Impact of Diffusion-Weighted Imaging Alberta Stroke Program Early Computed Tomography Score on the Success of Endovascular Reperfusion Therapy

Manabu Inoue, MD, PhD*; Jean-Marc Olivot, MD, PhD*; Julien Labreuche, BST; Michael Mlynash, MD, MS; Waiiena Tai, MD; Jean-François Albucher, MD; Elena Meseguer, MD; Pierre Amarenco, MD; Mikael Mazighi, MD, PhD

Background and Purpose—In acute ischemic stroke patients treated by intravenous thrombolysis, a diffusion-weighted imaging (DWI) Alberta Stroke Program Early Computed Tomography Score (ASPECTS) is an independent factor of functional outcomes. Our aim was to assess the impact of pretreatment DWI-ASPECTS on outcomes after endovascular therapy, with a specific emphasis on recanalization.

Methods—We analyzed data collected between April 2007 and March 2013 in a prospective clinical registry of acute ischemic stroke patients treated by endovascular approach. Every patient with a documented internal carotid artery or middle cerebral artery occlusion who underwent an acute DWI-MRI before treatment was eligible for this study. The primary outcome was a favorable outcome defined by modified Rankin Scale of 0 to 2 at 90 days.

Results—Two hundred ten patients were included and median DWI-ASPECTS was 7 (interquartile range, 4–8). DWI-ASPECTS ≥5 was the optimal threshold to predict a favorable outcome (area under the curve=0.69; sensitivity, 90%; specificity, 38%). In a multivariate analysis including confounding variables, the adjusted odds ratio for favorable outcomes associated with a DWI-ASPECTS of ≥5 was 5.06 (95% confidence interval, 1.86–13.77; P=0.002). Nonetheless, the occurrence of a complete recanalization was associated with an increased rate of favorable outcomes in patients with DWI-ASPECTS under 5 (50% versus 3%, P<0.001).

Conclusions—DWI-ASPECTS ≥5 seems to be the optimal threshold to predict favorable outcomes among patients undergoing endovascular reperfusion within 6 hours. Selected patients with a DWI-ASPECTS of <5 may still benefit when a complete recanalization is achieved. (Stroke. 2014;45:1992-1998.)

Key Words: brain magnetic resonance imaging ■ diffusion ■ endovascular therapy ■ stroke
recanalization achieved by endovascular treatment may influence the relationships observed between acute DWI lesion volume and functional outcomes.17 Last year, Aoki et al16 showed in an AIS patient cohort with M1 middle cerebral artery occlusion treated by intravenous rtPA that a DWI-ASPECTS of >7 was the optimal cutoff to predict a dramatic recovery (>10 points improvement in National Institutes of Health Stroke Scale). The occurrence of a recanalization was associated with an increased rate of favorable outcomes (modified Rankin Scale score 0–2 at 3 months) only in the subgroup of patients with a DWI-ASPECTS of <7. This result suggests that some patients with a DWI-ASPECTS of <7 may still benefit from an early recanalization.

With this as a background, we evaluated in an AIS patients cohort eligible for endovascular therapy which DWI-ASPECTS value will predict a functional outcome and whether the occurrence of a complete reperfusion would have an impact on this relationship.

**Methods**

**Bichat Stroke Program**

Patients were identified from a prospective clinical registry of patients with AIS treated between April 2007 and March 2013 at Bichat University Hospital. Detailed material and methods have been previously reported.17 All patients underwent a magnetic resonance angiography or CT angiography before treatment to document arterial occlusion. Patients eligible for intravenous thrombolysis were treated with conventional intravenous thrombolysis in case of no documented arterial occlusion and with a systematic intravenous–intra-arterial approach in case of documented arterial occlusion. Patients with a documented arterial occlusion received an intravenous rtPA dose of 0.6 mg/kg followed by an intra-arterial dose of 0.3 mg/kg (except in case of complete recanalization after intravenous thrombolysis). In case of persistent occlusion after intravenous/intra-arterial rtPA administration, additional mechanical endovascular therapy (MET) was performed using either the snare (eV3) or the Solitaire (Covidien) devices.18 Patients with a documented arterial occlusion who were not eligible for intravenous tissue-type plasminogen activator were treated by intra-arterial tissue-type plasminogen activator (dose 0.5 mg/kg), followed by adjunctive MET if the occlusion persisted. Finally, in patients with a contraindication to tissue-type plasminogen activator, a direct MET approach was considered.19 Endovascular therapy (either intra-arterial rtPA and MET) was performed beyond 6 hours after symptom onset.

**Patient Consent and Protocol Approval**

Informed consent was obtained from the patient or surrogate, and the research protocol was approved by the Ethics Committee from Ambroise Pare Hospital.

**Sample Selection**

Patients with a complete occlusion of internal carotid artery or middle cerebral artery (M1 and M2 segments) treated by endovascular therapy and explored and evaluated by a pretreatment DWI imaging were enrolled in this substudy.

**Data Collection**

Data were prospectively collected using a structured questionnaire.17 The severity of the ischemic stroke was assessed using the National Institutes of Health Stroke Scale score at admission, 1, 3, and 24 hours after symptom onset.

Below is the table showing baseline characteristics according to DWI-ASPECTS.

<table>
<thead>
<tr>
<th>Table. Baseline Characteristics According to DWI-ASPECTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DVI volume, cc, median (IQR)</td>
</tr>
<tr>
<td>Age, y, mean (SD)</td>
</tr>
<tr>
<td>Men</td>
</tr>
<tr>
<td>Medical history</td>
</tr>
<tr>
<td>Hypertension</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>Hypercholesterolemia</td>
</tr>
<tr>
<td>Current or former smoker</td>
</tr>
<tr>
<td>Antithrombotic medications</td>
</tr>
<tr>
<td>Clinical measure</td>
</tr>
<tr>
<td>Blood glucose, mg/dL, median (IQR)</td>
</tr>
<tr>
<td>Systolic BP, mm Hg, mean (SD)</td>
</tr>
<tr>
<td>Diastolic BP, mm Hg, mean (SD)</td>
</tr>
<tr>
<td>NIHSS score, median (IQR)</td>
</tr>
<tr>
<td>Cardiogenic pathogenesis</td>
</tr>
<tr>
<td>ICA occlusion (isolated or tandem with MCA)</td>
</tr>
<tr>
<td>Prior intravenous rtPA</td>
</tr>
<tr>
<td>MET</td>
</tr>
<tr>
<td>Time to MRI from symptom onset, min, median (IQR)</td>
</tr>
<tr>
<td>Time to intra-arterial treatment from MRI, min, median (IQR)</td>
</tr>
</tbody>
</table>

Data are presented as n (%) unless otherwise indicated. ASPECTS indicates Alberta Stroke Program Early Computed Tomography Score; BP, blood pressure; DWI, diffusion-weighted imaging; ICA, internal carotid artery; IQR, interquartile range; MCA, middle cerebral artery; MET, mechanical endovascular therapy; NIHSS, National Institutes of Health Stroke Scale; and rtPA, recombinant tissue-type plasminogen activator.
after initiation of treatment. Time from symptom onset to cerebral imaging (MRI), to initiation of therapy (rtPA administration by intravenous or intra-arterial if contraindicated or local thrombectomy device deployment if rtPA is contraindicated) were also recorded. Arterial status of the occluded artery was monitored with conventional angiography during the intra-arterial approach and time to recanalization was noted. Recanalization was measured using the Thrombolysis In Myocardial Infarction (TIMI) score by 2 members of the staff (E.M. and M.M.). Successful recanalization was defined as a complete restoration of blood flow (TIMI 3). All patients had a CT or MRI scan 24 hours after treatment onset to assess hemorrhagic complications. The modified Rankin Scale at 3 months was assessed during face-to-face interviews or via telephone calls by a senior vascular neurologist (E.M. or M.M.) certified for modified Rankin Scale scoring.

**DWI Measurements**

DWI volumes were calculated retrospectively by using an automated software program: RApid processing of PerfusIon and Diffusion which uses a delay-independent deconvolution approach. DWI-ASPECTS was assessed by 2 stroke neurologists blinded from any clinical information (W.T. and M.I.).

**Clinical Outcome Definitions**

The primary study outcome was the percentage of patients who achieved a favorable outcome at 90 days, defined by a modified Rankin Scale score of 0 to 2. Secondary outcomes included 90-day mortality and symptomatic intracerebral hemorrhage per European-Australasian Acute Stroke Study (ECASS) II definition.

**Statistical Analysis**

Data are presented as mean (SD) or median (interquartile range [IQR]) for continuous variables and percentage (count) for categorical variables. DWI-ASPECTS were divided into tertiles to describe the association with baseline characteristics and outcomes. Comparisons between tertiles were made using the Cochran–Mantel–Haenszel trend test for categorical variables and analysis of variance (nonparametric for skewed baseline data) with linear contrast. Similar results were obtained when DWI-ASPECTS was analyzed as a continuous variable (using the Spearman rank correlation for continuous baseline data and Mann–Whitney U test for categorical variables). For each clinical outcome, we calculated the odds ratios (ORs) of outcomes by using as reference the lowest tertile of DWI-ASPECTS for primary outcome and the highest tertile for secondary outcomes. Heterogeneities in the ORs across patients with prior or no use of intravenous rtPA (ie, comparing the group treated by intravenous/intra-arterial therapy and the group treated by intra-arterial therapy only) and across patients treated or not by MET were tested by introducing an interaction term into logistic regression model. Receiver operating characteristics (ROC) curve analysis was performed to estimate the optimal cutoff value for discriminating outcomes. We determined the optimal thresholds by maximizing the Youden index. Using logistic regression analysis, ORs for tertiles and optimal cutoff values of DWI-ASPECTS were further adjusted for type of treatment (including prior intravenous rtPA use and MET) and for other potential confounding factors selected on the basis of their significance with DWI-ASPECTS in univariate analyses (P<0.20).

Finally, to further evaluate the impact of DWI-ASPECTS on the success of reperfusion therapy, we compared outcomes between patients who achieved a complete recanalization and those who did not according to DWI-ASPECTS subgroups (defined using the optimal cutoff value). Comparisons were done using the $\chi^2$ test (or Fisher exact test when the expected cell frequency was <5) and a Breslow–Day test for homogeneity was done.

Statistical testing was done at a 2-tailed $\alpha$ level of 0.05. Data were analyzed using the SAS software package, release 9.3 (SAS Institute, Cary, NC).

**Results**

During a 5-year study period, 285 consecutive AIS patients complicating an acute internal carotid artery or middle cerebral artery occlusion were treated by endovascular therapy. Of these, 232 patients (81%) underwent MRI before recanalization therapy. Twenty-two patients with no or poor-quality DWI were excluded, resulting in a sample size of 210

![Figure 1. Modified Rankin Scale score at 90 days (A) and intracerebral hemorrhage within 24 to 36 hours (B) by diffusion-weighted imaging Alberta Stroke Program Early Computed Tomography Score (DWI-ASPECTS).](http://stroke.ahajournals.org/)

Downloaded from http://stroke.ahajournals.org/ by guest on July 13, 2017
patients with a measure of DWI-ASPECTS (Figure I in the online-only Data Supplement). The baseline characteristics of these patients are shown in the Table, overall and according to DWI-ASPECTS tertiles. The median delay from symptom onset to MRI was 105 minutes (IQR, 75–178) and the median DWI-ASPECTS was 7 (IQR, 4–8). A weak but significant negative correlation between MRI delay and DWI-ASPECTS score was found ($r = -0.18; P = 0.009$). As shown in Figure II in the online-only Data Supplement, there was a strong correlation between DWI-ASPECTS and DWI lesion volume ($r = -0.85; P < 0.001$). In addition, there was a negative correlation between DWI-ASPECTS and National Institutes of Health Stroke Scale at admission ($r = -0.33; P < 0.001$). Age, blood pressure values, prior intravenous rtPA use, and internal carotid artery occlusion presence were also associated with DWI-ASPECTS (Table). Fifteen patients did have a median baseline DWI lesion volume above 100 mL; 14 of them did have a DWI-ASPECTS of ≤2.

**DWI-ASPECTS and Clinical Outcomes**

Lower values of DWI-ASPECTS were associated with increased mortality and intracranial hemorrhage rates (Figure 1). As shown in Figure 2, by comparison with patients with a DWI-ASPECTS of ≥5, patients with a DWI-ASPECTS of <5 had a lower rate of favorable outcomes and a higher rate of mortality and symptomatic intracranial hemorrhage (sICH).

After categorization of DWI-ASPECTS into tertiles, the upper 2 tertiles of DWI-ASPECTS score were both significantly associated with an increased rate of favorable outcomes, while the lower tertile of DWI-ASPECTS was associated with an increased rate of death and sICH. There was no heterogeneity in the association between DWI-ASPECTS with outcomes according to prior use of intravenous rtPA (all $P$ for heterogeneity $>0.36$) or according to MET use (all $P$ for heterogeneity $>0.47$). These relationships remained unchanged in multivariate analysis including potential confounding factors (Figure 2). ROC analysis (Figure 3) showed that DWI-ASPECTS ≥5 was the optimal threshold to predict a favorable functional outcome with an area under the curve (AUC) of 0.69 (95% confidence interval [CI], 0.62–0.76), a sensitivity of 90% (95% CI, 84–96), and a specificity of 38% (95% CI, 29–47). In addition, the optimal DWI-ASPECTS threshold to predict 90-day mortality (AUC, 0.67 [95% CI, 0.59–0.76]; sensitivity, 47% [95% CI, 35–59]; specificity, 85% [95% CI, 78–91]) and sICH (AUC, 0.72 [95% CI, 0.58–0.85]; sensitivity, 65% [95% CI, 42–88]; specificity, 73% [95% CI, 72–84]) was also <5. In multivariate analysis, the adjusted OR of favorable outcomes was 4.70 (95% CI, 1.71–12.89) for DWI-ASPECTS ≥5, the adjusted OR of 90-day mortality was 6.80 (95% CI, 2.61–17.70) for DWI-ASPECTS <5 and the adjusted OR of intracranial hemorrhage was 8.10 (95% CI, 2.29–28.66) DWI-ASPECTS <5 (Figure 2).

![Figure 2](http://stroke.ahajournals.org/) Impact of diffusion-weighted imaging (DWI) Alberta Stroke Program Early Computed Tomography Score (ASPECTS) on clinical outcomes. DWI-ASPECTS was categorized into 3 groups of similar sample size and was further dichotomized according to the optimal cutoff calculated from receiver operating characteristics curves. Odds ratios (ORs) were calculated using as reference group, the lowest ASPECTS scores for favorable outcomes and the upper ASPECTS scores for death and symptomatic intracranial hemorrhage (sICH). ORs were adjusted for age, admission systolic and diastolic blood pressure, internal carotid artery occlusion, prior use of intravenous thrombolysis, mechanical endovascular therapy, time from symptom onset to MRI, and admission National Institutes of Health Stroke Scale score. CI indicates confidence interval.
Ninety-eight patients (47%) experienced a complete recanalization (TIMI 3) within a median delay from symptom onset of 248 minutes (IQR, 206–290). Patients with TIMI 3 had a higher median DWI-ASPECTS than patients with TIMI 0 to 2 (no or partial recanalization) (7 [IQR, 5–9] versus 6 [IQR, 3–8, \( P=0.001 \)). As shown in Figure 4, the impact of TIMI 3 on clinical outcomes was stronger in patients with DWI-ASPECTS <5 than in patients with DWI-ASPECTS ≥5 (\( P<0.002 \)) for heterogeneity. Favorable outcomes were more frequent in patients with TIMI 3 than with TIMI 0 to 2 in the subgroup with DWI-ASPECTS ≥5 (67% versus 41%, \( P=0.001 \)) as well as in the subgroup with DWI-ASPECTS <5 (50% versus 3%, \( P<0.001 \)).

The median DWI lesion volume measured among the patients with a DWI-ASPECTS of <5 who did recanalize was not different from the DWI lesion volume measured among the nonrecanalizers 75 mL (43–95) and 70 mL (50–105) among the recanalizers (\( P=0.66 \)). The favorable outcome rate in patients with DWI-ASPECTS <5 and TIMI 3 was comparable with the rate observed among patients with DWI-ASPECTS ≥5 and TIMI 0 to 2. The occurrence of a complete recanalization was associated with a decreased mortality rate at 90 days in the subgroup of patients with a DWI-ASPECTS of <5 (25% versus 73%, \( P=0.001 \)) but not among patients with a higher DWI-ASPECTS (17% versus 28%, \( P=0.10 \)). Finally, the sICH rate was 27% in patients DWI-ASPECTS <5 and TIMI 0 to 2, whereas it was lower than 7% in other subgroups (Figure 4). In ROC curve analyses (Figure III in the online-only Data Supplement), DWI-ASPECTS predicted favorable outcomes in patients with TIMI 0 to 2 (AUC=0.76; optimal cutoff point ≥5 with a sensitivity=97% and specificity=45%), but not in patients with TIMI 3 (AUC=0.57).

**Discussion**

Our results suggest that a DWI-ASPECTS of 5 seems to be in our cohort the optimal cutoff to predict functional outcomes in AIS patients eligible for an endovascular treatment. These findings concur with the results of previous studies, showing that a low ASPECTS on CT or MRI is a strong predictor of functional outcomes after intravenous or intra-arterial thrombolysis. As previously shown, our results demonstrate a strong correlation between DWI-ASPECTS and DWI lesion volume quantified by the RApid processing of Perfusion and Diffusion software. For example, 14 of the 15 patients with a large infarction on baseline DWI (>100 mL) did have a DWI-ASPECTS of ≤2. We have previously reported in the same cohort that DWI lesion volume had a strong impact on the clinical outcome, but were unable to identify a predictive volumetric threshold in this current study. Conversely, ROC curve analyses isolated an optimal cutoff of the ordinal DWI-ASPECTS scale associated with patient outcomes. DWI-ASPECTS <5 predicted 90-day mortality and sICH with specificity values, respectively, of 85% and 73%. These relationships were strong, as illustrated by the adjusted ORs, (associated with a DWI-ASPECTS<5), which was 6.74 (95% CI, 2.63–17.28) for 90-day mortality. In addition, a DWI-ASPECTS of ≥5 predicted a favorable functional outcome with a sensitivity value of 90% and was strongly associated with the occurrence of a favorable outcome 5.06 (95% CI, 1.86–13.77). However, its specificity was only 38%, suggesting that a subset of patients with a DWI-ASPECTS of <5 may still experience a favorable outcome.

**Figure 3.** Receiver operating characteristic curves of diffusion-weighted imaging Alberta Stroke Program Early Computed Tomography Score (ASPECTS) for the prediction of favorable outcomes (A), 90-day mortality (B), and symptomatic intracranial hemorrhage (C). AUC indicates area under the curve; and CI, confidence interval.
The occurrence of a complete recanalization was associated with an increased rate of clinical recovery and a decreased rate of mortality and sICH. Interestingly, the magnitude of this effect was higher in the subgroup of patients with a DWI-ASPECTS of <5 compared with the rate observed in patients with a DWI-ASPECTS of ≥5. ROC curve analyses confirmed that DWI-ASPECTS >5 was the optimal cutoff to predict outcomes overall and in case of an incomplete recanalization while no cutoff could be isolated among the 99 (47%) patients who experienced a complete recanalization. These results do have several implications. First they support the use of DWI-ASPECTS, an ordinal visual scale, as a default measurement of DWI lesion volume in the absence of any available reliable volumetric measurement. Second, they suggest that a DWI-ASPECTS of 5 may outperform the commonly accepted threshold of 7 to select the patient who may still benefit from revascularization therapy. However, despite this improvement, several patients who did experience clinical recovery after reperfusion would have been excluded by these criteria. As an illustration, 16 of the 32 (50%) patients with a DWI-ASPECTS of <5 and 22 of the 37 patients (56%) with a DWI-ASPECTS of <7 did experience a favorable outcome after a complete recanalization. Therefore, DWI-ASPECTS seems to be an insufficient tool for the selection of the candidate for an emergent recanalization. Additional criteria may be useful to estimate the benefit/risk ratio of endovascular therapy in the subgroup of patients with a large DWI lesion.

Several factors may explain this critical finding. First, a recent study suggested that DWI-ASPECTS may in some cases overestimate the extension of DWI lesion. We could then hypothesize that patients with a low DWI-ASPECTS who did experience a favorable outcome after a complete recanalization may have had a smaller DWI lesion. We tested this hypothesis in the subgroup of patients with a DWI-ASPECTS <5. In this subgroup analysis, baseline DWI lesion volume measured among the patients who recanalized was equivalent to the volume measured among the nonrecanalizers. Second, it is plausible that some patients with a significant DWI lesion may still exhibit a large perfusion deficit. Third, in our study patients were scanned after a median delay of 1.7 hours and revascularized 4.1 hours after symptom onset. By comparison, Diffusion and Perfusion Imaging Evaluation for Understanding Stroke Evolution (DEFUSE) 2 study patients were scanned 4.1 hours and endovascular procedure started 6.2 hours after symptom onset, while magnetic resonance rescue patients were enrolled after a median delay of 5.2 hours. The results of both studies suggested that patients with a large ischemic lesion on DWI did not experience a good outcome after reperfusion. Therefore, our results may not be extrapolated to a time window where DWI lesion has demonstrated a critical impact even among recanalizers. Finally, the retrospective and monocentric design of our study has undoubtedly contributed to selection biases.

In conclusion, a DWI-ASPECTS cutoff of 5 seems to be the optimal cutoff to predict the outcome of patients undergoing endovascular therapy within 6 hours of symptom onset. Complete recanalization may still play a role on favorable outcomes in patients with DWI-ASPECTS <5, suggesting that DWI-ASPECTS is a limited tool for endovascular therapy patient eligibility.

Sources of Funding
This study, in part, was supported by SOS-Attaque Cerebrale.

Disclosures
Dr Olivot reports speaker fees and travel expenses from Boehringer Ingelheim. Dr Mazighi reports travel expenses from Boehringer Ingelheim, Covidiien and Bayer. The other authors report no conflicts.
References


Impact of Diffusion-Weighted Imaging Alberta Stroke Program Early Computed Tomography Score on the Success of Endovascular Reperfusion Therapy
Manabu Inoue, Jean-Marc Olivot, Julien Labreuche, Michael Mlynash, Waimea Tai, Jean-François Albucher, Elena Meseguer, Pierre Amarenco and Mikael Mazighi

Stroke. 2014;45:1992-1998; originally published online June 12, 2014; doi: 10.1161/STROKEAHA.114.005084

Stroke is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2014 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/45/7/1992

Data Supplement (unedited) at:
http://stroke.ahajournals.org/content/suppl/2014/06/12/STROKEAHA.114.005084.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/
Supplementary Figures

Supplementary Figure I. Study Flow-Chart.

730 AIS patients treated by IV or IA therapy 
between April 2007 and March 2013

28 patients with no MRA or CTA before treatment 
(all treated by IVT)

702 AIS patients with arterial examination by 
angiography before treatment 
(IURA, n=546; CTA, n=156)

311 patients with no complete vessel occlusion 
(all treated by IVT)

394 AIS patients with vessel occlusion 
documented before treatment

37 patients without ICA and/or MCA occlusion 
(IVT only, n=8; IVT/IA, n=14; IA, n=15)

354 AIS patients with ICA and/or MCA 
occlusion documented before treatment:

63 patients treated by IVT only for the following reasons 
- endovascular therapist not available (n=41) 
- contraindications to IA (n=12) 
- recanalisation achieved before AT (n=8) 
- failure to catheterization of occluded vessel (n=7) 
- included in clinical trial (n=1)

285 AIS patients with ICA and/or MCA 
occlusion treated by IA T

53 patients with CT scan before treatment

292 patients with MRI before treatment

210 patients with DWI ASPECTS 
measurement

- 148 IVT/IA (MET, n=57) 
- 02 IA (MET, n=34)

Abbreviations: ASPECTS= Alberta Stroke Program Early CT Score; CTA = computed tomography angiography; CT scan= computed tomography scan; DWI= diffusion-weighted imaging; IA= intra-arterial therapy; ICA= internal carotid artery; IVT= intravenous thrombolysis; MCA= middle cerebral artery; MRA=magnetic resonance angiography MET= mechanical endovascular therapy; MRI= magnetic resonance imaging.
Supplementary Figure II. Correlation between DWI-ASPECTS and DWI lesion volume

Abbreviations: ASPECTS = Alberta Stroke Program Early CT Score; DWI = diffusion-weighted imaging.
Supplementary Figure III. Receiver operating characteristic curves of DWI-ASPECTS for the prediction of Favourable Outcome in patients with no or partial recanalization (TIMI 0-2) and in patients with complete recanalization (TIMI 3).