Transoesophageal echocardiography in selecting patients for anticoagulation after ischaemic stroke or transient ischaemic attack

M Strandberg, R J Martila, H Helenius, J Hartiala

PAPER

Objective: To investigate prospectively the role of transoesophageal echocardiography (TEE) in selecting patients for anticoagulation in an unselected stroke population.

Method: Transthoracic echocardiography (TTE) and TEE were done in all clinically suitable hospitalised patients (n = 457) with transient ischaemic attack or ischaemic stroke in the acute phase during a two year period in Turku University Hospital. 441 patients were successfully evaluated for cardiac sources of embolism using TEE within 31 days of the event.

Results: A major risk factor for a cardiac source of embolism excluding atrial fibrillation, acute myocardial infarction, and prosthetic valve was detected in 10% of patients and a minor risk factor for a cardiac source of embolism in 46%. When a major risk factor of a cardiac source of embolism was detected using TTE or TEE and no contraindications were present, the patient was given anticoagulation drugs. If a minor risk factor for a cardiac source of embolism was detected, anticoagulation treatment was started after clinical assessment, if no contraindications were present. In 62 (14%) cases, the patient was given oral anticoagulation drugs or the necessity of ongoing anticoagulation treatment was confirmed on the basis of TEE. When these anticoagulation treated patients were evaluated using logistic regression analysis, they were found to have significantly more atrial fibrillation and histories of myocardial infarctions. Moreover, the patients were mainly men. When patients in sinus rhythm and without any history of cardiac disease were analysed, 8% of patients were found to have been given anticoagulation drugs on the basis of TEE data.

Conclusion: This study suggests that TEE should be used in patients with stroke even without any clinical evidence of cardiac disease when the patients are candidates for anticoagulation.
The echocardiographic examinations were done using the Acuson 128 XP (Acuson Corp, Mountain View, California, USA) echocardiographic system and a 2.5–3.5 MHz scanning frequency linear array transducer for TTE, as well as a 5.0 MHz biplane and a 5.0 MHz multiplane transducer for TEE. TTE was done before TEE in all patients. The TEE study was done in awake patients using lidocaine gel for local pharyngeal anesthesia; no other medication was needed. Standard imaging TTE and TEE planes (basal short axis, two chamber, four chamber, transgastric short axis and thoracic aorta) were viewed in all patients.20 Dimensions were measured from the TTE parasternal long axis view, and an injection of intravenous sterile isotonic saline and Valsalva manoeuvre were routinely given to every patient. The echocardiograms were stored on videotape.

The echocardiographic findings were categorised according to a modification of Hart’s classification.23 24 Consequently, echocardiographic abnormalities were considered major or minor risk factors for cardiac sources of embolism (table 1). When a major risk factor for a cardiac source of embolus was detected in TEE and no contraindications were present, the patient was given anticoagulation drugs. Atrial fibrillation, acute myocardial infarction, and prosthetic valve were not included in the major risk factors in this study because they are identified before TEE. If a minor risk factor for a cardiac source of embolism was detected, anticoagulation treatment was started after clinical consideration of the probability of cardiac embolism and treatment hazards.

### Statistical analysis

The statistical analyses were done using SAS statistical software (version 8.00 for Windows, SAS Institute, Cary, North Carolina, USA). The results are expressed as means (SD) and percentages where appropriate. Two by two tables were constructed to analyse associations between the groups. Significance was tested using the $\chi^2$ test and Fisher’s exact test. The level of significance for testing all null hypotheses was a two tailed $p < 0.05$. Odds ratios (ORs) and confidence intervals (95% CIs) were calculated for the risk factors. A logistic regression analysis was used to model the profile of the person to be in that group where TEE findings changed or confirmed the necessity of management. The two sample $t$ test was used to compare the mean age of patients receiving anticoagulation drugs with the mean age of the other examined patients.

### RESULTS

Of all 441 studied patients, 73% had an ischaemic stroke and 27% had a TIA. Table 2 shows a more specific division by subtype. Coronary artery disease was present in 24% of the patients and 50% of them also had a history of myocardial infarction, and three patients had an acute myocardial infarction when hospitalised. Of these patients, 23% had undergone coronary artery bypass or percutaneous transluminal coronary angioplasty. Of all examined patients, 7% had had manifestations of congestive heart failure, 2% had a history of valve disease, and only 2% had been given anticoagulation drugs previously. Fourteen per cent of the patients had a history of chronic (2%) or paroxysmal (12%) atrial fibrillation.

We identified a major or a minor risk factor for a cardiac source of embolism (table 1) in 49% of patients examined, and when the plaques in the descending aorta were included, in 57%. A major risk factor was identified in 10% of patients and a minor risk factor in 46% in the study population. Of those with stroke or TIA, 62 (14%) were being given anticoagulation drugs or their ongoing anticoagulation treatment was justified on the basis of TEE. In 17 of the 62 patients, the suspected source of embolism had already been detected on TTE, but even in these cases TEE often gave useful additional information (eight thrombi, two slow flows, and four aortic plaques). Only in five cases did TEE not give additional information.

Patients with atrial fibrillation had significantly more major (p < 0.001, OR 6.8, 95% CI 3.5 to 13.3) and minor (p = 0.01, OR 2.1, 95% CI 1.2 to 3.6) risk factors for cardiac sources of embolism than those in sinus rhythm. If patients with atrial fibrillation were excluded, 36 of 381 (9%) were still receiving anticoagulation drugs on the basis of TEE data: 23 of 36 because of a major and 13 of 36 because of a minor risk factor for a cardiac source.

In the anticoagulation treated group (n = 62), 41 thrombi were found on TEE (table 3). Of these, 21 were in the left atrial appendage, eight in the descending aorta, seven in the aortic

### Table 1  Modification of Hart’s classification of echocardiographic findings

<table>
<thead>
<tr>
<th>Major risk factors</th>
<th>Minor risk factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left atrial cavity thrombus</td>
<td>Mitral valve prolapse</td>
</tr>
<tr>
<td>Left atrial appendage thrombus</td>
<td>Mitral annular calcification</td>
</tr>
<tr>
<td>Left ventricular thrombus</td>
<td>Calcified aortic stenosis</td>
</tr>
<tr>
<td>Aortic thrombus</td>
<td>Patent foramen ovale</td>
</tr>
<tr>
<td>Atrial myxoma</td>
<td>Slow flow (spontaneous echo contrast)</td>
</tr>
<tr>
<td>Vegetation</td>
<td>Atrial septal aneurysm</td>
</tr>
<tr>
<td>Infective endocarditis</td>
<td>Left ventricular aneurysm</td>
</tr>
<tr>
<td>Marantic endocarditis</td>
<td>Aortic aneurysm</td>
</tr>
<tr>
<td>Dilated cardiomyopathy</td>
<td>False tendon</td>
</tr>
<tr>
<td>Mitral valve stenosis</td>
<td>Aortic arch plaques</td>
</tr>
</tbody>
</table>

Abnormalities on transoesophageal echocardiography (TEE) that are potential cardiac sources of embolism are listed as major or minor risk factors. Atrial fibrillation, acute myocardial infarction, and prosthetic valve are also major risk factors but not listed here because they can be identified without TEE.

### Table 2  Classification of ischaemic stroke and transient ischaemic strokes (TIA) by subtypes

<table>
<thead>
<tr>
<th>Subtype</th>
<th>No (%)</th>
<th>Male (%)</th>
<th>Mean (SD) age (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transient ischemic attack</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carotid TIA</td>
<td>68 (16)</td>
<td>59</td>
<td>59 (11)</td>
</tr>
<tr>
<td>Vertebrobasilar TIA</td>
<td>50 (11)</td>
<td>64</td>
<td>64 (9)</td>
</tr>
<tr>
<td>Infarction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anterior cerebral artery</td>
<td>9 (2)</td>
<td>56</td>
<td>65 (3)</td>
</tr>
<tr>
<td>Middle cerebral artery</td>
<td>186 (42)</td>
<td>58</td>
<td>64 (11)</td>
</tr>
<tr>
<td>Posterior cerebral artery</td>
<td>32 (7)</td>
<td>53</td>
<td>61 (12)</td>
</tr>
<tr>
<td>Brainstem</td>
<td>51 (12)</td>
<td>59</td>
<td>63 (11)</td>
</tr>
<tr>
<td>Cerebellum</td>
<td>24 (5)</td>
<td>63</td>
<td>59 (12)</td>
</tr>
<tr>
<td>Lacunar infarction</td>
<td>21 (5)</td>
<td>57</td>
<td>65 (8)</td>
</tr>
<tr>
<td>Total</td>
<td>441 (100)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The patients were divided into subgroups by a neurologist on the basis of computed tomography or magnetic resonance imaging findings, or of clinical manifestations.
arch, one in the left ventricle, one in a left ventricular aneurysm, one in an aortic arch aneurysm, one in an atrial septal aneurysm, and one attached to a prosthetic mitral valve. Of the patients receiving anticoagulation drugs, 15 of 62 (24%) had a patent foramen ovale. Twelve of these 15 patients were receiving anticoagulation drugs on the basis of the patent foramen ovale, and in all these cases pronounced right to left shunting was seen on Valsalva manoeuvre. In 12 of 62 (19%) cases, the left ventricle was dilated, but in only two was it in the patient’s recorded history. Slow flow (spontaneous echo contrast) was detected in 16 of 62 (26%) patients, and in five of seven patients they experienced their ischaemic attacks. Two of the patients had a prosthetic mitral valve, and in five of seven patients anticoagulation treatment was inadequate.

In this study, 26 of 62 patients could already have been given anticoagulation drugs on the basis of atrial fibrillation. There were still 36 patients in sinus rhythm who were treated on the basis of their TEE findings. When these 36 patients were analysed more closely, significantly more men (p < 0.001, OR 5.1, 95% CI 1.9 to 13.5) were seen in this group with a significantly higher prevalence of coronary artery disease (p = 0.02, OR 2.4, 95% CI 1.2 to 5.0) and previous myocardial infarctions (p = 0.02, OR 3.0, 95% CI 1.3 to 6.8) than were seen in other patients in sinus rhythm. When the patients in sinus rhythm and with no history of cardiac disease were evaluated as an independent group, in 22 of 286 (8%) patients anticoagulation treatment appeared to be based on TEE data. In this group, a major risk factor for a cardiac source of embolism treatment was inadequate.

On logistic regression analysis (n = 441), adjusted by the other variables, the strongest predictor of the effect of TEE on
the decision to give the patient anticoagulation drugs was, as expected, atrial fibrillation (p < 0.001, OR 7.7, 95%CI 4.0 to 14.7). The other significant predictors were male sex (p < 0.003, OR 2.8, 95%CI 1.4 to 5.6) and previous myocardial infarction (p = 0.005, OR 2.9, 95%CI 1.4 to 6.1).

DISCUSSION

TEE is a useful tool for detecting potential intracardiac or aortic sources of embolism. It has proved to be superior to TTE in the identification of structural changes related to possible cardiac embolism, especially in the absence of any clinical evidence of cardiac disease. Such cardiac changes include thrombi, patent foramen ovale, atrial septal aneurysm, slow left atrial flow, and myxomatous degeneration of the mitral valve associated with mitral valve prolapse. However, it remains to be determined whether all patients should undergo TEE. Previous studies with TEE have shown a high frequency of cardiac changes in patients with stroke, not only in those with but also in those without heart disease.

No established guidelines for patient selection are available yet. Our study was done to determine the usefulness of TEE as a routine examination in unselected patients with stroke. TEE was done in 441 patients with ischaemic stroke or TIA very soon after the onset of symptoms (mean 5.5 days), and in 62 (14%) cases it led to anticoagulation treatment. In some cases, TEE was done rather late and something important may therefore have been overlooked. When all patients with atrial fibrillation were excluded from the analysis, it was found that TEE caused a change in or confirmed the appropriateness of management in 36 of 381 (9%) patients.

The presence of a major risk factor for a cardiac source of embolism (table 1) or some of the minor risk factors detected by TEE may predict future thromboembolic events, indicating the need for long term anticoagulation treatment. Cardiac evaluation may be indicated in patients even when a coexistent explanation for the event exists, for example, when a cerebral ischaemic event can be clinically associated with atherosclerotic disease of the carotid artery. Reportedly, 13 to 48% of patients with a potential cardiac source of embolism have significant cerebrovascular atherosclerosis. For example, when patients with critical carotid stenosis on carotid ultrasound in our study were analysed as a group, 8 of 47 (17%) were found to have been given anticoagulation drugs on the basis of TEE findings, although a coexistent explanation was also available. Some clinical factors have been independently associated with stroke in previous analyses. These include increasing age, previous TIA or stroke, history of diabetes, history of heart failure, or history of hypertension. We found in our analysis that patients with an identified cardiac source of embolism were significantly more often men and more often had coronary artery disease, previous myocardial infarction, known valve disease, myocardial insufficiency, or atrial fibrillation.

The decision to do TEE after stroke or TIA should be based on the likelihood of the findings contributing to the patient's management. Consequently, TEE should not be considered if the patient is not a candidate for anticoagulation treatment. An algorithm has already been proposed for the use of TEE in evaluating patients with stroke or TIA. Considering that most patients with atrial fibrillation are candidates for empirical anticoagulation treatment, the use of this algorithm would limit the use of TEE to patients with clinical evidence of heart disease but without atrial fibrillation and to those with TEE findings suggestive of a severe abnormality. This would decrease the number of TEEs by at least two thirds. However, in our study, where TEE was done in an unselected stroke population, there were reasonably many patients in sinus rhythm with no history of cardiac disease with an obvious cardiac source of embolism (22 of 286). Of these patients, 5% had a major risk factor for a cardiac source of embolism and 39% had a minor risk factor and, consequently, 8% of these patients were given anticoagulation drugs solely on the basis of TEE findings. In conclusion, the effect of TEE on the decision to give anticoagulation drugs was found to be higher than previously reported. Therefore, TEE should be used more often in patients with stroke or TIA who are candidates for receiving anticoagulation drugs and in sinus rhythm.

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REFERENCES

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