Stroke Thrombolysis
Save a Minute, Save a Day

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Background and Purpose—Stroke thrombolysis is highly time-critical, but data on long-term effects of small reductions in treatment delays have not been available. Our objective was to quantify patient lifetime benefits gained from faster treatment.

Methods—Observational prospective data of consecutive stroke patients treated with intravenous thrombolysis in Australian and Finnish centers (1998–2011; n=2258) provided distributions of age, sex, stroke severity, onset-to-treatment times, and 3-month modified Rankin Scale in daily clinical practice. Treatment effects derived from a pooled analysis of thrombolysis trials were used to model the shift in 3-month modified Rankin Scale distributions with reducing treatment delays, from which we derived the expected lifetime and level of long-term disability with faster treatment.

Results—Each minute of onset-to-treatment time saved granted on average 1.8 days of extra healthy life (95% prediction interval, 0.9–2.7). Benefit was observed in all groups: each minute provided 0.6 day in old severe (age, 80 years; National Institutes of Health Stroke Scale [NIHSS] score, 20) patients, 0.9 day in old mild (age, 80 years; NIHSS score, 4) patients, 2.7 days in young mild (age, 50 years; NIHSS score, 4) patients, and 3.5 days in young severe (age, 50 years; NIHSS score, 20) patients. Women gained slightly more than men over their longer lifetimes. In the whole cohort, each 15 minute decrease in treatment delay provided an average equivalent of 1 month of additional disability-free life.

Conclusions—Realistically achievable small reductions in stroke thrombolysis delays would result in significant and robust average health benefits over patients’ lifetimes. The awareness of concrete importance of speed could promote practice change. (Stroke. 2014;45:1053-1058.)

Key Words: stroke ■ thrombolytic therapy

Intravenous thrombolysis (tissue-type plasminogen activator, tPA) is the only medical therapy shown to improve patient outcomes in acute ischemic stroke. The treatment is more effective when given early after symptom onset. The odds ratio (OR) of tPA compared with placebo for disability-free outcome is 2.6 when treatment is initiated <1.5 hours of symptom onset and 1.3 when started later, at 3 to 4.5 hours. The number needed to treat to achieve a disability-free, 3-month outcome correspondingly increases from 5 to 14.

However, measures such as OR and number needed to treat communicate poorly the overall patient health benefits of being treated slightly faster. Physiological modeling exercises examining brief time increments suggest an average of 2 million neurons gained every minute with earlier reperfusion of a major ischemic stroke. Clinically, outcomes depend heavily on the age of the patient, severity of stroke, and treatment delays.

Although numerous interventions to reduce delays in ischemic stroke thrombolysis have been described with median door-to-needle times down to 20 minutes at the best practice centers, median in-hospital delays in American, Australian, and European centers are at 70 to 80 minutes. Therefore, the potential for accelerating treatment by up to an hour exists in an average patient. Quantifying the long-term health benefits of faster treatment could help promote practice change.

The aim of the present study was to estimate the effect of speed in stroke thrombolysis over a patient’s lifetime.

Methods

Overview of the Model
To estimate the effect of tPA treatment delays on patient lifetime outcomes, we constructed a model based on an observational cohort of consecutive tPA patients, published pooled analysis of tPA

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randomized controlled trials, general population survival data, and previously reported disability weights for various modified Rankin Scale (mRS) categories (Figure 1). The observational cohort was used to derive demographic and outcome distributions in real-life tPA use; the pooled analysis was used to derive how the treatment effect of tPA varies by treatment delays; the population survival data were used to model long-term survival of patients at various mRS categories compared with the general population; and the disability weights were used to value the loss of healthy life in each mRS category.

Observational Cohort

Our observational cohort consisted of 2 databases: the Helsinki Stroke Thrombolysis Registry and the Safe Implementation of Treatments in Stroke (SITS)-Australia. Between March 1998 and December 2011, there were 1998 patients treated with tPA in the Helsinki University Central Hospital. After excluding patients treated >4.5 hours (n=150, of which 118 basilar artery occlusions treated at median 12 hours from symptom onset) and those with missing data on onset-to-treatment time, stroke severity (National Institutes of Health Stroke Scale, NIHSS) or mRS outcome (n=65), and basilar artery occlusions pretreated with heparin infusion (n=56), we included 1727 patients from Helsinki. Additionally, there were 704 patients registered in the SITS-Australia database between December 2002 and December 2008 from 14 hospitals. Of these, we excluded 173 with missing data and included 531 patients. The observational registries have been approved by institutional authorities. Because these are routine observational quality registries, no patient consent for registration was required. This made it possible to register all consecutive patients.

The observational cohort was used to construct binary logistic regression models estimating baseline probabilities of individual mRS categories for any given combinations of age, baseline NIHSS, and onset-to-treatment time (Methods in the online-only Data Supplement).

Treatment Effect Over Time

To estimate how treatment effect of tPA changes with onset-to-treatment time, we used the pooled analysis of tPA randomized controlled trials by Lees et al. This analysis provides ORs by onset-to-treatment time for favorable outcome (mRS, 0–1) and mortality (mRS, 6) of tPA compared with placebo. We used these to model how a change in onset-to-treatment time affects the probability of mRS 0 to 1 and mRS 6 (Figure 1; see also Methods in the online-only Data Supplement).

We assumed no tPA treatment after 270 minutes, because that is the evidence-based upper time limit, also adopted in current guidelines. For simulating extended delays, we assumed mRS 0 to 1 and mRS 6 probabilities that correspond to OR=1, that is, that of placebo, when treatment could not be initiated <270 minutes from stroke onset.

Disability-Adjusted Life-Years Lost

From observational data, we had 3-month mRS probabilities for each patient at the observed onset-to-treatment time, and from pooled analysis, we could derive how those probabilities shifted if treatment delays would have changed. To translate this 3-month outcome data into a meaningful long-term metric, we used disability-adjusted life-years (DALY’s) lost. DALY is a measure consisting of 2 components: years of life lost due to premature death (YLL), and years of life lost due to disability (YLD).

YLL is calculated as the difference between life expectancy of a person in the general population at a given age and sex, that is, life expectancy of a person without a stroke, and age- and sex-matched life expectancy of a stroke patient in a certain mRS category.

Figure 1. Overview of the model. DALY indicates disability-adjusted life-years; mRS, modified Rankin Scale; NIHSS, National Institutes of Health Stroke Scale; OTT, onset-to-treatment time; and tPA, tissue-type plasminogen activator.
long-term annual risk of death after stroke was taken from published literature (1.53, 1.52, 2.17, 3.18, 4.55, and 6.55 times that of the general population for mRS categories 0–5, respectively). We used Australian Bureau of Statistics data for age- and sex-specific life expectancies of the general population,10 The average life expectancy for Australians and Finns differs little and is presently, at birth, 79.2 years in men and 83.8 versus 83.3 years in women.11

The World Health Organization (WHO) made a major policy change in 2012, principally denotes that years lost beyond the age of 63 progressively are of less value than those lost during productive years. In 2012, the World Health Organization (WHO) made a major policy change and stopped using age-weighting and discounting for DALY calculations.15 We report our data according to this new policy, but addition-ally weighting the value of future years. 9,13,14 Age-weighting principally denotes that years lost beyond the age of 63 progressively are of less value than those lost during productive years. In 2012, the World Health Organization (WHO) made a major policy change and stopped using age-weighting and discounting for DALY calculations.15 We report our data according to this new policy, but additionally provide sensitivity analyses with discounting to present values at 3% per annum, both with or without age-weighting, according to standard methodology.16

Robustness Analysis

To evaluate model robustness with regard to uncertainties in inputs, we first performed 1-way analyses by varying each model input to their upper and lower 95% confidence interval, followed by probabilistic robustness analysis (Methods in the online-only Data Supplement), and report the 95% prediction interval of these simulations.

Implementation

mRS category–specific life expectancies and DALYs lost for each combination of age and sex were calculated on linked Excel 2010 worksheets (Microsoft Corp, Redmont, WA); all other analyses were performed on STATA IC version 12 (StataCorp, College Station, TX).

Table 1. Characteristics of the Observational Cohort

<table>
<thead>
<tr>
<th>Characteristics and Outcomes</th>
<th>Total (n=2258)</th>
<th>Helsinki (n=1727)</th>
<th>SITS-Australia (n=531)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y</td>
<td>70 (60–78)</td>
<td>70 (60–77)</td>
<td>73 (62–80)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Male sex</td>
<td>68±13</td>
<td>67±13</td>
<td>70±13</td>
<td>&lt;0.001</td>
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<tr>
<td>Hypertension</td>
<td>1247 (55%)</td>
<td>939 (54%)</td>
<td>308 (58%)</td>
<td>0.161</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>1361 (60%)</td>
<td>1018 (59%)</td>
<td>343 (65%)</td>
<td>0.020</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>329 (15%)</td>
<td>242 (14%)</td>
<td>87 (16%)</td>
<td>0.176</td>
</tr>
<tr>
<td>NIHSS at baseline</td>
<td>9 (6–15)</td>
<td>8 (5–14)</td>
<td>13 (8–19)</td>
<td>0.001</td>
</tr>
<tr>
<td>Onset-to-treatment time, min</td>
<td>11±6</td>
<td>10±6</td>
<td>14±7</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Door-to-needle time, min</td>
<td>129±46</td>
<td>125±49</td>
<td>143±32</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>sICH</td>
<td>36 (20–67)</td>
<td>26 (17–48)</td>
<td>74 (56–97)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>3-Month mRS score 0 to 1</td>
<td>47±36</td>
<td>37±31</td>
<td>79±32</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>3-Month mRS score 0 to 2</td>
<td>1290 (57.1%)</td>
<td>1031 (59.7%)</td>
<td>259 (48.8%)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Data are n (%), median (interquartile range), or mean±SD. Distributions of Helsinki and SITS-Australia data compared with Mann–Whitney U test, χ2 test, or Student t test as appropriate, with 2-sided statistical significance set at P=0.05. mRS indicates modified Rankin Scale; NIHSS, National Institutes of Health Stroke Scale; sICH, symptomatic intracerebral hemorrhage (second European-Australasian Acute Stroke Study definition); and SITS, Safe Implementation of Treatments in Stroke.

Results

The observational tPA cohort consisted of 2258 patients (Table 1). In the whole cohort, each minute saved provided a mean 1.8 days of DALY (SD, 0.8; median, 1.7; interquartile range, 1.1–2.3; range, 0.1–4.6 days). The effect of faster treatment varied with age and NIHSS. Each minute saved provided on average 0.6 day in old patients with severe stroke, 0.9 day in old and mild, 2.7 days in young and mild, and 3.5 days in young and severe patients (Figure 2). Greatest gains from faster treatment were reaped by youngest patients with longest life expectancies after their stroke, and women gained a little more over their longer lifetime (Figure 3; Table I in the online-only Data Supplement for 95% prediction intervals). The benefit was greatest in patients with moderately severe stroke deficits at presentation (NIHSS, 10–19).

Robustness Analyses

Our results were generally robust. Discounting and age-weighting varied the tPA effect differently for young and old patients as shown in Figure 2. In the whole cohort, each minute saved produced on average 1.3 days of DALYs after discounting and 0.9 day of DALYs after discounting and age-weighting. In 1-way robustness analyses, varying the model inputs one at a time only slightly changed the results (Table 2). Incorporating input uncertainties simultaneously in probabilistic robustness analyses provided a 95% prediction interval of 0.9 to 2.7 days per minute saved around our point estimate of 1.8 days per minute.

Discussion

This study demonstrates that a few minutes saved in delivering intravenous tPA translates to significant benefits equivalent to days, weeks, and even months of disability-free life over
the patient’s lifetime. Although patients of all age and disease severity seem to benefit, younger patients and women gain more from faster treatment over their longer lifetime. Except for oldest patients with most severe strokes, patients gain an equivalent of at least a day of healthy life for each minute saved; hence Save a Minute, Save a Day summarizes our findings.

Observational cohorts suggest that faster treatment is associated with better in-hospital and 3-month outcomes, and that tPA efficacy in real life and in randomized controlled trials is similar. Compared with a pooled analysis of these trials, our patients were slightly older (median age, 70 versus 68 years), with milder strokes (median NIHSS, 9 versus 11), lower
effect of increased mortality close to the end of treatment time.23,24 The effect of age on outcome1 was significant, but this requires heavy investment in personnel, training, and equipment. Our data provide inputs for evaluations of cost-effectiveness of such services.

Several interventions are known to reduce thrombolysis delays, although optimal reductions in delays are not achievable by any single intervention but rather result from continuous analysis and stepwise improvement of the system as a whole.4,5,20–24 Although typical routine practice in a stroke center has substantial room for improvement,6 many centers around the world are already down to <30 minutes from arrival to treatment.5,21 It is important to realize, based on the present analysis, that finetuning even the best of services is beneficial.

Prehospital thrombolysis using portable CT machines and point-of-care laboratories in ambulances has been recently demonstrated feasible.25,26 There is potential for significant reductions in treatment delays where such advanced service is available, but this requires heavy investment in personnel, education, and equipment. Our data provide inputs for evaluations of cost-effectiveness of such services.

One finding in our analysis relates to the previously reported effect of increased mortality2 close to the end of treatment time window at around 4 to 4.5 hours from symptom onset, compared with not treating at all (Figure 2). It would seem that when the absolute risk of death is high and the absolute chance of becoming disability-free is small, as is the case with most severe strokes, treating around the 4.5-hour time mark may reduce the long-term overall outcome of patients, that is, the relatively small mortality increase is large in absolute terms and outweighs the small absolute increase in the chance of becoming disability-free. However, the Effect of the European Cooperative Acute Stroke Study (ECASS) III trial subgroup analyses did not demonstrate loss of treatment effect at 4 to 4.5 hours or in the most severe cases when analyzed at 3 months, so our results regarding theoretical loss of efficacy over a patient’s lifetime in this specific situation should be interpreted with caution.

**Study Limitations**

First, we used observational data from select centers in Australia and Finland with special interest and experience in stroke thrombolysis. Other centers may have different distributions of age, severity, and treatment delays although our patient characteristics were not strikingly different from published series or randomized controlled trials. The robustness analysis demonstrated that the observational cohort was of sufficient size to estimate the effect of patient characteristics on outcome with very high precision (Table 2). Second, there is uncertainty about disability and excess death at various mRS categories.9,12 We used disability weights for various mRS categories derived using the original expert-based WHO methodology. The recent WHO methodology provides weights as valued by the general public for mild (0.021), moderate (0.076–0.312), and severe (0.539–0.567) stroke, but these cannot be directly translated to mRS categories.28 The expert-based granular mRS disability weights we used generally mapped well to the lay-person based disability weights. Excess postacute risk of death after stroke was from patients of 1990 to 2006.9 Survival after stroke might have improved mainly in the first 3 months and likely otherwise reflect general population trends. Third, our assumption on how the treatment effect of tPA is increased over time was derived from pooled analysis of tPA randomized controlled trials.7 The effectiveness of tPA may be different in routine clinical practice. To counteract this, we started our model with observed 3-month outcomes of real-life patients and only used the relative efficacy data of randomized controlled trials to demonstrate the effect of changing treatment delays.

Fourth, it is known that around half of the patients who are given tPA do not recanalize. Therefore, in practice, half of the patients do not benefit from faster tPA treatment and the other half benefit twice as much as we describe here; however, there is no precise method of identifying the patients that will or will not recanalize, so haste should be made in all patients. Finally, our model did not take into account the fact that reductions in delays potentially allow for tPA treatment of more patients who would otherwise have been too late for thrombolysis. We did not have detailed data on consecutive non-tPA–treated patients from our hospitals, but other series suggest that only 3% of suitable ischemic stroke patients arrive in the 4– to 5.5-hour time window, and the effect of adding these patients into our model would have been small.20,30

**Conclusions**

We demonstrated that minutes saved in stroke thrombolysis translate to days, weeks, and months of disability-free life over a patient’s lifetime. Therefore, all attempts should be made to reduce treatment delays. A gap of around 60 minutes exists between the best and the average centers. The methods to close this gap have been clearly described.5,6,21,31 These are simple organization changes that cost little or nothing. Every 15 minutes of expediting tPA can provide on average an equivalent of 1 month of healthy life for each treated patient.
Acknowledgments
Dr Meretoja, M. Keshkhtaran, and Dr Churilov conceived the study and analyzed the data. Dr Meretoja drafted the manuscript. M. Keshkhtaran and Dr Churilov performed the statistical analyses. Drs Donnan and Churilov supervised and coordinated the study and obtained study funding. Drs Meretoja, Tatlisumak, Parsons, and Kaste acquired the data. All authors interpreted the data, edited the manuscript for intellectual content, and approved the final submission.

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Disclosures
Dr Saver has consulted for Lundbeck, held grants from Lundbeck and the National Institutes of Health/National Institute of Neurological Disorders and Stroke, and his employer, the University of California, has some patent rights on retrieval devices for stroke, and he receives financial payments for his services as a scientific consultant on clinical trial design and conduct from Grifols, St. Jude Medical, Coviden, and BrainsGate. Dr Tatlisumak has served on an advisory board and developed educational material for Boehringer Ingelheim; consulted for Lundbeck A/S, Aventis, PhotoThera Inc, and Mitsubishi Pharma; holds a patent for mast cell stabilization in thrombolytic therapy for stroke; and held grants and received travel and accommodation reimbursements from not-for-profit organizations. Dr Kaste has served on steering committees, lectured, and consulted for Mitsubishi Pharma Europe Ltd, Lundbeck A/S, and Boehringer Ingelheim. Dr Davis has consulted for Orsan Technologies and EVER Pharma. Dr Donnan has consulted for and received support for meeting costs from Boehringer Ingelheim. The other authors have no conflicts to report.

References
 ONLINE SUPPLEMENT
 Meretoja et al. Stroke Thrombolysis. Save a Minute – Save a Day.

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Supplementary Figure I. Histogram of onset-to-treatment time distributions
Supplementary Statistical Methods.

Step 1: Generating patient-specific probabilities of achieving specific modified Rankin Scale (mRS) categories at the cohort observed onset-to-treatment time (OTT) $t_0$.

Using a randomly selected 80% sample of the combined observational cohort, we constructed seven separate binary logistic regression models with individual mRS category as the dependent variable and age, baseline National Institutes of Health Stroke Scale (NIHSS), and OTT as independent variables and used those to generate patient-specific predicted probabilities for each mRS. Following a simple normalization scaling procedure to ensure that the sum of probabilities of individual mRS categories for every patient is equal to one, the resulting probabilities were validated on the remaining 20% of the data through simulation. Twenty independent simulation runs were undertaken where each patient in the 20% sample was assigned a mRS according to the patient-specific mRS probability distribution generated earlier and the resulting distribution was compared with the distribution actually observed in the 20% subgroup. Despite a large sample resulting from this simulation, no significant differences in mRS profiles were observed using the chi-square test ($P=0.51$), thus validating the derived probability profiles. The resulting distributions were subsequently used to generate patient-specific probabilities of achieving a given mRS category at the observed OTTs $t_0$.

Step 2: Changing probabilities of achieving mRS 0-1 and mRS 6 over time.

To model how changing the onset-to-treatment time affects the probability of mRS0–1 and mRS6 for a specific patient, the graphs expressing the OR of achieving mRS0-1 and mRS6 as a function of OTT between 60 and 360 minutes presented by Lees et al. (Lancet 2010;375(9727):695–1703) were utilized. As no analytical expressions for the relationships depicted in these graphs were presented by Lees et al (2010), we derived relevant analytic expressions for mRS0-1 and mRS6 curves using the best fit (as judged by $R^2$) criterion. For both curves the corresponding values were 0.999. The role of these equations is to express the ORs for mRS0-1 and mRS6 as a function of OTT for any value of OTT between 0 and 270 minutes.

The $OR(t)$ reported by Lees et al (2010) presents the ratio of odds of achieving mRS0-1 (or, respectively, mRS6), by the patients treated with tPA at a time point $t$ and the odds of achieving the same outcome by the patients not treated by tPA.
Assuming that:

a) for any given patient not treated with tPA, the odds of achieving a specific mRS outcome remain constant over the specified time period;

b) the probability of achieving mRS0-1 for a non-treated patient is equal to that of a probability for a treated patient at \( t_{mRS0-1} = 350 \text{min} \) (based on Lees et al. 2010);

c) the probability of achieving mRS6 for a non-treated patient is equal to that of a probability for a treated patient at \( t_{mRS6} = 165 \text{min} \) (based on Lees et al. 2010);

to estimate the probabilities of mRS0-1 and mRS6 at any given time \( t \), we used the formula:

\[
p(t) = \frac{1}{1 + \left( \frac{OR(t)}{OR(t_0)} \right) \left( (1-p(t_0))/p(t_0) \right)}
\]

where \( p(t_0) \) represents the probability of mRS0-1 (or, respectively, mRS6) at OTT=\( t_0 \) time, and \( OR(t) \) represents the fitted value of ORs for mRS0-1 (mRS6) at a given time.

**Step3: Estimating probabilities of achieving a specific mRS at any time**

As the results reported by Lees et al (2010) only concerned mRS0-1 and mRS6, there was no direct way to use these results to analytically estimate the probabilities for all mRS categories at any given time \( t \). In order to achieve this, having previously estimated patient-specific probabilities of achieving mRS0-1 and mRS6 at any given time \( t \), we estimated the probabilities of achieving individual mRS categories (both for treated and non-treated patients) so that the ratios of probabilities for achieving individual mRS categories remain identical to those obtained in Step 1 from the logistic regression models based on the observed cohort data. In other words, given patient-specific probabilities of achieving mRS0-1 and mRS6 at any time point \( t \), the relative ratios of probabilities of achieving mRS0 and mRS1, as well as the relative ratios of achieving mRS categories 2-5, are assumed to be identical to those at the observed time \( t_0 \) and to remain constant for any time \( t \) between 0 and 270 min.

**Step4: Disability-adjusted life years (DALY) lost**

DALY lost is calculated from the formula \( DALY = YLL + YLD \), where \( YLL \) is the years of life lost due to premature death and \( YLD \) is the years of healthy life lost due to disability. Specific details are presented in the main article.
Step 5: Robustness analysis

Two approaches were applied to verify the robustness of the model: one-way analysis and probabilistic analysis. In the one-way analysis, we varied different inputs of the model to their upper and lower 95% CI and evaluated the model robustness with regard to those uncertainties in the inputs. In regard to the uncertainties of the cohort data, we performed a series of one-way analyses by substituting the upper and lower 95% CI value for the coefficients for the age and NIHSS, with one change at a time, generated by the binary logistic regression models. In regard to uncertainties of the pooled analysis by Lees et al (2010), we modified the equations of \( OR(t) \) for mRS 0-1 and mRS6 in the mRS probability distribution formula to sequentially reflect the upper and lower 95% confidence limits for these two mRS categories as reported by Lees et al (2010). The results are reported in Table in the main article.

Probabilistic robustness analyses were performed by sampling according to an underlying Normal distribution from the feasible space of the mRS0-1 and mRS6 \( OR(t) \) curves bounded by the 95% confidence limits reported by Lees et al (2010) and reflecting various potential time effects based on the pooled analysis, through set of 1000 independent runs. The resulting probability profiles for all mRS categories were then used to estimate DALYs gained or lost if either the whole cohort or an individual patient would have been treated faster or slower.
Supplementary Table I. Point estimates and 95% prediction intervals for disability adjusted days gained per minute saved in tPA delivery, per sex, age, and stroke severity.

<table>
<thead>
<tr>
<th>Sex, Age</th>
<th>NIHSS 0-4</th>
<th>NIHSS 5-9</th>
<th>NIHSS 10-14</th>
<th>NIHSS 15-19</th>
<th>NIHSS 20 +</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;45</td>
<td>3.01 (1.02-5.01)</td>
<td>3.40 (1.56-5.24)</td>
<td>3.67 (1.62-5.73)</td>
<td>3.75 (1.91-5.60)</td>
<td>3.83 (2.18-5.48)</td>
</tr>
<tr>
<td>45-54</td>
<td>2.30 (0.80-3.79)</td>
<td>2.70 (1.08-4.31)</td>
<td>3.02 (1.26-4.79)</td>
<td>3.17 (1.26-5.08)</td>
<td>2.86 (1.31-4.41)</td>
</tr>
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<td>55-64</td>
<td>1.87 (0.73-3.01)</td>
<td>2.20 (0.97-3.43)</td>
<td>2.49 (1.08-3.90)</td>
<td>2.45 (1.23-3.68)</td>
<td>2.11 (1.06-3.15)</td>
</tr>
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<td>65-74</td>
<td>1.45 (0.72-2.18)</td>
<td>1.61 (0.71-2.52)</td>
<td>1.81 (0.82-2.80)</td>
<td>1.69 (0.81-2.57)</td>
<td>1.19 (0.68-1.69)</td>
</tr>
<tr>
<td>75-84</td>
<td>0.97 (0.51-1.44)</td>
<td>1.08 (0.48-1.68)</td>
<td>1.09 (0.56-1.62)</td>
<td>0.91 (0.44-1.37)</td>
<td>0.65 (0.29-1.01)</td>
</tr>
<tr>
<td>85 +</td>
<td>0.59 (0.37-0.81)</td>
<td>0.63 (0.29-0.97)</td>
<td>0.57 (0.27-0.86)</td>
<td>0.45 (0.25-0.64)</td>
<td>0.26 (0.14-0.37)</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;45</td>
<td>3.24 (1.80-4.67)</td>
<td>3.79 (1.90-5.67)</td>
<td>4.05 (1.74-6.36)</td>
<td>4.30 (2.57-6.04)</td>
<td>3.86 (2.16-5.55)</td>
</tr>
<tr>
<td>45-54</td>
<td>2.54 (1.03-4.05)</td>
<td>2.98 (1.25-4.71)</td>
<td>3.40 (1.33-5.47)</td>
<td>3.55 (1.80-5.29)</td>
<td>3.48 (0.47-6.50)</td>
</tr>
<tr>
<td>55-64</td>
<td>2.14 (0.98-3.31)</td>
<td>2.48 (1.17-3.79)</td>
<td>2.89 (1.49-4.29)</td>
<td>2.95 (1.44-4.45)</td>
<td>2.45 (1.05-3.84)</td>
</tr>
<tr>
<td>65-74</td>
<td>1.65 (0.78-2.52)</td>
<td>1.91 (0.91-2.91)</td>
<td>2.07 (0.97-3.18)</td>
<td>1.93 (0.96-2.90)</td>
<td>1.66 (0.74-2.58)</td>
</tr>
<tr>
<td>75-84</td>
<td>1.16 (0.58-1.75)</td>
<td>1.28 (0.62-1.94)</td>
<td>1.32 (0.70-1.94)</td>
<td>1.09 (0.54-1.64)</td>
<td>0.76 (0.37-1.15)</td>
</tr>
<tr>
<td>85 +</td>
<td>0.67 (0.37-0.98)</td>
<td>0.76 (0.46-1.06)</td>
<td>0.62 (0.35-0.89)</td>
<td>0.45 (0.27-0.63)</td>
<td>0.33 (0.15-0.51)</td>
</tr>
</tbody>
</table>
Supplementary Table II. Studies comparing long-term utility of tPA vs. no tPA in acute ischemic stroke.

<table>
<thead>
<tr>
<th>Study</th>
<th>Population</th>
<th>Time horizon</th>
<th>Discount rate of future utilities</th>
<th>QALYs or DALYs gained per tPA treated patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fagan et al. 1998¹</td>
<td>USA</td>
<td>30 years</td>
<td>0%</td>
<td>0.75</td>
</tr>
<tr>
<td>Sinclair et al. 2001²</td>
<td>Canada</td>
<td>30 years</td>
<td>3%</td>
<td>3.46</td>
</tr>
<tr>
<td>Sandercock et al. 2004³</td>
<td>UK</td>
<td>Lifetime</td>
<td>6%</td>
<td>0.04</td>
</tr>
<tr>
<td>Mar et al. 2005⁴</td>
<td>Spain</td>
<td>Lifetime</td>
<td>3%</td>
<td>0.53 to 0.66</td>
</tr>
<tr>
<td>Ehlers et al. 2007⁵</td>
<td>Denmark</td>
<td>30 years</td>
<td>5%</td>
<td>0.43</td>
</tr>
<tr>
<td>Johnston 2010⁶</td>
<td>USA</td>
<td>30 years</td>
<td>0%</td>
<td>0.75</td>
</tr>
<tr>
<td>Tung et al. 2011⁷</td>
<td>USA</td>
<td>Lifetime</td>
<td>3%</td>
<td>0.28</td>
</tr>
<tr>
<td>NICE TA264⁸</td>
<td>UK</td>
<td>Lifetime</td>
<td>3.5%</td>
<td>0.33</td>
</tr>
<tr>
<td>Present paper</td>
<td>Finland and Australia</td>
<td>Lifetime</td>
<td>0%</td>
<td>0.71*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3%</td>
<td>0.52*</td>
</tr>
</tbody>
</table>

*Median onset-to-treatment of 125 minutes compared to not treating at all.

References

Supplementary Figure I. Histogram of onset-to-treatment time distributions.
脳卒中の血管内治療

Abstract

Stroke Thrombolysis
Save a Minute, Save a Day
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脳卒中に見られる血栓溶解療法
急速に開始すると健康な寿命が延長する

背景および目的：脳卒中の血栓溶解療法は治療開始時間が短い程で効果が高まるが、治療を遅く始める場合の長期効果のデータはまだ得られていなかった。本研究は、脳卒中治療開始によって得られる患者の生後期生を定量化することを目的とした。

方法：オーストラリアとフィンランドの医療機関で静脈内血栓溶解療法を受けた脳卒中症例（1998年から2011年、n = 2.258）の前向き観察研究データから、年齢、性別、脳卒中の重症度、発症から治療開始までの時間、および日間食において3カ月目の再発Rankinスケール（6RS）の分布を調べた。血栓溶解療法試験の結果をブール解析して得られた治療効果を用いて、3カ月目の6RSの変化のモデルを作成し、迅速な治療開始による予測寿命と長期健康の程度を得た。

結果：発症から治療開始までの時間を短縮することにより、健康寿命を1年半も延長できた（95%信頼区間：1.8年）；この結果は全群で認められ、健康寿命は重度の高齢患者では0.6日（80歳）、および高齢患者では0.9日（80歳、NIHSS: 4）、軽度の高齢患者では2.7日（50歳、NIHSS: 4）、重度の若年患者では3.5日（50歳、NIHSS: 20）延長できた。女性は男性よりもわずかではあるが健康寿命を延長できた。コホート全体では、治療開始時間15分以内で改善することに、障害のない日常生活を平均で約1カ月間延長することができた。

結論：脳卒中患者に対して実際に観察可能な血栓溶解療法開始までの時間短縮は、患者の生涯を通じて有意で確実な健康増加をもたらす。速度の重要性を事前に認識することは日常生活の変化を促進させると考えられる。

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図3 早期治療開始（1分以内）により得られた障害調査済み日数と、年齢および脳卒中重症度の関係。治療開始前の脳卒中重症度は、米国国立衛生研究所脳卒中スケール（NIHSS）スコアで測定した。スコアが高いほど脳卒中が重症であることを示す。