Recanalisation of middle cerebral artery occlusion after intra-arterial thrombolysis: different recanalisation grading systems and clinical functional outcome

M Arnold, K Nedeltchev, L Remonda, U Fischer, C Brekenfeld, B Keserue, G Schroth, H P Matte

METHODS
From December 1992 to September 2003, 278 patients with ischaemic stroke were treated with intra-arterial thrombolysis (IAT) at our institution. Several aspects of some of these patients, including indications for treatment, have been published previously.1–12 The 149 patients with occlusions of the M1 or M2 segments of the middle cerebral artery were the focus of this analysis. Their neurological status was assessed on admission by a neurologist using the NIHSS score.13 All patients underwent computed tomography (CT) or magnetic resonance imaging (MRI) to exclude cerebral haemorrhage immediately after neurological evaluation. Early parenchymal CT signs of ischaemia were defined according to the criteria of von Kummer et al.14 Arteriography was carried out using a transfemoral approach. All patients had four vessel diagnostic arteriography to assess the complete vessel status and collateral circulation, if present.

Urokinase (mean dose, 950 000; range, 200 000 to 1 000 000 IU) was infused directly into or near the proximal end of the occluding thrombus over a period of 60 to 90 minutes. In 20 patients with M1 or M2 occlusion, aspiration or mechanical disruption of the clot or both were carried out in addition to pharmacological thrombolysis. In five patients with persistent occlusion after urokinase infusion, percutaneous transluminal angioplasty of the middle cerebral artery was undertaken using a FastStealth balloon dilatation catheter (Target Therapeutics, Fremont, California, USA) with a balloon diameter of 2 mm. In 16 patients with additional ipsilateral high grade carotid stenosis or occlusion, endovascular treatment of the internal carotid artery with stent placement was carried out before thrombolysis of the middle cerebral artery. These groups were not analysed separately because of the small number of patients.

Abbreviations: IAT, intra-arterial thrombolysis; mRS, modified Rankin scale; NIHSS, National Institutes of Health stroke scale; TIMI, thrombolysis in myocardial infarction grading system
Table 1  Grading systems for vessel recanalisation on cerebral arteriography

<table>
<thead>
<tr>
<th>Grading system</th>
<th>Grade</th>
<th>Criteria on arteriography</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIMI</td>
<td>0</td>
<td>No recanalisation</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Partial recanalisation</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Complete recanalisation</td>
</tr>
<tr>
<td>Mori</td>
<td>0</td>
<td>No reperfusion</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Minimal reperfusion</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Reperfusion of less than 50% of the territory of the occluded artery</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Reperfusion of more than 50% of the territory of the occluded artery</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Complete reperfusion</td>
</tr>
</tbody>
</table>

Mori, classification by Mori and coworkers; TIMI, thrombolysis in myocardial infarction.

Treatment effect was documented by arteriography immediately after IAT. Recanalisation of the middle cerebral artery was classified according to TIMI grades and Mori grades retrospectively by a neuroradiologist (LR or GS) who was blinded to the clinical follow up examinations after three months but not to the initial clinical course of the patient during the hospital admission (table 1). To assess interobserver agreement on the Mori grading system, a neurologist (UF), who was blinded to the first assessment of the neuroradiologist but not to the clinical findings, reviewed all angiograms with partial recanalisation and classified recanalisation with the Mori grading system. Stroke aetiology was determined using additional investigations as necessary and classified according to TOAST criteria. Clinical functional outcome was assessed by different neurologists (mostly MA) three months after the stroke by clinical examination using the modified Rankin scale (mRS). The neurologists were not blinded to the initial patient history. Two patients were lost to follow up at three months and were excluded from the study. Modified Rankin scale (mRS) scores of 0 to 2 were defined as “favourable” and mRS scores of 3 to 5 as a “poor” outcome. Death corresponds to an mRS score of 6.

Statistics
Statistical analysis was carried out with the SPSS® for Macintosh. For comparison of baseline variables between the different recanalisation groups the χ² or Mann–Whitney tests were used for categorical variables and the Kruskal–Wallis test for continuous variables. For the analysis of predictors of clinical outcome we dichotomised patients into two groups (those with favourable outcome (mRS ≤2) versus those with poor outcome or death (mRS 3–6)). In addition, a logistic regression analysis with a forward stepwise method was used to determine the independent association of outcome with clinical and radiological factors. The following variables were analysed: age, sex, time from symptom onset to treatment, stroke aetiology, hypertension, diabetes, hypercholesterolaemia, current smoking, initial NIHSS score, hyperdense middle cerebral artery sign, occluded vessel segment, dose of urokinase, and leptomeningeal collaterals. All the analyses were done for both the TIMI and the Mori grading system. Two sided probability (p) values of less than 0.05 were considered significant. Interobserver agreement between the neuroradiologist and the neurologist was analysed using κ statistics.

RESULTS
Baseline demographic data and clinical and radiological findings
We analysed 147 patients (78 men, 69 women), with a mean (SD) age of 60 (13) years (range 18 to 82), with M1 or M2 segment occlusions of the middle cerebral artery; 108 had M1 occlusions and 39 had M2 occlusions. The median baseline NIHSS score on admission was 15 (range 4 to 24). The mean time from symptom onset to initiation of IAT was 242 minutes. Sixty seven patients (46%) showed early parenchymal CT signs of ischaemia. A hyperdense middle cerebral artery sign was noted in 69 patients (47%). Presumed stroke aetiologies were cardiac emboli in 85 patients (58%), large artery disease in 16 (11%), other reasons in 13 (9%), and undetermined in 33 (22%).

Vessel recanalisation
TIMI grades
Recanalisation in the 147 patients was categorised as TIMI grade 0 in 17 patients (12%), TIMI grade 1 in 16 (11%), TIMI grade 2 in 83 (56%), and TIMI 3 in 31 (21%).

Mori grades
Mori grade 0 reperfusion was observed in 17 patients (12%), grade 1 in 16 (11%), grade 2 in 37 (25%), grade 3 in 46 (31%), and grade 4 in 31 (21%). Patients classified as Mori grade 0, 1, and 4 were identical with patients classified as TIMI grade 0, 1, and 3.

The interobserver agreement between the neuroradiologist and the neurologist in the differentiation between the Mori grades 2 and 3 was high (κ = 0.952).

Clinical outcome and complications
Three months after the stroke mRS was 2 or less in 87 patients (58%) indicating a favourable outcome. Forty four patients (30%) had a poor outcome (mRS 3 to 5) and 18 (12%) were dead. Nine patients (6%) suffered a symptomatic intracerebral haemorrhage. Four patients (3%) had non-life-threatening extracranial haemorrhages.

Association of vessel recanalisation and clinical outcome
There were no significant differences in clinical and demographic baseline variables between groups with different recanalisation grades, either for the TIMI or the Mori grading systems (table 2). Outcome was favourable in six of 17...
patients (35%) with TIMI grade 0 recanalisation, five of 16 (31%) with TIMI grade 1, 48 of 83 (58%) with TIMI grade 2, and 27 of 31 (87%) with TIMI grade 3 (fig 1A).

Six of 17 patients (35%) with Mori grade 0 reperfusion, five of 16 (31%) with grade 1, 13 of 37 (41%) with grade 2, 33 of 46 (72%) with grade 3, and 27 of 31 (87%) with grade 4 had a favourable outcome as assessed three months after the stroke (fig 1B).

In logistic regression analysis recanalisation as classified by TIMI grades or reperfusion as assessed by Mori grades were independent predictors of a favourable clinical outcome (mRS ≤ 2) after three months (p < 0.0001 for both grading systems).

Clinical outcome of patients without recanalisation and of patients with minimal recanalisation (TIMI 0 v TIMI 1 and Mori 0 v Mori 1) did not differ, but partial reperfusion made a significant difference for clinical outcome when it was less than or more than 50% (Mori 2 v Mori 3; p = 0.008).

### DISCUSSION

This study shows a highly significant independent association of vessel recanalisation and clinical functional outcome using logistic regression analysis for both the TIMI and Mori grading systems. These results are consistent with previous studies. Recanalisation is a powerful predictor of outcome in stroke, as has been shown in patients without treatment and in patients who received intra-arterial or intravenous thrombolysis. Recanalisation is increasingly used as a surrogate marker for efficacy in stroke trials. Mori grading gives additional information to the widely used TIMI classification. Mori is more refined in giving prognostic information. If reperfusion is missing, minimal, or complete, there is no difference between these two grading systems. However, in the frequent case with partial recanalisation or reperfusion, Mori grading gives additional information to the widely used TIMI classification.

In conclusion, our study indicates that both grading systems, TIMI and Mori, are useful to predict clinical functional outcome three months after stroke caused by middle cerebral artery occlusions. When recanalisation or reperfusion is missing, minimal, or complete, there is no difference between these two grading systems. However, in the frequent case with partial recanalisation or reperfusion, Mori grading gives additional information to the widely used TIMI classification.

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### REFERENCES


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