Ischemic strokes with low NIHSS scores what to do?

Rui Osório¹, Patricia Ferreira², Marisa Mariano², and Ana Paiva Nunes²

From the Lisbon Stroke Summit, Lisbon, Portugal. 6–7 April 2018.

Abstract

A 40-year-old male, past medical history of hypertension, dyslipidemia, ST elevation myocardial infarction, intraventricular thrombus (2 years ago, with acenocumarol) and chronic Hepatitis B, presented to the emergency department with left side weakness and slurred speech. In the admission, dysarthria, flattened left nasolabial fold and left side hemiparesis (NIHSS 3) were observed. Cranial computerized tomography (CT) scan revealed no acute ischemic lesions and the angio-CT showed occlusion of M1 segment of right middle cerebral artery (RMCA), with good collateral circulation.

After a thorough discussion, weighing the benefits and risks in a young patient with neurologic deficits, with an M1 RMCA occlusion, low NIHSS score and INR 1, fibrinolytic therapy was performed and the patient was transferred to our hospital. At arrival, a neurological deterioration with NIHSS 8 due to partial gaze palsy, complete hemianopia, partial facial weakness, left side hemiparesis, left hypoesthesia, dysarthria. Mechanical thrombectomy was performed with complete perfusion (TICI 3).

Magnetic resonance showed multiple small ischemic lesions in deep and superficial territories of the RMCA. Transthoracic echocardiography revealed no intraventricular thrombus and no major structural changes. The transesophageal echocardiography found no intraventricular thrombus but revealed altered segmental myocardial contractility.

The patient was discharged with no neurologic symptoms. It was assumed ischemic stroke of undetermined etiology, however due to a strong cardioembolic suspicion hypocoagulation was re-introduced.

Low NIHSS: should we treat immediately or wait for a deterioration?