prognosis in ICH. As more hematoma growth is observed in patients who present rapidly to the hospital,\(^7\) an earlier initiation of such treatment may provide larger protection against poor outcomes after ICH. The INTEnsive blood pressure Reduction in Acute Cerebral hemorrhage Trial (INTERACT) pilot phase demonstrated that early intensive BP-lowering reduced hematoma growth in patients with ICH.\(^5\),6 Additional information is provided here about the effects of treatment on hematoma growth by time from onset to randomization.

Methods

The design of the INTERACT study has been described in detail elsewhere.\(^5\),6,8,9 Briefly, 404 patients with CT-confirmed ICH, elevated systolic BP (150–220 mm Hg), and capacity to commence BP-lowering within 6 hours of onset were randomly assigned to an intensive lowering of BP using routine intravenous agents (target systolic BP \(<140\) mm Hg) or guideline-based management of BP (180 mm Hg). The study protocol was approved by the ethics committee at each participating site and the procedures followed were in accordance with institutional guidelines. Written informed consent was obtained from each patient or their legal surrogate.
Outcomes for the present investigation were proportional and absolute increases in hematoma volume during the first 72 hours after ICH. Sites were required to perform CT scans according to standardized techniques at baseline and at 24/3, 48/3, and 72/3 hours after the initial CT. Hematoma volume was calculated independently by 2 trained neurologists who were blind to treatment allocation (intraclass correlation coefficient for 10% CT = 0.97) using MiStar Version 3.2 (Apollo Medical Imaging Technology).

Groups of participants defined by quartiles of time from onset to randomization were used. The present subgroup analysis was not prespecified. The effects of intensive BP-lowering on hematoma growth over 72 hours were ascertained by generalized estimating equations using hematoma increases at 24 and 72 hours as repeat measures. Proportional change was log-transformed to remove skewness after addition of the value 1.1 to eliminate negative values, and 95% CI for the differences in adjusted means of proportional change were calculated using the bootstrap method. Comparisons of treatment effects across subgroups were performed by adding an interaction term.

Results

Overall, 296 patients had all 3 CT available for analyses. Patients with repeat CT scans involved fewer subjects with low Glasgow Coma Scale score and had smaller hematomas at baseline (Table I in the online-only Data Supplement). Table II in the online-only Data Supplement shows that the baseline characteristics of patients were broadly similar across quartile groups defined by time from onset to randomization. There were no significant differences between randomized groups in each subgroup except for previous ICH in the 2.9- to 3.6-hour group. The mean differences in systolic BP (mm Hg) between randomized groups during 1 to 24 hours were 14.2 (95% CI, 7.5–20.9), 6.3 (1.7 to 14.3), 13.5 (7.3–19.7), and 12.5 (4.4–20.6) for the quartile groups defined by time from onset to randomization of <2.9, 2.9 to 3.6, 3.7 to 4.8, and ≥4.9 hours, respectively (P trend = 0.96). Reductions in proportional hematoma growth (%) produced by more intensive BP-lowering over 72 hours decreased progressively with delays in initiation of study treatment even after adjustment for hematoma location: 22 (95% CI, 1–43), 17% (1 to 32), 9% (-2 to 21), and 3% (-14 to 21) for the quartile groups (Figure 1; P trend = 0.001). There were also smaller absolute reductions (mL) in hematoma growth with delays in initiation of treatment even after adjustment for location and baseline volume of hematoma: 6.5 (95% CI, 0.5–12.5), 3.3 (0.5–6.0), 0.9 (−1.0 to 2.8), and 0.6 (−1.1 to 2.3), although the trend did not reach statistical significance (Figure 2; P trend = 0.12). Similar results were obtained for crude analyses (Figures I and II in the online-only Data Supplement).

Discussion

The present analysis suggests that patients who receive early start of intensive BP-lowering treatment obtain a larger reduction in hematoma growth after ICH. Our findings are consistent with those obtained from the Factor seven for Acute hemorrhagic Stroke Trial (FAST), which identified greater reduction in hematoma growth in a subgroup of patients who received hemostatic therapy based on recombinant activated factor VII within 3 hours after ICH onset than those who received recombinant activated factor VII during 3 to 4 hours after onset. The FAST trial also demonstrated that favorable effects of recombinant activated factor VII on clinical outcomes were only ob-
served in patients who received treatment within 2.5 hours from onset. These findings support the hypothesis concerning a larger protection against hematoma growth and subsequent poor outcomes associated with earlier initiation of treatment after ICH.

Key strengths of INTERACT are the relatively large sample size of patients with early and rigorous evaluations made after acute ICH. However, the trial still had relatively limited power to define significant heterogeneity of treatment effects in each set of analysis. Moreover, because the present evaluation was restricted to those patients with repeat CT, who had better clinical status at baseline, the findings may not be applicable to patients with severe ICH.

Summary
The present data support the possibility that maximum beneficial effects on hematoma growth and subsequent poor clinical outcomes are likely to be obtained in those patients who receive intensive BP-lowering within the first few hours from onset of ICH.

Sources of Funding
The INTERACT study was supported by a Program Grant (358395) from the National Health and Medical Research Council. The study was designed, conducted, analyzed and interpreted by the investigators independent of sponsors.

Disclosures
None.

References