Management of acute ischemic stroke under routine infection prevention practices for COVID-19

We greatly appreciate the comments made by Leslie-Mazwi et al. As they mentioned, the lack of a 90-day modified Rankin Scale (mRS) was a major limitation of our study. In order to share our first-hand experience as soon as possible during the pandemic, we only reported 7-day outcomes. However, the 90-day follow-up was pre-planned, as we stated in response to peer review comments. As shown in figure 1, a good clinical outcome (mRS ≤2) was seen in 52.9% (9/17) in the pandemic group compared with 39.4% (13/33) in the pre-pandemic group; this difference was not statistically significant (p=0.361). No significant difference was identified for either 90-day mortality (4/17 (23.5%) vs 5/33 (15.2%), p=0.732) or 90-day National Institutes of Health Stroke Scale score (4, IQR 1–12 vs 8, IQR 4–10; p=0.320). No significant difference was found in terms of the transition ward plays a key role. In our center, the transition ward is actually in a separate building, with relatively independent diagnosis and treatment systems including an independent emergency department, ward, CT examination room, and a negative pressure angiography suite. An intensive care unit with two beds was also set up in the transition ward. We assume all stroke patients with large vessel occlusion are suspected COVID-19 cases until proven otherwise. All diagnosis and treatment for ischemic stroke can be completed in the transition ward without waiting for the results of COVID-19 screening. Patients are referred to a general ward or designated COVID-19 hospitals later according to the results of COVID-19 screening. To date, no nosocomial COVID-19 patients or staff have been infected in our center.

We agree with the opinion of Leslie-Mazwi et al on ‘the elusive denominator’. Recent reports from many countries around the world have shown that the number of patient admissions with AIS has decreased significantly during the pandemic. Currently, there is no evidence to confirm any reduction in the incidence of AIS during the pandemic. When we do not know when the pandemic will really end, at this stage of routine infection prevention, we should pay more attention to ways to find these missing patients with AIS and provide them with a timely diagnosis and treatment.

Figure 1  Distribution of functional outcomes at 90 days. Modified Rankin scale scores are shown for patients in the pre-pandemic and pandemic groups. One patient was lost to follow-up in the pre-pandemic group and four patients were lost to follow-up in the pandemic group, and the data were not imputed. Percentages may not total 100 because of rounding.
REFERENCES


