Over half of ischemic strokes in the US are mild in severity (National Institutes of Health Stroke Scale [NIHSS] ≤5).1 Single-center, prospective cohorts suggest that 30% will have significant disability at 3 months after mild stroke. 2 However, the optimal acute treatment of patients with mild deficits, who are otherwise eligible for intravenous recombinant tissue-type plasminogen activator (IV r-tPA), remains unestablished. Initial randomized-controlled trials of IV r-tPA explicitly excluded mild strokes.3

The more recent third International Stroke Trial (IST-3)4 was designed to determine whether a wider range of patients with ischemic stroke, including mild strokes (NIHSS ≤5), might benefit from IV r-tPA. However, among mild stroke patients enrolled in this randomized trial, 221 of 304 (72.7%) r-tPA versus 232 of 308 (75.3%) control subjects were alive and independent (Oxfordshire Handicap Score [OHS], 0–2) at 6 months.

We sought to determine whether a further, randomized trial in patients with mild ischemic stroke was justified. We, therefore, examined the effect of r-tPA in the subset of IST-3 patients who met the eligibility criteria for our planned trial.5

**Background and Purpose**—Randomized trial evidence on the risk/benefit ratio of thrombolysis for mild stroke is limited. We sought to determine the efficacy of intravenous recombinant tissue-type plasminogen activator (IV r-tPA) in a subset of patients with mild deficit in the third International Stroke Trial (IST-3).

**Methods**—IST-3 compared IV r-tPA with control within 6 hours of onset in patients for whom IV r-tPA was considered promising but unproven. Analysis was restricted to subjects randomized within 3 hours of onset with a baseline National Institutes of Health Stroke Scale ≤5, pretreatment blood pressure <185/110, and no other r-tPA exclusion criteria. We compared r-tPA and control arms for primary (Oxfordshire Handicap Score [OHS] 0–2) and secondary (ordinal OHS and OHS 0–1) outcomes at 6 months.

**Results**—Among 3035 IST-3 subjects, 612 (20.2%) had an NIHSS ≤5; of these 106 (17.6%) met the restricted criteria. Allocation to r-tPA was associated with an increase in OHS 0 to 2 (84% r-tPA versus 65% control; adjusted odds ratio, 3.31; 95% confidence interval, 1.24–8.79) and a favorable shift in OHS distribution (adjusted odds ratio, 2.38; 95% confidence interval, 1.17–4.85). There was no significant effect of r-tPA on OHS 0 to 1 (60% versus 51%; adjusted odds ratio, 1.92; 95% confidence interval, 0.83–4.43).

**Conclusions**—This post hoc analysis in a highly selected sample of IST-3 supports the rationale of A Study of the Efficacy and Safety of Activase (Alteplase) in Patients With Mild Stroke (PRISMS) trial—a randomized, phase IIIb study to evaluate IV r-tPA in mild ischemic stroke. (Stroke. 2015;46:2325-2327. DOI: 10.1161/STROKEAHA.115.009951.)

**Key Words:** clinical trials ■ stroke ■ thrombolytic therapy

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**Effect of Intravenous Recombinant Tissue-Type Plasminogen Activator in Patients With Mild Stroke in the Third International Stroke Trial-3 Post Hoc Analysis**

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1. Randomized within 3 hours of last known well
2. Pretreatment blood pressure <185/110
3. Met all other standard IV r-tPA eligibility criteria

Consistent with the parent trial, the primary outcome for this analysis was the proportion alive and independent (OHS, 0–2) at 6 months, and secondary outcomes were the ordinal analysis of OHS and the proportion alive and with favorable outcome (OHS, 0–1) at 6 months, adjusted for age, time to randomization, and presence of ischemic change on baseline scan.

Results
Among 3035 subjects enrolled in IST-3, 612 (20%) subjects had an NIHSS ≤5. Among 612 subjects with low NIHSS score, 106 (18%) had mild stroke as the sole reason for uncertainty. Specifically, 487 were excluded for randomization beyond 3 hours from last known well, 87 for blood pressure ≥185/110 (including 68 with both exclusions); none were excluded for other standard IV r-tPA exclusion criteria.

Among these 106 subjects, 55 were treated with IV r-tPA and 51 received standard medical management. Patients in each treatment arm were relatively well matched for baseline demographics and comorbidities (Table 1).

Comparing IV r-tPA and control patients, we found a nominally significant increase in the proportion alive and independent (84% versus 65%; unadjusted odds ratio [OR], 2.79; 95% confidence interval [CI], 1.03–7.91; P=0.03; adjusted OR, 3.31; 95% CI, 1.24–8.79; P=0.02), and a favorable shift in distribution of OHS grades (unadjusted OR, 1.98; 95% CI, 0.99–3.96; P=0.05; adjusted OR, 2.38; 95% CI, 1.17–4.85; P=0.05; adjusted OR, 2.38; 95% CI, 1.17–4.85; P=0.05; adjusted OR, 2.38; 95% CI, 1.17–4.85; P=0.05; adjusted OR, 2.38; 95% CI, 1.17–4.85; P=0.05). There was no significant effect on favorable outcome (60% versus 51%; unadjusted OR, 1.44; 95% CI, 0.62–3.34; P=0.35; adjusted OR, 1.92; 95% CI, 0.83–4.43; P=0.13).

There were no symptomatic intracranial hemorrhages in the r-tPA–treated group (0/55; 95% CI, 0%–8%), as per the IST-3 trial definition of significant neurological deterioration within 7 days, accompanied by radiological evidence of sufficient intracranial hemorrhage to account for the deterioration.

Discussion
This post hoc analysis supports further testing of IV r-tPA in patients with mild ischemic strokes. A nominally significant effect was observed for the prespecified primary outcome of the parent IST-3, and the direction of effect was supportive for secondary outcomes as well.

This analysis approach allowed us to estimate the effect of r-tPA in the type of mild stroke patient likely to be included in our planned trial because the majority (82%) of the overall IST-3 cohort with NIHSS 0 to 5 had other relative contraindications to r-tPA. Chiefly, 80% were treated beyond 3 hours of stroke onset, and the potential benefit of reperfusion therapies is known to be highly time-dependent. In addition, 14% had the contraindication to IV r-tPA of elevated baseline blood pressure.

Previous randomized trials of IV r-tPA had excluded patients with milder strokes based on varied exclusion criteria (Table 2). Poled analysis of the few subjects with NIHSS 0 to 4 enrolled in these major completed trials has demonstrated encouraging results of potential IV r-tPA efficacy in mild stroke despite a 0.9% risk of fatal intracranial hemorrhage. However, recent exploratory data from IST-3 have suggested an adverse effect of r-tPA within 6 hours of stroke onset on long-term survival among strokes with better predicted prognosis (>50% with functional recovery). Limitations of this analysis include its post hoc design and small sample size. Randomized, prospective data are needed to confirm this finding. This is particularly relevant to estimating the risk of fatal or disabling intracranial hemorrhage.

Our analysis of this highly selected sample of IST-3 supports the rationale of A Study of the Efficacy and Safety of Activase (Alteplase) in Patients With Mild Stroke (PRISMS) trial, an ongoing, randomized, placebo-controlled, phase IIIb, 948-subject, 75-center, study evaluating the efficacy and particularly the safety of IV r-tPA in mild ischemic strokes. Mild stroke is defined as NIHSS ≤5 and not clearly disabling.
(ie, deficit would prevent return to work or conduct of basic activities of daily living).

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**Disclosures**

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**References**


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