Favorable Vascular Profile is an Independent Predictor of Outcome
A Post Hoc Analysis of the Safety and Efficacy of NeuroFlo Technology in Ischemic Stroke Trial

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Background and Purpose—We hypothesized that a favorable vascular profile (FVP) defined as anatomic intactness of the Circle of Willis combined with a stable cerebral perfusion pressure (mean arterial blood pressure > 65 mm Hg) is a prerequisite for collateral recruitment and maintenance and may improve outcome. We performed post hoc analyses of a subset of the Safety and Efficacy of NeuroFlo Technology in Ischemic Stroke (SENTIS) trial data set to identify whether FVP is associated with independent outcome.

Methods—SENTIS was a randomized, controlled device trial comparing hemodynamic augmentation with the NeuroFlo device to best medical treatment. We identified all patients from the primary dataset (n=515 patients) with available intracranial vascular imaging at baseline. Vascular imaging data were read blind to clinical and treatment data. We performed univariate and multivariate analyses to identify predictors of independent outcome (modified Rankin Scale 0–2) at 90 days.

Results—A total of 192/515 SENTIS subjects had available baseline vascular imaging (91 treated/101 controls). Baseline characteristics did not differ between groups. Overall, FVP was seen in 89.6% of patients and predicted independent outcome in univariate (odds ratio, 7.46; 95% confidence interval, 1.68–33.18; P=0.0082) and multiple logistic regression analyses (odds ratio, 10.22; 95% confidence interval, 1.78–58.57; P=0.0091). Aside from FVP, only baseline National Institutes of Health Stroke Scales (NIHSS; odds ratio, 0.74; 95% confidence interval, 0.67–0.82, P<0.0001) entered the predictive model. There was no interaction with randomization to treatment or control.

Conclusions—FVP and baseline NIHSS independently predicted outcome in this subset of the SENTIS population. FVP is a novel parameter to predict outcome of acute stroke patients and further studies will establish its potential role for selection of optimal candidates for hemodynamic augmentation.


Key Words: aortic occlusion ■ brain perfusion augmentation ■ clinical trials ■ ischemic stroke ■ SENTIS

Recently, the primary results of the Safety and Efficacy of NeuroFlo Technology in Ischemic Stroke (SENTIS) trial were published.1 NeuroFlo therapy involves partial occlusion of the abdominal aorta that results in a prompt increase in blood volume above the peripheral arterial occlusion and has been shown to increase cerebral blood flow specifically.2–4 In the intent-to-treat analysis, the SENTIS results did not achieve statistical significance for the primary efficacy end point; however, safety of the procedure was established and favorable trends, especially with regard to stroke-related mortality, were observed.

We hypothesized that a favorable vascular profile (FVP) combined with a stable cerebral perfusion pressure is a prerequisite for collateral recruitment and maintenance. We performed post hoc analyses of the SENTIS trial to identify whether a FVP is associated with independent outcome.

Methods
For the detailed methods of the trial, we refer to the original publication of the SENTIS trial (ClinicalTrials.gov, #NCT00119717).1 The trial was funded by CoAxia, Inc. All authors vouch for the accuracy and completeness of the data and analysis. All authors had access to all the data in the study and had final responsibility for submission of this publication. Briefly, patients were allocated to NeuroFlo treatment with standard medical management (treatment) or standard medical management alone (control) using a 1:1 randomization scheme.
were randomized to the treatment group (intent-to-treat patients were randomized to the control group and 258 patients enrolled in the SENTIS trial at 68 centers. A total of 257 patients were randomized to treatment did not receive treatment, and 1 patient randomized to the control group received NeuroFlo treatment (both were protocol deviations) resulting in 261 nontreated patients and 226 treated patients in the modified as treated analysis.1

A total of 192/515 SENTIS subjects had available baseline vascular imaging (91 treated/101 controls). Baseline characteristics did not differ between groups (Table 1).

Between October 2005 and January 2010, 515 patients were enrolled in the SENTIS trial at 68 centers. A total of 257 patients were randomized to the control group and 258 patients were randomized to the treatment group (intent-to-treat population). Twenty-eight patients randomized to treatment were excluded because of prespecified criteria, 5 patients randomized to treatment did not receive treatment, and 1 patient randomized to the control group received NeuroFlo treatment (both were protocol deviations) resulting in 261 nontreated patients and 226 treated patients in the modified as treated analysis.1

A total of 192/515 SENTIS subjects had available baseline vascular imaging (91 treated/101 controls). Baseline characteristics did not differ between groups (Table 1).

Results

Between October 2005 and January 2010, 515 patients were enrolled in the SENTIS trial at 68 centers. A total of 257 patients were randomized to the control group and 258 patients were randomized to the treatment group (intent-to-treat population). Twenty-eight patients randomized to treatment were excluded because of prespecified criteria, 5 patients randomized to treatment did not receive treatment, and 1 patient randomized to the control group received NeuroFlo treatment (both were protocol deviations) resulting in 261 nontreated patients and 226 treated patients in the modified as treated analysis.1

A total of 192/515 SENTIS subjects had available baseline vascular imaging (91 treated/101 controls). Baseline characteristics did not differ between groups (Table 1).

There were also no major differences between patients with (n=172) and without (n=20) FVP except for higher NIHSS scores in the latter subgroup (mean 10.8±4.3 versus 12.9±5.0; median 11 versus 14.5; P=0.0401). Overall, FVP was seen in 89.6% of patients with a trend in favor of treated patients (94.5% versus 85.2%; P=0.0562). Variables used in univariate logistic regression models to determine if they are associated with mRS 0 to 2 at 90 days are listed in Table 2. In the univariate models, the following were associated with the outcome (all P values<0.10): FVP, baseline NIHSS, and history of atrial fibrillation. These variables were used in a multivariable model. Mortality and severe disability were higher in the group without FVP (17.4% versus 45%). The presence of FVP predicted independent outcome in univariate (odds ratio, 7.46; 95% confidence interval, 1.68–33.18; P=0.0082) and multiple logistic regression analyses after adjustment for all variables (odds ratio, 10.22; 95% confidence interval, 1.78–58.57; P=0.0091). Aside from FVP, only baseline NIHSS (odds ratio, 0.74; 95% confidence interval, 0.51–1.09) and NIHSS 3–4 at baseline were associated with the outcome (odds ratio, 3.58; 95% confidence interval, 1.02–12.64; P=0.0466).

Table 1. Baseline Characteristics of FVP Subset

<table>
<thead>
<tr>
<th>Baseline Stroke Presentation Characteristics</th>
<th>Treated</th>
<th>Nontreated</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>FVP (CoW intact and MAP&gt;65 mmHg) % (n/N)</td>
<td>94.5% (86/91)</td>
<td>85.1% (86/101)</td>
<td>0.0562</td>
</tr>
<tr>
<td>Time from symptom onset to BL, h Mean±SD</td>
<td>7.7±2.7</td>
<td>8.1±3.0</td>
<td>0.2817</td>
</tr>
<tr>
<td>Time from symptom onset to Rz, h Mean±SD</td>
<td>8.2±2.6</td>
<td>8.4±2.8</td>
<td>0.5530</td>
</tr>
<tr>
<td>Baseline NIHSS Mean±SD</td>
<td>11.5±4.3</td>
<td>10.7±4.4</td>
<td>0.2737</td>
</tr>
<tr>
<td>Systolic blood pressure, mmHg Mean±SD</td>
<td>155.6±22.9</td>
<td>157.3±25.9</td>
<td>0.6420</td>
</tr>
<tr>
<td>Diastolic blood pressure, mmHg Mean±SD</td>
<td>83.5±16.4</td>
<td>86.2±16.9</td>
<td>0.2725</td>
</tr>
<tr>
<td>Glucose, mg/dL Mean±SD</td>
<td>136.9±51.9</td>
<td>128.5±38.9</td>
<td>0.2653</td>
</tr>
<tr>
<td>Temperature, °C Mean±SD</td>
<td>36.7±0.5</td>
<td>36.6±0.5</td>
<td>0.3882</td>
</tr>
<tr>
<td>Heart rate, bpm Mean±SD</td>
<td>82.1±16.4</td>
<td>78.4±17.4</td>
<td>0.1077</td>
</tr>
<tr>
<td>Respiratory rate Mean±SD</td>
<td>18.3±3.2</td>
<td>17.5±3.1</td>
<td>0.1395</td>
</tr>
<tr>
<td>Side of infarct (right) % (n/N)</td>
<td>45.1% (41/91)</td>
<td>55.4% (56/101)</td>
<td>0.1932</td>
</tr>
</tbody>
</table>

Baseline characteristics of the FVP subset of the Safety and Efficacy of NeuroFlo Technology in Ischemic Stroke trial. BL indicates baseline; CoW, Circle of Willis; FVP, favorable vascular profile; and MAP, mean arterial blood pressure; NIHSS, National Institutes of Health Stroke Scales.
Table 2. Logistic Regression Analysis

<table>
<thead>
<tr>
<th>Variables</th>
<th>β (SE)</th>
<th>OR [95% CI]</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>1.67 (0.65)</td>
<td>...</td>
<td>0.0098</td>
</tr>
<tr>
<td>FVP vs. no FVP</td>
<td>1.16 (0.45)</td>
<td>10.22 [1.78–58.57]</td>
<td>0.0091</td>
</tr>
<tr>
<td>Baseline NIHSS*</td>
<td>−0.30 (0.05)</td>
<td>0.74 [0.67–0.82]</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>History of Afib</td>
<td>0.36 (0.22)</td>
<td>2.07 [0.89–4.81]</td>
<td>0.0909</td>
</tr>
</tbody>
</table>

List of variables in univariate logistic regression model (association with mRS 0–2 at 90 days): treated arm, FVP, baseline NIHSS, age, infarct side, glucose, time from symptom onset to randomization, sex, race (black, white, other), SBP, DBP, Afib, diabetes mellitus, hypertension, hyperlipidemia, CII, TIA, seizures, valvular disease, myocardial infarction, angina, peripheral vascular disease, percutaneous transluminal coronary angioplasty, coronary artery bypass graft, and smoking status. Afib indicates atrial fibrillation; CI indicates confidence interval; DBP, diastolic blood pressure; FVP, favorable vascular profile; NIHSS, National Institutes of Health Stroke Scales; and SBP, systolic blood pressure.

Although further analysis of the acquired imaging data are necessary, it may be assumed that the procedure, by improving collateral flow to ischemic penumbral brain, reduces infarct size. Stroke size has been repeatedly established as a predictor for outcome and mortality. Whether presence of FVP in combination with hemodynamic augmentation reduces infarct size and this effect again results in improved clinical outcomes remains to be seen. FVP is a novel parameter to predict outcome of acute stroke patients and further studies will establish its potential role for selection of optimal candidates for hemodynamic augmentation.

Our analysis is limited by its nature as a post hoc calculation; however, the size of our subgroup and the nature of the source data generated from a randomized trial add to its importance. Another limitation by virtue of performed imaging is the lack of assessment of extra- to intracranial collaterals, which is mostly a domain of Doppler ultrasound (eg, the ophthalmic collateral).

At the current stage, it is not known whether the NeuroFlo device will be the subject of further study. If so, systematic assessment of FVP including extra- to intracranial collaterals may be an important protocol feature.

**Sources of Funding**
CoAxia, Inc provided funding for the SENTIS Trial.

**Disclosures**
Drs Schellinger, Liu, Dillon, Nogueira, Shuaib, Liebeskind have received honoraria, travel grants, and/or consulting fees from CoAxia. Dr Kohrmann has no conflicts to report.

**References**
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*Stroke*. published online April 2, 2013;

*Stroke* is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2013 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/early/2013/03/28/STROKEAHA.111.000709

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