Evaluation of Short Term Outcome of Acute Ischemic Stroke by Modified Rankin Scale

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Abstract

Background: Stroke is the most common cause of morbidity and mortality worldwide. There are two types of stroke, ischemic stroke and haemorrhagic stroke. The most important diagnostic tool of acute stroke is CT scan of brain. In acute ischemic stroke, there are diverse CT scan findings especially in respect of anatomic location of ischemic change or character. After the event of acute ischemic stroke the patient may become completely stable or may develop complications or may die within a few days. Objective: This study is designed to access short term outcome of Modified Rankin Scale of acute ischemic stroke. Methodology: This is a prospective observational study done in Rangpur Medical College Hospital during the period of July, 2015 to June, 2017. Total 60 cases were enrolled from the admitted patients in Medicine and Neuromedicine department of Rangpur Medical College Hospital, in this study by purposive consecutive sampling technique fulfilling the inclusion and exclusion criteria. CT scan of brain was done for each patient after taking informed consent. Radiological evidence of acute ischemic stroke was ascertained by radiologist. Data were collected from each patient and/or attendants by taking meticulous history, clinical examination and relevant investigations. Clinical status and afterwards outcome after 7 days of admission was measured by Modified Rankin Scale. All data were collected in individual predetermined case record form and analysed by SPSS version 17.0. Results: Total number of patients was 60. Male female ratio was 1.2:1. During study period 22% (N=13) died out of 60 patients. Thirty six(60%) patients had infarction due to proximal occlusion of artery mostly middle cerebral artery and 24(40%) patients had lacunar infarcts. Morbidity was measured by modified Rankin scale at the time of admission and during follow up after 7 days. Morbidity was found to be significantly increased in proximal occlusion stroke than lacunar stroke (P value <0.05). Mortality was also significantly higher in proximal occlusion stroke than lacunar stroke (P value 0.04). Conclusion: In this study it is found that CT scan findings can predict the short term outcome of acute ischemic stroke. This will provide insight about better understanding in predicting accuracy of CT scan of brain.

Keywords: Ischemic stroke, CT scan, Modified Rankin Scale, Ischemic infarction of brain.

INTRODUCTION

Stroke is the second leading cause of death worldwide [1]. Patients who have experienced a stroke will most likely be taken to a nearby hospital. Upon arriving at the hospital, medical staff will attempt to treat the patient, considering the clinical presentation together with information obtained from an emergency non-contrast computed tomography (CT) scan of the patient’s brain [2]. Eligibility for stroke treatment depends not only upon time from stroke onset, but also on the extent of ischemic damage on CT scans. Changes on the CT scan denote predominately irreversibly infarcted tissue that appears hypodense, representing the infarct core. In the first 6 hours following stroke onset, stroke detection is challenging and requires significant expertise, as only subtle signs of cerebral ischemia are present on CT. Early computed tomographic (CT) signs of cerebral infarction seen within 6 hours after onset of symptoms of stroke may be predictive of poor functional outcome [3]. Neurologic symptoms caused by fociol brain ischemia do not necessarily represent irreversible brain damage. The critical perfusion level...
for functional disturbance is at 15–25 mL/100 g per minute and above the critical perfusion level for tissue death (10–15 mL/100g per minute). Neuronal tissue can survive with cerebral blood flow values higher than 12 mL/100 g per minute in a state of dysfunction for an undefined period. This difference in critical blood flow levels for reversible dysfunction and irreversible tissue damage allows spontaneous or treatment-induced recovery.

The focal degree of ischemia determines the delay between the onset of symptoms and induction of irreversible brain damage. Information on whether the ischemic brain has a chance to survive or is already dead is important to assess the effect of treatment. Because of time constraints, a reliable method of cerebral blood flow measurement that could clearly facilitate the prediction, from cerebral blood flow values, of which brain regions will die and which will survive is not routinely applicable. Even with histologic staining, identification of irreversible damage is difficult in experimental animals within the first hours after arterial occlusion [4–8]. One of the most sensitive indicators of acute middle cerebral artery (MCA) ischaemia is loss of the insular ribbon [9-11]. The hyperdense MCA sign has also been reported as a sign of acute ischemia, in which high attenuation blood clot is identified within the MCA as it traverses the sylvian fissure.

This sign, however, has limited value, especially with modern CT scanners, with which the MCA frequently appears bright, even in normal patients [12]. Other indicators of acute stroke include loss of gray-white differentiation, especially in the region of the basal ganglia and internal capsule [13]. Sulcal effacement can result from cortical swelling, which decreases the size of the CSF spaces surrounding affected gyri [14]. These signs can be confidently identified by a neuro-radiologist [15]. Treatment of acute ischemic stroke is aimed at salvaging potentially viable ischemic brain. Final infarct size is reduced and functional outcomes are better if this is achieved rapidly. CT scanning has demonstrated a possible role as a prognostic and triage test. The observation of early infarct signs involving extensive areas of the middle cerebral artery territory has been implicated in poor outcome [16-18]. The primary outcome measure of stroke is poor clinical outcome assessed by the mRS. A score of 0–2 represents good outcome, and a score of 3–6 represents poor outcome [19].

OBJECTIVE
General objective
1. To find out short term outcome of Modified Rankin Scale of acute ischaemic stroke.

Specific objective
2. Association of CT Scan Findings with Short Term Outcome of Acute Ischaemic Stroke
3. To find out the association of CT scan findings with Modified Rankin Scale of acute ischaemic stroke
4. To find out short term outcome of Modified Rankin Scale of acute ischaemic stroke.

METHODOLOGY

<table>
<thead>
<tr>
<th>Type of study</th>
<th>It was a Prospective observational study.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place of study</td>
<td>Department of Medicine and Neuromedicine, Rangpur Medical College Hospital, Rongpur</td>
</tr>
<tr>
<td>Study period</td>
<td>24 months (July 2015 to June 2017)</td>
</tr>
<tr>
<td>Study population</td>
<td>All ischemic stroke patients admitted in the department of Medicine and Neuromedicine, Rangpur Medical College Hospital, Rangpur.</td>
</tr>
<tr>
<td>Sampling technique</td>
<td>Purposive sampling method</td>
</tr>
</tbody>
</table>

SELECTION CRITERIA

Inclusion criteria
1. All ischemic stroke patients irrespective of age and sex

Exclusion criteria
2. Stroke with other systemic disease.e.g. DM, IHD, CKD
4. H/O previous stroke

Procedure of data collection
Data was collected and recorded from standard pre-designed data collection form.

Statistical Analysis
All data generated was statistically analyzed using the computer based SPSS (Statistical Package for Social Science) in 17.0 version of windows. Levels of significance were calculated at a confidence interval of 95% (P<0.05) by using t test.

RESULTS
During the study period from July 2015 to June 2017, a total 60 patients of ischaemic stroke were enrolled in this study to see the association of CT scan findings with their short term outcome. Short term outcome was measured by modified Rankin Scale during the time of hospital admission and upto 7 days of in hospital follow up.
Age distribution of patients in this study was ranging from 29 to 83 years. Occurrence of ischaemic strokes were more in middle and advanced aged people. Of the total 60 patients, most of the patients 18(30%) patients were in the age group 61-70 years.

Both male and female patients were included in this study by purposive sampling method. Among them 33(55%) were males and remaining 27(45%) patients were females in the enrollment.

Majority of the patients were poor and came from low socio-economic condition status. The low, middle and high socio-economic status of patients were respectively 58.33%, 31.67% and 10% of total patients. In proximal occlusion stroke patients of low socio-economic status was 30.2% and in lacunar stroke was 28.13%. In statistical analysis it is found that p value is 1.39 that indicates there was no significant difference. Like this regarding middle and high socio-economic status there was no statistically significant difference in between proximal occlusion stroke and lacunar stroke (P value 0.95 in middle class and 0.52 in high class).

About half of the patients (51.67%) were current smokers, 20% of them were ex-smoker and remaining 28.33% were nonsmoker. In both proximal occlusion and lacunar stroke had statistically insignificant p-value of smoking status.

Family history was found to be positive only in 18.33% of patients. Both positive and negative family history had no statistically significant difference in between proximal occlusion stroke and lacunar stroke.

Among female patients 22.22% had the history of OCP intake. In proximal occlusion stroke, history of OCP intake was significantly higher than that of lacunar stroke. P-value was 0.03 that was statistically significant.

Of the total patients 36(60%) patients had infarction due to proximal occlusion of artery and mostly of middle cerebral artery and 24(40%) patients had lacunar infarcts. Mean modified Rankin scale score of proximal occlusion stroke patients was 2.5 with standard deviation of 0.58 after 7 days follow up and of lacunar stroke was 2.2 with standard deviation of 0.42. During follow up after 7 days the morbidity of the patients of proximal occlusion stroke was more than that of lacunar stroke. The morbidity was measured by modified Rankin scale score system. During statistical analysis student’s t-test was done and P-value was <0.05, that was statistically significant.

Regarding mortality proximal occlusion stroke was associated with increased mortality rate than that of lacunar stroke. During study period mortality rate was found 22% (N=13). Among them in proximal occlusion stroke mortality was 69% (N=10 out of 36) and lacunar stroke was 31% (N=3 out of 24) of total mortality. Chi-Square test was done and it is found that proximal occlusion stroke is associated with significantly increased mortality (P value 0.04).

### Age distribution of the patients (n=60)

<table>
<thead>
<tr>
<th>Age in years</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;31</td>
<td>1</td>
<td>1.7</td>
</tr>
<tr>
<td>31-40</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td>41-50</td>
<td>11</td>
<td>18.3</td>
</tr>
<tr>
<td>51-60</td>
<td>14</td>
<td>23.3</td>
</tr>
<tr>
<td>61-70</td>
<td>18</td>
<td>30.0</td>
</tr>
<tr>
<td>71-80</td>
<td>12</td>
<td>20.0</td>
</tr>
<tr>
<td>&gt;80</td>
<td>2</td>
<td>3.3</td>
</tr>
</tbody>
</table>

**Table-I:** Showing age distribution of patients. Most patients are in the group of age 61-70 years (30%)
Among 60 patients, 33 (55%) were male and 27 (45%) were female. Male female ratio was 1.2:1.

**Socio-economic status of patients**

**Table-II:** Most of the patients came from rural area in both proximal occlusion and lacunar stroke.

<table>
<thead>
<tr>
<th>Socio-economic status</th>
<th>Prox.occl. stroke (%)</th>
<th>Lacunar stroke (%)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>30.2</td>
<td>28.13</td>
<td>1.39</td>
</tr>
<tr>
<td>Middle</td>
<td>16</td>
<td>15.67</td>
<td>0.95</td>
</tr>
<tr>
<td>High</td>
<td>6</td>
<td>4</td>
<td>0.52</td>
</tr>
</tbody>
</table>

**Distribution of patients according to family history of stroke**

**Table-III:** showing most patients have negative family history in both proximal and lacunar stroke

<table>
<thead>
<tr>
<th>Family history</th>
<th>Prox.Occl.stroke (%)</th>
<th>Lacunar stroke (%)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>10.12</td>
<td>8.21</td>
<td>0.65</td>
</tr>
<tr>
<td>Negative</td>
<td>36.32</td>
<td>45.35</td>
<td>0.31</td>
</tr>
</tbody>
</table>

**Smoking status of the patients**

**Table-IV:** shows most of the stroke patients are current smoker

<table>
<thead>
<tr>
<th>Smoking status</th>
<th>Prox.Occl.stroke (%)</th>
<th>Lacunar stroke (%)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoker</td>
<td>30.11</td>
<td>21.56</td>
<td>0.23</td>
</tr>
<tr>
<td>Nonsmoker</td>
<td>16.12</td>
<td>12.21</td>
<td>0.46</td>
</tr>
<tr>
<td>Ex smoker</td>
<td>12.23</td>
<td>7.77</td>
<td>0.32</td>
</tr>
</tbody>
</table>

**Distribution of female patients with history of OCP use**

**Table-V:** Among OCP user Incidence of proximal occlusion stroke is significantly higher than that of lacunar stroke

<table>
<thead>
<tr>
<th>OCP user</th>
<th>Prox.Occl. stroke (%)</th>
<th>Lacunar stroke (%)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>16.11</td>
<td>6.11</td>
<td>0.03</td>
</tr>
<tr>
<td>No</td>
<td>40.45</td>
<td>37.33</td>
<td>0.72</td>
</tr>
</tbody>
</table>

**Mobidity of patients based on MRS according to CT scan findings**

**Table-VI:** Showing higher mean MRS on admission and after 7 days follow up.

<table>
<thead>
<tr>
<th>Mean MRS</th>
<th>Proximal occlusion stroke</th>
<th>Lacunar stroke</th>
</tr>
</thead>
<tbody>
<tr>
<td>On admission</td>
<td>2.5</td>
<td>2.2</td>
</tr>
<tr>
<td>After 7 days follow up</td>
<td>3.2</td>
<td>2.5</td>
</tr>
</tbody>
</table>
Fig-III: Among 60 patients 13(22%) patients died

Fig-IV: Among 13 dead patients 11(79%) was due to proximal artery infarction

**DISCUSSION**

CT scan findings were observed as the involvement of large arterial territories and lacunar stroke. The age group of the patients was ranged from 20 to over 80. Among them most patients was of 50 to 80 years. Collins et al. grouped their patients with ischaemic stroke into five categories; under 45 years (2.4%), 45-54 years (10.3%), 55-64 years (21.9%), 65-74 years (39.1%), and 75 years and older (26.3%) [20]. In this study, most patients are of advanced age ranging from 50 to 90 years that is near about similar to previous results.

Regarding sex distribution 55% was male and 45% was female. 60% patients were affected in large arterial territory and 40% patients were affected as lacunar stroke. In this study it is found that proximal occlusion stroke is associated with statistically significant increased mortality in comparison with lacunar infants. So the study results regarding mortality of acute ischaemic stroke on the basis of CT scan findings is similar to previous study results.

**Limitation of The Study**

All lacunar stroke patients in our country usually do not get admitted into hospital. This study was done in a tertiary level hospital. All costly investigations were not possible in all cases due to financial constrain.

**CONCLUSION**

The outcomes of acute ischaemic stroke patients can be predicted by the seeing the radiological area of brain involvements and appropriate measure can be taken immediately. Hence for management of acute ischaemic patients CT scan findings is a reliable tool for assessing the prognosis of the patients affected by acute ischemic stroke.
REFERENCES


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