PRESS RELEASE

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Less frequent stroke monitoring is safe, effective, and frees up resources, study finds

(Wednesday, 21 May 2025, Helsinki, Finland) Halving the number of times vital signs and neurological function are checked in low-risk patients after treatment for acute ischaemic stroke does not compromise care or recovery, according to new findings presented at the European Stroke Organisation Conference (ESOC) 2025.

Results from the Optimal Post rTpa-Iv Monitoring in Ischaemic Stroke Trial (OPTIMISTmain)[1], simultaneously published in The Lancet, also showed that this approach had flow-on benefits for nursing workflow and intensive care resources. The trial was led by Professor Craig Anderson from The George Institute for Global Health and UNSW Sydney, and Professor Victor C. Urrutia from Johns Hopkins University School of Medicine.

Professor Anderson said that guideline-recommended monitoring in the 24 hours after thrombolysis (clot-busting) treatment, originally developed in the 1990s, takes up considerable nursing time and intensive care unit (ICU) beds.

“As well as shifting nurses’ attention away from other aspects of care, such as education, counselling, and supporting anxious family members, this level of monitoring disrupts patients’ sleep and may not even be needed for those considered to be ‘low risk’,” he added.

To find out whether the frequency of monitoring could be safely reduced, researchers studied a total of 4,515 patients with acute ischaemic stroke across 8 countries. Patients were either monitored according to a low intensity protocol (19 assessments over 24 hours post-thrombolysis) or standard care (39 assessments).

In both groups, vital signs and neurological assessments were conducted every 15 minutes in the first two hours. Over the next eight hours, patients were monitored every two hours in the low-intensity monitoring group, versus every 30 minutes in the standard group. Up until 24 hours, the low-intensity group was checked every four hours, versus hourly monitoring in the standard group.

A comparable proportion of patients experienced a poor functional outcome (death or disability) after 90 days, with 31.7% (809 of 2552 participants) in the low-intensity group, and 30.9% (606 of 1963) in the standard monitoring group.

The occurrence of intracerebral haemorrhage (brain bleed) - the most serious complication of thrombolytic therapy - was low in both groups, seen in 0.2% of patients in the low-intensity group and 0.4% patients in the standard monitoring group. Serious adverse events were similar between the low-intensity and standard monitoring groups at 11.1% and 11.3%, respectively.

Professor Anderson said that this is the first study of this scale to show that low-intensity nursing is safe and effective in stroke care.

“Regular monitoring during the first hours of stroke onset is critical, but we felt that hourly check-ups may be unnecessary in the subsequent 24 hours. Our findings show that low-intensity monitoring is safe and does not compromise patient recovery, outcomes, or satisfaction with care.

“We expect this approach will be adopted by hospitals worldwide, especially where resources are constrained, as it can streamline care and enable nurses to spend more time on other important aspects of the complex care of these patients.”

As well as freeing up nursing time, the protocol also improved availability of ICU beds, particularly in the USA where the proportion of patients admitted to ICUs was 30% lower among hospitals adopting low-intensity monitoring.

Professor Urrutia, senior author on the study and Medical Director of the Comprehensive Stroke Center at The Johns Hopkins Hospital, said that this new approach could support more resilient stroke care.

“This study was partly conducted during the COVID-19 pandemic, when healthcare resources were under extreme strain. While we may have overcome many of the pressures of that period, shortages of healthcare staff and hospital beds persist. We anticipate that a lower intensity monitoring system for eligible stroke patients will help alleviate the capacity challenges that continue to threaten high quality stroke care.”

Stroke is the second leading cause of death and third most common cause of disability of all noncommunicable diseases worldwide.[2] Acute ischaemic stroke is caused by decreased blood flow due to a clot blocking one of the large blood vessels in the brain.[3] It comprises 65% of all stroke cases and at least one third of patients with ischaemic stroke experience mild to moderate neurological impairment.[2,4]

OPTIMISTmain was conducted in hospital sites across eight countries, including four high-income countries (Australia, Chile, UK, and the USA) and four low- and middle-income countries (China, Malaysia, Mexico, and Vietnam).

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References:

1. Anderson, C. S., et al. (2025). The main Optimal Post rTpa-Iv Monitoring in Ischaemic Stroke Trial (OPTIMISTmain): An international, pragmatic, stepped wedge, cluster randomised, controlled non-inferiority trial. *The Lancet*. https://doi.org/10.1016/S0140-6736(25)00549-5
2. Feigin, V. L., et al. (2024). Global, regional, and national burden of stroke and its risk factors, 1990–2021: A systematic analysis for the Global Burden of Disease Study 2021. *The Lancet Neurology*. https://doi.org/10.1016/S1474-4422(24)00369-7
3. Walter, K. (2022). What is acute ischemic stroke? *JAMA*, 327(14), 1381–1382. https://doi.org/10.1001/jama.2022.1420

4. Man, S., et al. (2020). Association between thrombolytic door-to-needle time and 1-year mortality and readmission in patients with acute ischemic stroke. *JAMA*, 323(21), 2170–2180. https://doi.org/10.1001/jama.2020.5697

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About The George Institute for Global Health:

The George Institute for Global Health is an independent medical research institute aiming to improve the health of millions of people worldwide by generating effective, evidence-based, and affordable solutions to the world's biggest health challenges. Established in Sydney, with major centres in China, India, and the UK, it has projects in more than 45 countries and affiliations with world-class universities. In 2018, The George Institute was ranked the number one independent research institute in Australia by Times Higher Education.

For further information, please refer to the slides here.

Tirofiban administration for stroke after intravenous thrombolysis

(Wednesday, 21 May 2025, Helsinki, Finland) Presented during the European Stroke Organisation Conference (ESOC) 2025, this randomised trial performed in China investigated tirofiban, an IV antiplatelet medication, as an adjunct treatment for acute ischaemic stroke treated with IV thrombolysis. More patients treated with tirofiban achieved an excellent functional outcome but experienced a higher incidence of intracranial bleeding.[1]

Intravenous thrombolysis (IVT) is the cornerstone treatment for acute ischaemic stroke (AIS) within 4.5 hours after onset. Guidelines recommend that antiplatelet medications be administered 24 hours after IVT. However, vascular re-occlusion can occur after IVT.

The ASSET-IT trial sought to investigate whether administration of tirofiban (an IV antiplatelet drug) shortly after receipt of IV thrombolysis would improve clinical outcomes.

ASSET-IT is a phase 3, randomised, placebo-controlled, double-blind clinical trial conducted at 38 centres in China. Patients with acute non-cardioembolic stroke who received IVT within 4.5 hours of symptom onset were randomly assigned to receive either intravenous tirofiban or placebo within 60 minutes of completing thrombolysis. The primary efficacy outcome was the proportion of patients achieving a 90-day modified Rankin Scale score of 0-1, indicating no significant functional disability. The safety outcomes were symptomatic intracranial haemorrhage within 24 hours and all-cause death at 90 days.

The ASSET-IT trial enrolled 832 patients in total. The median (IQR) age of patients was 69 (59–76) years, the median [IQR] baseline NIHSS score was 6 [5-9]. In the tirofiban arm, 65.9% achieved a mRS score of 0-1 compared with 54.9% in the control arm (Risk Ratio [RR] 1.20, 95% CI 1.07-1.34). Symptomatic intracranial haemorrhage rates were 1.7% in the tirofiban arm and 0% in the control arm. Mortality at 90 days was 3.8% in the placebo and 4.1% in the tirofiban group.

The ASSET-IT trial demonstrated that IV tirofiban when given after IV thrombolysis was associated with a greater likelihood of an excellent functional outcome. The incidence of intracranial haemorrhage was low overall but was increased with tirofiban.

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References:

1. Hu, W., et al. *Advancing stroke safety and efficacy through early tirofiban administration after intravenous thrombolysis: The ASSET-IT randomized clinical trial*. Presentation O176, presented at the European Stroke Organisation Conference; 21 May 2025; Helsinki, Finland.

New analysis of DISTAL study finds endovascular stroke treatment helps save more brain tissue at risk

(Wednesday, 21 May 2025, Helsinki, Finland) A new sub-analysis of the DISTAL trial, presented today at the European Stroke Organisation Conference (ESOC) 2025 in Helsinki, reveals that endovascular therapy (EVT), when added to best medical treatment (BMT), increases the probability of brain tissue preservation in patients with acute ischaemic stroke due to medium distal vessel occlusion (MDVO).[1]

The DISTAL trial[2] had previously shown no clear functional benefit of EVT over BMT in MDVO patients at 90 days, possibly explained by the smaller tissue territory at risk and greater procedural risks offsetting the benefit of reperfusion, thereby sparking debate over the procedure's role in this subset of stroke cases. This new imaging-based analysis, however, approached the question from a different angle—focusing on how much threatened brain tissue was actually saved with treatment.

Using baseline perfusion and 24-hour follow-up imaging from 447 trial participants, researchers assessed the proportion of brain tissue at risk of infarction that was ultimately spared. Patients receiving EVT plus BMT were more likely to preserve at least 80% of the at-risk tissue (53%) compared to those receiving BMT alone (41%). Furthermore, saving more than 80% of threatened tissue was strongly associated with better functional outcomes at discharge and at 90 days.

"These results suggest that even in patients with smaller strokes due to MDVO, the amount of salvaged brain tissue plays a critical role in recovery," said Dr. Aikaterini Anastasiou, who presented the study results. "Our analysis indicates that successful reperfusion through EVT can significantly increase the likelihood of saving brain tissue—and, in turn, improve outcomes."

Importantly, patients with successful reperfusion, defined by an mTICI score of ≥2b, had even higher odds of significant tissue salvage (adjusted odds ratio: 2.54). The study also found no difference in outcomes between groups when less than 80% of the tissue was saved, underscoring the importance of achieving high-quality reperfusion.

"This study gives a different perspective into how we interpret treatment success in MDVO stroke," concluded Dr. Anastasiou. "Rather than focusing solely on a functional score that potentially does not capture improvements of less severe strokes, we could also consider the extent of brain tissue that can be saved."

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References:

1. Anastasiou, A., et al. *Mismatch and saved brain tissue volume in patients with a medium/distal vessel occlusion stroke: A sub-analysis of the DISTAL trial.* Presentation O178, presented at the European Stroke Organisation Conference; 21 May 2025; Helsinki, Finland.
2. Psychogios, M., Brehm, A., Ribo, M., et al. (2025). Endovascular treatment for stroke due to occlusion of medium or distal vessels. *New England Journal of Medicine, 392*(14), 1374–1384.

About the DISTAL trial:

The DISTAL trial (NCT05029414)1 is a multicenter, randomised clinical trial conducted at 59 sites across 11 countries. It compares EVT plus BMT to BMT alone in patients with isolated occlusion of medium-sized cerebral arteries within 24 hours of stroke symptom onset.

For further information, please refer to the slides here.

Collateral status on CT angiography impact on outcome in medium vessel occlusion stroke: post-hoc analysis of the ESCAPE-MeVO trial

(Wednesday, 21 May 2025, Helsinki, Finland) A post-hoc imaging analysis of the ESCAPE-MeVO trial, led by Dr. Mayank Goyal, Dr. Michael Hill and collaborators, shows that collateral perfusion status on baseline CT angiography is the only imaging feature significantly associated with 90-day functional outcome in patients with medium vessel occlusion (MeVO) stroke, while occlusion location and vessel diameter did not modify the effect of endovascular treatment (EVT). These findings may help refine selection criteria for reperfusion therapies in MeVO stroke.[1]

Medium vessel occlusions account for a heterogeneous subgroup of acute ischaemic strokes with variable clinical presentations and imaging features. The ESCAPE-MeVO randomised trial compared EVT plus best medical management versus best medical management alone in MeVO stroke, finding no overall difference in outcomes.

This post-hoc analysis aimed to identify whether specific baseline imaging characteristics – including occlusion site, vessel diameter, and collateral status on CT angiography (CTA) – are associated with prognosis and with the efficacy of intravenous thrombolysis (IVT) and EVT.

All 529 patients in the intention-to-treat population of ESCAPE-MeVO were included. CTA was used to determine occlusion location (e.g., M3, A3 segments) and to grade collateral status as good, moderate, or poor. Vessel diameter was measured at the occlusion site. Univariable and multivariable ordinal logistic regression models assessed associations of imaging variables with the primary outcome (90-day modified Rankin Scale) and with treatment effects of IVT and EVT.

Results included:

- Anatomical distribution: 84.7 % of MeVOs involved the middle cerebral artery (MCA) territory; the M3 segment was the most common (41.4 %)
- Vessel size: The median occlusion diameter was 1.9 mm (IQR 1.7–2.2)
- Collateral status: 24.4 % had good, 52.2 % moderate, and 21.0 % poor collaterals on CTA
- Prognostic associations: In univariable analysis, each one-tier worsening of collateral grade was linked to 25 % lower odds of a favourable outcome (common OR 0.75, 95 % CI 0.62–0.89); this remained directionally consistent in multivariable analysis (adjusted OR 0.82, 95 % CI 0.67–0.998). No significant associations were found for occlusion site or vessel diameter

Based on the results, CTA-based collateral status emerges as a potential imaging predictor of outcome after MeVO stroke and may inform patient selection for reperfusion strategies. Further studies will aid in stratifying patients more likely to benefit from intervention.

Dr Michael D Hill, Cumming School of Medicine, Hotchkiss Brain Institute, University of Calgary, Canada, commented: “These data suggest that among patients with stroke due to MeVO with very poor or absent collateral filling on baseline CT angiography, EVT may be

harmful and in those with excellent collaterals, EVT may be beneficial. We hope to confirm these observations in future pooled analyses of these trial data."

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References:

1. Hill, M., et al. *Association of Imaging Features with Prognosis and Effect of Reperfusion Therapies in Patients with Medium Vessel Occlusion Stroke.* Presentation O179, presented at the European Stroke Organisation Conference; 21 May 2025; Helsinki, Finland.

Extended anticoagulation after cerebral vein thrombosis shows no clear benefit: EXCOA-CVT trial results highlight need for individualised strategies

(Wednesday, 21 May 2025, Helsinki, Finland) At the European Stroke Organisation Conference (ESOC) 2025, the 12-month results from the international EXCOA-CVT trial were presented, addressing the optimal duration of oral anticoagulation after acute cerebral vein thrombosis (CVT). This large, international, multicentre study included both a cluster-randomised trial and a parallel observational cohort, enrolling a total of 1,269 patients from 21 countries. The aim was to compare the efficacy and safety of short-term (3–6 months) versus long-term (12 months) oral anticoagulation for the prevention of recurrent venous thromboembolic events (VTEs) after CVT.

In the randomised trial, 460 patients were assigned to either short- or long-term anticoagulation policies, while 809 patients were included in the observational cohort at centres with pre-established treatment protocols.

At the 12-month follow-up, the risk of recurrent VTE was low in both groups. Among the randomised patients, VTE occurred in 4.0% of those receiving short-term anticoagulation and in 3.1% of those on long-term treatment.

Major bleeding rates were also low and not statistically different between groups, with 1.3% in the short-term and 2.2% in the long-term group. All-cause mortality rates at 12 months were 0.4% in the short-term group and 2.2% in the long-term group.

The observational cohort showed consistent findings, with no significant differences in the rates of VTE recurrence, major bleeding, or regarding the composite outcome of VTE or major bleeding between short- and long-term treatment groups.

Overall, the EXCOA-CVT trial found no clear significant benefit of prolonged oral anticoagulation in patients with CVT. The risk of recurrent VTE in the first year after CVT was lower than anticipated, and numerically higher rates of vascular death were observed in the long-term anticoagulation group.

Professor Diana Aguiar de Sousa, from the EXCOA-CVT coordinating team, commented: “Our study design with both a cluster randomised and a real-world observational approach shows that extending anticoagulation seems to not meaningfully improve outcomes in the first year following CVT. Clinicians should use this information to support individualised decisions, weighing patient-specific risks.”

The authors further acknowledge that the study’s premature termination, the open-label design and potential residual confounding factors may constitute relevant limitations. Further insights are expected from the ongoing 24-month follow-up, which will help clarify longer-term risks and further inform future guidelines.

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References:

1. Aguiar De Sousa, D., et al. *Extending oral anticoagulation treatment after acute cerebral vein thrombosis: 12-month results of the EXCOA-CVT cluster-randomised trial.* Presentation O180, presented at the European Stroke Organisation Conference; 21 May 2025; Helsinki, Finland.

For further information, please refer to the slides here.

Home visits after stroke offer no measurable benefit over in-hospital preparation for discharge: Findings from HOME-Rehab trial presented at ESOC 2025

(Wednesday, 21 May 2025, Helsinki, Finland) New findings presented today at the European Stroke Organisation Conference (ESOC) 2025 challenge long-standing clinical guidelines recommending predischarge occupational therapy home visits for stroke survivors.[1,2] The HOME-Rehab trial, a large-scale, randomised controlled study, found no significant benefit of a home visit program over standardised, in-hospital discharge planning by an occupational therapist in improving patients' participation in daily life activities.

The HOME-Rehab trial enrolled 307 stroke survivors from 10 sites in four Australian states. Participants, all aged 45 years or older and transitioning from inpatient rehabilitation to home, were randomised to receive either an enhanced, occupational therapist-led home visit programme (intervention group) or standardised in-hospital discharge planning programme (control group).

The study's primary outcome – participation measured by the Nottingham Extended Activities of Daily Living (NEADL) scale – showed no statistically or clinically significant difference between groups (mean difference: 0.96, 95% CI: -1.88 to 3.81). Secondary outcomes such as hospital readmission, disability, and function also did not differ meaningfully between groups.

"Despite widespread guideline support, our trial found no evidence that predischarge home visits improve outcomes for stroke survivors returning to independent living," said Professor Natasha A. Lannin, Principal Investigator from Monash University and Alfred Health, Melbourne, Australia. "These results suggest a need to re-evaluate the value of this common practice in stroke rehabilitation."

Importantly, the study employed a robust, blinded-endpoint design and followed an intention-to-treat approach, strengthening the reliability of its findings. Based on the primary outcome, researchers concluded with over 99% frequentist confidence that home visits did not yield a clinically meaningful improvement in participation.

The HOME-Rehab trial addresses a critical gap in stroke recovery research by rigorously testing a previously unproven yet widely implemented intervention. Its results may inform future updates to rehabilitation guidelines and optimise the allocation of healthcare resources in stroke aftercare.

References:

1. Lannin NA, et al. *Effectiveness of predischarge occupational therapy homevisits after stroke: A prospective, blinded endpoint, randomised controlled trial (HOME Rehab).* Presentation O181, presented at the European Stroke Organisation Conference; 21 May 2025; Helsinki, Finland.
2. Lannin, N. A., et al. (2021). Effect of occupational therapy home visit discharge planning on participation after stroke: Protocol for the HOME Rehab trial. *BMJ Open,* 11(7), e044573. https://doi.org/10.1136/bmjopen-2020-044573

About the HOME-Rehab Trial

The HOME-Rehab study is a phase III, prospective, randomised controlled trial supported by the National Health and Medical Research Council of Australia (GNT 1141561) and conducted by a collaborative team across Monash University, Alfred Health, and additional academic and clinical partners.

For further information, please refer to the slides here.

StroCare study highlights challenges and opportunities in long-term post-stroke management

(Wednesday, 21 May 2025, Helsinki, Finland) In the German multicentre interventional StroCare study, a cross-sectoral, coordinated care program for stroke patients did not improve the primary outcome of self-reported physical health at 12 and 24 months after stroke.[1] Benefits in terms of functional outcome and perceived reassurance and engagement, however, indicate potential benefits of structured post-stroke care.

Improving life after stroke remains one of the key challenges in stroke care. Over the past years, several studies have failed to demonstrate benefits of coordinated care programmes for post-stroke care in terms of reducing adverse outcome events or improving health-related quality of life after stroke. Now, new results from the German multicentre StroCare study offer encouraging signs that structured, coordinated post-stroke care may lead to better long-term recovery – even if the primary goal of improving self-reported physical health was not met.

The StroCare study, conducted across three German stroke centres, enrolled 406 patients with ischemic stroke, haemorrhagic stroke, or transient ischemic attack. In a sequentially controlled intervention study, patients were assigned to either standard care (control group) or an innovative, cross-sectoral intervention involving repeated specialist visits, individualised treatment plans, and case management support. The intervention lasted 24 months, with outcome assessments performed at 12 and 24 months. The primary outcome was self-reported physical health, assessed using the PROMIS-10 instrument. Secondary outcomes included additional measures of health-related quality of life, functional outcome assessed by the modified Rankin Scale (mRS), mortality, and recurrent stroke.

Among the 194 patients in the intervention group, mean physical health scores at 12 and 24 months were comparable to those of the 212 patients in the control group (12 months: 42.4 vs. 41.4; estimated mean difference: 0.96, p=0.11; 24 months: 42.0 vs. 41.0, estimated mean difference 0.95, p=0.139). There were also no differences among the treatment groups in mental health scores, mortality, or rates of recurrent stroke, but patients in the intervention group had better functional outcome at both 12 months, with an odds ratio of 0.51 (95% confidence interval 0.34-0.77, p=0.001), and 24 months, with an odds ratio of 0.54 (95% confidence interval 0.35-0.83, p=0.004).

Dr. Rafael Bourry, who presented the results at the European Stroke Organisation Conference (ESOC) 2025, commented on the findings: “Even though the primary endpoint was neutral, these results suggest that structured follow-up and coordinated care can translate into meaningful functional improvements for stroke survivors.”

Prof. Götz Thomalla, the principal investigator of StroCare referred to further insights from qualitative analysis of semi-structured interviews of patients enrolled in the study: “Patients perceived the intervention as reassuring and helpful. They reported an increased feeling of security and control and the possibility to gain information and voice fears and questions.”

In conclusion, although the study did not meet its primary endpoint, StroCare adds valuable evidence to the literature aimed at improving long-term outcomes of stroke. As stroke remains a leading cause of disability worldwide, the results underscore the critical

importance of further research into the development and implementation of post-stroke care models.

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References:

1. Bourry R, et al. *Cross-sectoral, coordinated treatment of stroke patients with patient-oriented outcome measurement (StroCare) – Final results of a multi-center sequentially controlled interventional study*. Presentation O182, presented at the European Stroke Organisation Conference; 21 May 2025; Helsinki, Finland.

New evidence on coordinated long-term support after stroke: The LAST-long trial

(Wednesday, 21 May 2025, Helsinki, Finland) A multimodal, individualised long-term follow-up program involving monthly meetings with a stroke coordinator did not reduce functional decline after stroke compared to standard care in the LAST-long trial, presented today at the European Stroke Organisation Conference (ESOC) 2025.[1] While the primary and secondary outcomes showed no statistically significant differences, the study demonstrated that a structured long-term support program after stroke is feasible and implementable across different clinical settings.

Stroke survivors face a high risk of functional decline even after completing initial rehabilitation. The Stroke Action Plan for Europe emphasises the need for coordinated long-term care, but robust evidence for effective follow-up strategies has been lacking. The LAST-long trial tested whether regular contact with a community-based stroke coordinator could improve long-term outcomes by addressing physical, cognitive, and psychosocial risk factors in an individualised manner.

LAST-long was a pragmatic, randomised, controlled multi-centre trial conducted between March 2019 and September 2024. Patients were enrolled three months post-stroke and followed for 18 months. The intervention group received regular meetings with a stroke coordinator every month, during which individual risk profiles were assessed using a multidomain checklist, and personalised goals and action points were defined. Outcomes were assessed at 6, 12, and 18 months. The primary endpoint was functional status measured by the modified Rankin Scale (mRS); secondary endpoints included Barthel Index, Nottingham I-ADL, Montreal Cognitive Assessment, Trail Making Tests A and B, and the Short Physical Performance Battery.

A total of 301 participants (48% women; mean age 71.3 years) with predominantly mild stroke (mean NIHSS 3.4; mean mRS at inclusion 1.6) were randomised to intervention (n=152) or standard care (n=149). At 18 months, the estimated difference in mRS was 0.03 (95% CI -0.16 to 0.22; p=0.789), with no significant differences in secondary outcomes.

Commenting on the findings, Torunn Askim, who presented the results at ESOC 2025, stated: “Although the intervention did not significantly impact clinical endpoints, it confirms that a structured, coordinated, and personalised long-term follow-up after stroke is feasible in different healthcare settings. This approach was well accepted and may be especially relevant for patients with more severe strokes or other chronic conditions.”

In conclusion, the LAST-long trial provides important feasibility data for the implementation of individualised, coordinator-led long-term support after stroke and supports ongoing discussions about structured follow-up in stroke care pathways.

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References:

1. Askim, T. et al. *A multimodal individualized long-term intervention to prevent functional decline after stroke. The LAST-long trial.* Presentation O183, presented at the European Stroke Organisation Conference; 21 May 2025; Helsinki, Finland.

For further information, please refer to the slides here.