



POSTER

Clinical and imagiological dissociation in acute ischemic stroke

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Abstract

Introduction: The NIHSS represents a fast evaluation of patients with acute ischemic stroke. A NIHSS of more than 11 has a positive predictive value for proximal occlusion of 81%. Yet an apparent minor stroke with low NIHSS does not exclude a proximal occlusion. Correctly identifying patients with acute ischemic stroke who might benefit from reperfusion treatment is crucial.

Case report: A 68 years old male patient presented to the emergency room of a level B Stroke Unit Hospital with a 2-hour evolution Broca aphasia. He performed brain CT who had an ASPECTS of 10. He started endovascular fibrinolysis and performed a cerebral Angio-CT who revealed an M1 left middle cerebral artery (CMA) occlusion. He was transferred to a tertiary hospital. At arriving he had only a central right facial paresis – NIHSS 1. It was decided to repeat the angio-CT with cervical evaluation which revealed the maintenance of the M1 occlusion and a sub-occlusion of the left internal carot-

id artery (ICA). Endovascular thrombectomy was performed with a final TIC1 of 3. Two days later after cerebral control CT with no vascular lesion a carotid stenting was performed.

A female patient with 65 years old who came to our emergency department with a one-hour evolution left hemiparesis G4+. The NIHSS at entrance was 3 with no cortical deficits. In the cerebral CT there was only a spontaneous hyperdensity in the right CMA. We performed a cervical and cerebral angio CT which revealed a right ICA sub-occlusion and a right M1 occlusion. She started intravenous fibrinolysis and went to endovascular thrombectomy, but a reperfusion was not possible.

Conclusion: These two cases represent the challenge of identifying proximal occlusion in patients with minor deficits. NIHSS should not guide us to define which patients should do a cerebral vascular evaluation.

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