



Abstracts

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Timing of symptomatic intracerebral hemorrhage after rt-PA treatment in ischemic stroke

Background We investigated patterns in the time from recombinant tissue-type plasminogen activator (rt-PA) treatment to symptomatic intracranial hemorrhage (sICH) onset in acute ischemic stroke.

Methods We retrospectively reviewed all admitted “stroke code” patients from 2003 to 2017 at the University of California San Diego Medical Center from a prospective stroke registry. We selected patients that received IV rt-PA within 4.5 hours after onset/last known well and had sICH prehospital discharge. sICH diagnosis was made by prospective review. Endovascular-treated patients were excluded, given the variability of practice. sICH was prospectively defined as any new radiographic (CT/MRI) hemorrhage after rt-PA treatment and any worsened neurologic examination. Time to sICH was the time from rt-PA administration start to documented STAT head CT order time with the first evidence of new hemorrhage. Charts were reviewed for examination time metrics, demographics, clinical history, and neuroimaging.

Results sICH was identified in 28 rt-PA-only treated patients. The mean time to sICH was 18.28 hours (range 2.4–34 hours). Median time to sICH was 18.25 hours. sICH was correlated with increased age ($p = 0.02$) and increased NIH Stroke Scale ($p = 0.01$).

Conclusion Our findings suggest that rt-PA patients have the highest risk of post rt-PA sICH within the first 24 hours after treatment. This supports monitoring of rt-PA-treated patients in specialized settings such as neuro-intensive care units or stroke units. Our findings suggest that the probability of sICH is low 36 hours post rt-PA. Future larger studies are warranted to identify the patterns of bleeding after rt-PA administration.

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Appointment completion in pediatric neurology telemedicine clinics serving underserved patients

Background To determine whether telemedicine improves access to outpatient neurology care for underserved patients, we compared appointment completion between urban, in-person clinics and telemedicine clinics held in rural and underserved communities where neurology consultations are provided remotely.

Methods In this retrospective study, we identified patients scheduled for outpatient care from UCDH pediatric neurologists between January 1, 2009, and July 31, 2017, in person and by telemedicine. Demographic and clinical variables were abstracted from electronic medical records. We evaluated the association between consultation modality and visit completion in overall and matched samples using hierarchical multivariable logistic regression.

Results We analyzed 13,311 in-person appointments by 3,831 patients and 1,158 telemedicine appointments by 381 patients. The average travel time to the site of care was 45.8 ± 52.1 minutes for the in-person cohort and 22.3 ± 22.7 minutes for the telemedicine cohort. Telemedicine sites were located at an average travel time of 217.1 ± 114.8 minutes from UCDH. Telemedicine patients were more likely to have nonprivate insurance, lower education, and lower household income. They had different diagnoses and fewer complex chronic conditions. Telemedicine visits were more likely to be completed than either “cancelled” or missed (“no show”) compared with in-person visits (OR 1.57, 95% CI: 1.34–1.83; OR 1.66, 95% CI: 1.31–2.10 matched on travel time to the site of care; OR 2.22, 95% CI: 1.66–2.98 matched on travel time to UCDH).

Conclusion The use of telemedicine for outpatient pediatric neurology visits has high odds of completion and can serve as an equal adjunct to in-person clinic visits

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