In acute ischemic stroke (AIS), persistent large artery occlusion (LAO) often causes severe neurological deficits or death. Current therapeutic strategies focus on recanalization as the most important factor to reduce damaged tissue and minimize neurological deficits. Intravenous (IV) tissue plasminogen activator (t-PA) is the only Food and Drug Administration–approved therapy to improve outcome for AIS. However, patients with stroke with proximal LAO have low recanalization rates with IV t-PA alone, leading to poor functional outcome despite treatment.

Intra-arterial therapy (IAT) has been an approach to recanalize LAO for 3 decades now. IV therapy followed immediately by IAT in selected cases may be safe, but only 1 controlled randomized trial of intra-arterial fibrinolysis has been performed, showing significant improvement in clinical outcome, and recent trials have not shown IAT to confer an increased benefit compared with IV t-PA or as an adjunctive approach to IV t-PA. IAT is resource intensive, requires specialized infrastructure and personnel.

Background and Purpose—Intra-arterial therapy (IAT) promotes recanalization of large artery occlusions in acute ischemic stroke. Despite high recanalization rates, poor clinical outcomes are common. We attempted to optimize a score that combines clinical and imaging variables to more accurately predict poor outcome after IAT in anterior circulation occlusions.

Methods—Patients with acute ischemic stroke undergoing IAT at University of Texas (UT) Houston for large artery occlusions (middle cerebral artery or internal carotid artery) were reviewed. Independent predictors of poor outcome (modified Rankin Scale, 4–6) were studied. External validation was performed on IAT-treated patients at Emory University.

Results—A total of 163 patients were identified at UT Houston. Independent predictors of poor outcome \( (P \leq 0.2) \) were identified as score variables using sensitivity analysis and logistic regression. Houston Intra-Arterial Therapy 2 (HIAT2) score ranges 0 to 10: age \( \leq 59 = 0, \ 60–79 = 2, \ \geq 80 \text{ years} = 4 \), glucose \( <150 = 0, \ \geq 150 = 1 \), National Institute Health Stroke Scale \( \leq 10 = 0, \ 11–20 = 1, \ \geq 21 = 2 \), the Alberta Stroke Program Early CT Score \( 8–10 = 0, \ \leq 7 = 3 \). Patients with HIAT2 \( \geq 5 \) were more likely to have poor outcomes at discharge (odds ratio, 6.43; 95% confidence interval, 2.75–15.02; \( P < 0.001 \)). After adjusting for reperfusion (Thrombolysis in Cerebral Infarction score \( \geq 2b \)) and time from symptom onset to recanalization, HIAT2 \( \geq 5 \) remained an independent predictor of poor outcome (odds ratio, 5.88; 95% confidence interval, 1.96–17.64; \( P = 0.02 \)). Results from the cohort of Emory (198 patients) were consistent; patients with HIAT2 score \( \geq 5 \) had 6× greater odds of poor outcome at discharge and at 90 days. HIAT2 outperformed other previously published predictive scores.

Conclusions—The HIAT2 score, which combines clinical and imaging variables, performed better than all previous scores in predicting poor outcome after IAT for anterior circulation large artery occlusions. (Stroke. 2013;44:00-00.)

Key Words: acute ischemic stroke ■ HIAT2 ■ intra-arterial therapy ■ prediction scores ■ thrombolysis

In acute ischemic stroke (AIS), persistent large artery occlusion (LAO) often causes severe neurological deficits or death. Current therapeutic strategies focus on recanalization as the most important factor to reduce damaged tissue and minimize neurological deficits. Intravenous (IV) tissue plasminogen activator (t-PA) is the only Food and Drug Administration–approved therapy to improve outcome for AIS. However, patients with stroke with proximal LAO have low recanalization rates with IV t-PA alone, leading to poor functional outcome despite treatment.
Decisions to pursue IAT are clinician dependent and rest on a number of different factors. In 2009 and in collaboration with University of California at Los Angeles, our group developed the Houston Intra-Arterial Therapy (HIAT) score, which estimates the chances of poor outcome after IAT. This score was developed on the Houston database and validated on the University Of California at Los Angeles, database. The score is entirely based on clinical variables (age, admission glucose, and admission National Institute Health Stroke Scale [NIHSS]). There are, however, a number of imaging factors that may correlate with outcome after fibrinolysis.

The Alberta Stroke Program Early CT Score (ASPECTS) has demonstrated usability in selecting candidates for recanalization strategies using a simple noncontrast head computed tomography (NCCT), Patients with an ASPECTS ≤7 are unlikely to have a good outcome despite treatment. Although numerous studies suggest the use of MRI, CT angiography (CTA), and CT perfusion findings in identifying patients who have poor outcome after thrombolysis, CT is more readily available, more efficient, requires the least technology, and remains easier to interpret as well as the only validated screening tool for patients undergoing IAT.

We hypothesized that the HIAT score could be improved to better select patients for IAT by inclusion of simple imaging variables, such as ASPECTS and clot burden score (CBS). First, we combined imaging and clinical variables to optimize a score that would better predict poor outcome after IAT for AIS. Then, we compared the performance of the new score against previous predictive scoring systems that relied either on clinical or imaging variables in patients undergoing IAT.

**Methods**

**Study Population**

This retrospective cohort used information from an ongoing, prospectively collected stroke registry. The registry contains information on consecutive patients with stroke presenting to our tertiary stroke academic center at University of Texas (UT) Houston. We retrospectively reviewed patients with AIS from January 2003 to May 2011 who underwent IAT with a final diagnosis of a large vessel anterior circulation occlusion (middle cerebral artery or internal carotid artery). All subjects included in our sample underwent clinical assessment and an acute NCCT followed by CTA of the head and neck. Exclusion criteria were premorbid modified Rankin Scale (mRS) score >2, documented early recanalization on CTA or transcranial Doppler before IAT (if the patient had received IV t-PA), IAT>8 hours or participation in clinical trials that involve the testing of other investigational therapies. Figure 1 shows patient enrollment flow sheet.

**Demographics, Variables, and Measurements**

Information on baseline demographics, vascular risk factors, admission blood glucose level, and NIHSS were obtained from our prospective stroke registry. Other clinical end points obtained from the registry included symptomatic intracerebral hemorrhage, defined as a parenchymal hematoma Grade 2 or worse with worsening neurological status thought to be related to the hematoma), neurological deterioration (defined as ≥4-point increase in NIHSS), and functional outcome on discharge as measured by mRS. Type of IAT, duration of procedure, and time to recanalization were also collected from our prospective intra-arterial database.

![Image](https://example.com/image.png)

**Figure 1.** Patient enrollment flow sheet and exclusion criteria.

**Imaging Analysis**

The ASPECTS methodology is well described by Barber et al and is shown to have high interobserver agreement. CBS is a scoring system to define the extent of thrombus found in the proximal anterior circulation.

NCCT head scans and CTA scans were independently reviewed by 2 staff neuroradiologists (C.S. and J.C.) and 1 vascular neurologist (A.B.D.) who were blinded to the patient’s clinical symptoms and outcomes except for the side of the lesion. There was good interobserver agreement in the ASPECTS scored by our 3 readers (κ=0.739; 95% confidence interval [CI], 0.604–0.835). A consensus ASPECTS and CBS score of these readers was used.

For recanalization, we used the Thrombolysis in Cerebral Infarction (TICI) score. Recanalization (partial and complete) was defined as TICI 2b or higher. Conventional angiograms were reviewed by a staff neuroradiologist (S.L.) who was blinded to the patient’s clinical symptoms and outcomes as well as their ASPECTS and CBS.

**External Validation Cohort**

To assess validity and generalizability, we used an external cohort that met the same inclusion and exclusion criteria of our internal cohort: consecutive patients treated with IAT at the Marcus Stroke and Neuroscience Center at Grady Memorial Hospital (MSNC; Emory University, Atlanta, GA) between October 1, 2010 and October 1, 2012. Furthermore, we evaluated HIAT2 performance in predicting poor outcomes at 90 days.

**Human Protection**

This study was approved by the University of Texas–Houston Health Science Center and Emory University Institutional Review Boards.

**Statistical Analysis**

A logistic regression model, involving the UT Houston cohort, was used to test multiple independent clinical and radiographic variables available before cerebral angiography. The independent variables included age, NIHSS, glucose, hypertension, diabetes mellitus, atrial fibrillation, ASPECTS and CBS, and the dependent variable was mRS=4 to 6 at discharge to determine whether they were significant independent predictors of poor outcome. Independent predictors of poor outcome (discharge mRS, 4–6) with P≤0.2 entered our final score as score variables and were evaluated at different values and dichotomizations using sensitivity analysis and logistic regression to identify cutoff points. Each continuous variable was evaluated using receiver-operating characteristics curves. Spearman correlation and receiver-operating characteristics curves were used to evaluate the final score. The points assigned to the variables were determined through the beta coefficients from the final logistic regression model.

**Results**

We identified 163 patients with AIS with LAO (middle cerebral artery or internal carotid artery) who underwent IAT at
UT Houston as shown in Figure 1. Median age was 64, median NIHSS was 18, medians for ASPECTS and CBS were 7 and 6, respectively, and median glucose at presentation was 125 mg/dL. Of all the patients, 75% of them received IV t-PA before IAT. Symptomatic intracerebral hemorrhage occurred in 2.5% of the patients, and recanalization rate was 78%. Three quarters of the patients had poor outcome at discharge, and overall in-hospital mortality was 18.4%. The cohort from MSNC consisted of 198 patients; Table 1 compares the baseline characteristics and clinical outcomes between UT and MSNC patients.

**Poor Clinical Outcome Predictors and Score Development**

The results of the logistic regression analyses in UT Houston for all the variables are shown in (Table 2). Age, NIHSS, glucose level at presentation, and ASPECTS were identified as independent predictors of poor outcome and entered into the final score. The HIAT2 score (Table 3) ranges 0 to 10: age ($\leq$59=0, 60–79=2, $\geq$80=3), NIHSS ($\leq$10=0, 11–20=1, $\geq$21=2), and ASPECTS ($\leq$80=0, $\geq$80=4), and enters the final score. The HIAT2 score (Table 3) ranges 0 to 10: age ($\leq$59=0, 60–79=2, $\geq$80=3), NIHSS ($\leq$10=0, 11–20=1, $\geq$21=2), and ASPECTS ($\leq$80=0, $\geq$80=4), and enters the final score.

Table 1. Baseline Characteristics and Clinical Outcomes in University of Texas and Emory Data Sets

<table>
<thead>
<tr>
<th>Variables</th>
<th>Emory (n=198)</th>
<th>UT (n=163)</th>
<th>P Value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, median (range)</td>
<td>65 (32–94)</td>
<td>66 (15–91)</td>
<td>0.9</td>
</tr>
<tr>
<td>Sex, % male</td>
<td>52</td>
<td>55</td>
<td>0.2</td>
</tr>
<tr>
<td>Smoker, %</td>
<td>17</td>
<td>19</td>
<td>0.5</td>
</tr>
<tr>
<td>Hypertension, %</td>
<td>72</td>
<td>68</td>
<td>0.9</td>
</tr>
<tr>
<td>Diabetes mellitus, %</td>
<td>28</td>
<td>26</td>
<td>0.3</td>
</tr>
<tr>
<td>Hyperlipidemia, %</td>
<td>23</td>
<td>22</td>
<td>0.5</td>
</tr>
<tr>
<td>Atrial fibrillation, %</td>
<td>30</td>
<td>28</td>
<td>0.9</td>
</tr>
<tr>
<td>NIHSS admission, median</td>
<td>19</td>
<td>18</td>
<td>0.1</td>
</tr>
<tr>
<td>ASPECTS</td>
<td>8 (4–10)</td>
<td>8 (0–10)</td>
<td>0.2</td>
</tr>
<tr>
<td>Glucose, median (range)</td>
<td>127 (68–472)</td>
<td>125 (75–381)</td>
<td>0.7</td>
</tr>
<tr>
<td>IVA-P-A, %</td>
<td>56</td>
<td>77</td>
<td>0.02</td>
</tr>
<tr>
<td>DC mRS, median (range)</td>
<td>4 (1–6)</td>
<td>4 (0–6)</td>
<td>0.02</td>
</tr>
<tr>
<td>mRS 4–6, %</td>
<td>59</td>
<td>72</td>
<td>0.001</td>
</tr>
<tr>
<td>Death, %</td>
<td>22</td>
<td>18</td>
<td>0.9</td>
</tr>
</tbody>
</table>

ASPECTS indicates Alberta Stroke Program Early CT Score; DC mRS, discharge modified Rankin Scale; IVA, intravenous; NIHSS, National Institute Health Stroke Scale; and t-PA, tissue plasminogen activator.

**Applying HIAT2 Score to Explore Clinical Outcomes**

Of all the patients, >80% of them with HIAT2 score ≥5 had poor outcome, and virtually all patients with a score >7 had poor outcome in UT data set. Patients with HIAT2 score ≥5 were more likely to have poor outcome at discharge (odds ratio [OR], 6.43; 95% CI, 2.75–15.02; P<0.001) than patients with HIAT2 score <5. Most importantly, a HIAT2 score ≥5 had a higher likelihood of mRS: 4 to 6 at 90 days (OR, 5.66; 95% CI, 3.06–10.47; P<0.0001) because >60% patients in the HIAT2 (5–7) score category had poor 90-day outcome and ≥80% with a score of 8 to 10 ended up with mRS: 4 to 6 at 3 months; Figure 2 compares the proportion of patients with poor outcome in the UT (discharge) and Emory patient populations (discharge and 90 days). Moreover, HIAT2 maintained its ability to predict poor outcome at 90 days after adjustment for recanalization, time from symptom onset to reperfusion, and the use of general anesthesia (OR, 5.12; 95% CI, 2.67–9.81; P<0.0001). Furthermore, HIAT2≥5 predicted poor outcome after adjustment for the use of stent retrievers (OR, 4.96; 95% CI, 2.58–9.56; P<0.0001).

**External Validation at Discharge and 90-Day Clinical Outcomes**

In the MSNC data set, patients with HIAT2 score ≥5 had 6× greater odds of poor outcome at discharge (OR, 6.22; 95% CI, 2.95–13.11; P<0.0001) than patients with score <5. Most importantly, a HIAT2 score ≥5 had a higher likelihood of mRS: 4 to 6 at 90 days (OR, 5.66; 95% CI, 3.06–10.47; P<0.0001) because >60% patients in the HIAT2 (5–7) score category had poor 90-day outcome and ≥80% with a score of 8 to 10 ended up with mRS: 4 to 6 at 3 months; Figure 2 compares the proportion of patients with poor outcome in the UT (discharge) and Emory patient populations (discharge and 90 days). Moreover, HIAT2 maintained its ability to predict poor outcome at 90 days after adjustment for recanalization, time from symptom onset to reperfusion, and the use of general anesthesia (OR, 5.12; 95% CI, 2.67–9.81; P<0.0001). Furthermore, HIAT2≥5 predicted poor outcome after adjustment for the use of stent retrievers (OR, 4.96; 95% CI, 2.58–9.56; P<0.0001).

**Comparing HIAT2 Performance With Previous Predictive Scores**

The HIAT2 score was compared with previously developed predictive scores (HIAT, Totaled Health Risks...)

### Table 2. Results of the Analyses Performed in the Score-Building Process Derived From the University of Texas Houston Data Set for all Tested Variables

<table>
<thead>
<tr>
<th>Variables</th>
<th>Univariate Analysis (P Value)</th>
<th>Multivariate Analysis (P Value)</th>
<th>P From the Multivariable Model</th>
<th>Score Given</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age*</td>
<td>0.200</td>
<td>Reference</td>
<td>Reference</td>
<td>0</td>
</tr>
<tr>
<td>≤59</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60–79</td>
<td>0.4962</td>
<td>0.3192</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>≥80</td>
<td>0.0230</td>
<td>1.0620</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Glucose*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;150</td>
<td>Reference</td>
<td>Reference</td>
<td>Reference</td>
<td>0</td>
</tr>
<tr>
<td>≥150</td>
<td>0.1576</td>
<td>0.8577</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>NIHSS*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤10</td>
<td>Reference</td>
<td>Reference</td>
<td>Reference</td>
<td>0</td>
</tr>
<tr>
<td>11–20</td>
<td>0.1797</td>
<td>0.8237</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>≥21</td>
<td>0.0340</td>
<td>1.6825</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>ASPECTS*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8–10</td>
<td>Reference</td>
<td>Reference</td>
<td>Reference</td>
<td>0</td>
</tr>
<tr>
<td>≤7</td>
<td>0.2798</td>
<td>0.6270</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>CBS**</td>
<td></td>
<td></td>
<td></td>
<td>0.387</td>
</tr>
<tr>
<td>DM**</td>
<td></td>
<td></td>
<td></td>
<td>0.499</td>
</tr>
<tr>
<td>HTN**</td>
<td></td>
<td></td>
<td></td>
<td>0.525</td>
</tr>
<tr>
<td>Atrial fibrillation**</td>
<td>0.988</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ASPECTS indicates Alberta Stroke Program Early CT Score; CBS, Clot Burden Score; DM, diabetes mellitus; HTN, hypertension; and NIHSS, National Institute Health Stroke Scale.

*Variables that met the ≤0.2 cut point for the P value in the univariate analysis and entered the final score.

**Variables that did not meet the ≤0.2 cut point for the P value in the univariate analysis.
in Vascular Events score [THRIVE], and ASPECTS; both continuous and dichotomized) in the UT cohort. Given that ASPECTS was created to predict good rather than poor outcomes, we also compared HIAT2 with the inverted ASPECTS. HIAT2 had a greater area under the curve (AUC=0.748) compared with THRIVE (0.695), HIAT (0.679), ASPECTS continuous and dichotomized (0.667 and 0.585, respectively). HIAT2 outperformed all other scores when compared with the 90-day poor outcomes of Emory (Figure 3B).

Examining the Importance of Adding Imaging Findings to HIAT2
To examine further the potential clinical and statistical value of adding ASPECTS to the HIAT2 scoring system, we removed ASPECTS from HIAT2 and created a modified 0 to 7 scoring system. Although the modified score continued to be a significant predictor of poor outcome, removing ASPECTS underestimated the patients’ odds of having poor clinical outcomes (2.79; 95% CI, 1.34–5.82; P=0.0061) and resulted in smaller AUCs (AUC=0.6139). This result was confirmed on the Emory cohort as well, further supporting the importance of adding the ASPECTS score to optimize HIAT2. This analysis then led us to add ASPECTS to the original HIAT score and to compare with HIAT2. Therefore, we added ASPECTS (a poor ASPECTS ≤7) to the original HIAT and created a 0 to 4 points score that we compared with HIAT. Adding ASPECTS to HIAT resulted in a score that better estimates poor outcome than the original HIAT score, with higher ORs, narrower CIs (6.17; 95% CI, 2.42–15.71; P=0.0001), and larger AUCs (0.6802), further proving the value of adding ASPECTS to the clinical scoring system. However, HIAT2 remained superior to this modified HIAT (AUC for HIAT2 0.7032 versus modified HIAT 0.6802).

Testing HIAT2 Performance in the Context of Reperfusion Status
To further evaluate the use of HIAT2 in patient selection for IAT, we studied poor clinical outcomes in patients with and without reperfusion, stratified by HIAT2 scores. Patients with a HIAT2 score ≥5 had significantly higher odds of poor outcome even if reperfusion (TICI≥2b) had been achieved (OR, 5.49; CI, 1.69–17.83; P=0.0046). Furthermore, patients who did not reperfuse (TICI<2b) showed an association for even worse odds for poor outcome although only approaching statistical significance (OR, 8; CI, 0.69–92.7; P=0.09).

Evaluating Clinical Outcomes of Patients Irrespective of Their Age: Ageless HIAT2
Some physicians may not want to use age in their decision to pursue IAT because there is supportive literature on the safety of IAT in >80-year-old patients. Because age weighs heavily in the scoring of HIAT2, we removed the age component

Table 3. The Houston Intra-Arterial Therapy 2 (HIAT2) Score

<table>
<thead>
<tr>
<th>Variables</th>
<th>Categories</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y</td>
<td>≤59</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>60–79</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>≥80</td>
<td>4</td>
</tr>
<tr>
<td>NIHSS score</td>
<td>≤10</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>11–20</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>≥21</td>
<td>2</td>
</tr>
<tr>
<td>Glucose, mg/dL</td>
<td>&lt;150</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>≥150</td>
<td>1</td>
</tr>
<tr>
<td>ASPECTS</td>
<td>8–10</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>≤7</td>
<td>3</td>
</tr>
<tr>
<td>Total possible points</td>
<td></td>
<td>10</td>
</tr>
</tbody>
</table>

ASPECTS indicates Alberta Stroke Program Early CT Score; and NIHSS, National Institute Health Stroke Scale.

Figure 2. A through C. Comparison of the proportion of patients with poor outcome in University of Texas (UT; discharge) and Emory (discharge and 90 days). HIAT2 indicates Houston Intra-Arterial Therapy 2; and mRS, modified Rankin Scale.
from HIAT2 and created the ageless HIAT2. We examined the ability of ageless HIAT2, a 6-point score (NIHSS, 0–2; ASPECTS, 0–3; and glucose level, 0–1) to predict poor clinical outcomes in both data sets (UT Houston and Emory’s discharge and 90 days). We found that a score of $\geq 3$ had 6.85 greater odds of poor outcome (95% CI, 2.21–21.2; $P=0.0008$ and AUC=0.693) at discharge and 3.79 greater odds of poor outcome (95% CI, 1.14–12.6; $P=0.0294$ and AUC=0.648) at 90 days. Nearly all (96.9%) patients in the 3 to 6 category had poor outcome at discharge in the UT data set; these results were consistent in the Emory data set because 80.8% with score $\geq 3$ had an mRS: 4 to 6 at discharge, and 68% of patients with scores $\geq 3$ had an mRS: 4 to 6 at 90 days (Figure 2C).

**Discussion**

Previous trials reported favorable clinical outcomes in patients with stroke treated with IAT.9,29,30 However, recent randomized trials have failed to show benefit of adjunctive endovascular therapy in patients given IV t-PA in comparison with IV thrombolysis alone; nor is endovascular therapy superior to IV thrombolysis when implemented within 4.5 hours of symptom onset.10,11 These studies suggest that better selection of patients may be needed to understand who might have a poor outcome after IAT. In an effort to improve the selection of patients eligible for IAT, we studied different clinical variables that are known to affect patient outcomes and incorporated radiographic variables associated with response to therapy in patients undergoing IAT at our center. Our novel scoring system may help physicians decide whether to pursue endovascular recanalization. The HIAT2 scoring system that we derived is a combined score incorporating age, admission glucose level, admission NIHSS, and radiographic (ischemic changes on CT) variables.

All components of the HIAT2 score have been supported in the literature as factors associated with outcome in patients with AIS. Although patients of advanced age benefit from IV or intra-arterial thrombolytic therapy,31,32 they tend to have lower recovery rates, higher incidences of complications, and worse outcomes in general. Poor outcomes in older people may be explained by multiple comorbidities, reduced physiological recovery reserve,33 diminished collateral circulation,34 and reduced neural plasticity.35 Admission hyperglycemia is widely reported as a poor prognostic factor in acute brain ischemia.36,37 Baseline NIHSS is the most powerful predictor of long-term outcome in patients with AIS,14,36,38 and patients with the most severe neurological deficits at admission are more likely to have futile recanalization with IAT.39 Multimodal imaging methods are widely used to identify salvageable tissue in patients with AIS, and ASPECTS has been a useful tool in selecting patients that may benefit from both IV40 and IA12 thrombolytic treatment.

Patients with HIAT2 $\geq 5$ were less likely to have a good outcome despite efforts to recanalize and reperfuse their ischemic bed. Although our results are in agreement with previous studies that reported the association between better clinical outcomes with higher recanalization rates,41,42 patients with HIAT2 $\geq 5$ still had poor outcome despite successful reperfusion.

Although other studies have chosen to examine patients who may respond favorably after IAT,43,44 we sought to devise a score that would predict poor outcome in spite of recanalization and thus improve our patient selection for IAT by excluding patients who will do poorly, even after a radiographically successful intervention. Furthermore, good clinical outcome also can depend heavily on multiple factors in the angiosuite after the decision to intervene, and many of these factors are difficult to account for or predict in advance, such as whether the procedure itself was successful or not, the length of the procedure,45,46 and the status of the patients’ collaterals and blood pressure during the intervention.

HIAT2 was originally designed with hospital discharge as the primary outcome. Some patients with poor outcome on discharge can have significant improvement in dependency after the acute phase of stroke. However, we validated our results on long-term outcome on an external data set from another stroke center with the same robustness.

HIAT2 combines both clinical and radiographic independent predictors in 1 score that uses easily retrievable variables.
and provides a quick assessment of the likelihood for a poor outcome if IAT is pursued, in contrast to more time-consuming approaches, such as MRI diffusion-perfusion mismatch. The HIAT2 score could provide a reliable tool in selecting patients for IAT given its superior performance when compared with all currently developed clinical (HIAT and THRIVE) as well as radiographic scores (ASPECTS). Few patients with HIAT2 scores of 5 to 7 may benefit from IAT. HIAT2 is the only method that combines both clinical and radiographic elements in a unified system that may help physicians in their decisions to pursue IAT by potentially excluding patients from treatment (possibly with scores >5 and even more likely >8).

Our study has several limitations. It is retrospectively designed and warrants a prospective validation. It extends >8 years during which notable changes and progressions were made in the field of interventional vascular neurology with the introduction of both Multi mechanical Embolus Removal in Cerebral Ischemia (MERCi) retriever and the Penumbra system. Moreover, with the growing data reporting the effectiveness, rapidity, higher recanalization rates, and favorable outcomes of the newer devices, it is also possible that the development of newer generation devices may improve the recanalization rate and could provide benefit for more patients and, although HIAT2 maintained its predictive ability after adjustment for the usage of stent retrievers, further validation of the score in trials that use stent retrievers is warranted. Our cohort of patients at UT was routinely mechanically ventilated for IAT, which might alter its outcomes negatively, however, we adjusted for this variable on Emory’s data set with no change in the results. Our analysis concentrated on NCCT and CTA changes as the main imaging variables; we did not study MRI perfusion-diffusion mismatch or CT-perfusion data in our analysis. A comparison of simple versus more advanced imaging methods against HIAT2 in predicting patient outcomes will be important in future studies. Furthermore, because ASPECTS plays a key role in HIAT2, it is important to point out that ASPECTS scoring can be challenging in real time in the emergency department and requires training and experience; however, the score does have good interobserver agreement as well as low variation between ASPECTS performed in real time and core laboratory/experts scores.

Conclusions

In an era where IAT is becoming a more used treatment for AIS, and in a field that lacks solid evidence showing superiority of IAT over the only proven standard of care (IV t-PA), HIAT2 may present a useful tool in deciding whether to pursue endovascular intervention for LAO. Based on the data from this study, we are designing a prospective trial to identify variables that predict long-term outcome in patients receiving IA therapy for AIS to further investigate predictors of poor outcomes in these patients.

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Disclosures

Dr Liebeskind is a Consultant to Stryker and CoAxia.

References


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