Clinical reviews

Our panel of GPs review recent research papers in their specialist areas that may influence the way you practise

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Cerebrovascular disease

Non-consensus TIA raises early and long-term risk of stroke

Patients with non-consensus transient ischaemic attack (TIA) have a raised seven-day risk of stroke, the Oxford Vascular Study (OXVASC) has found. The ten-year risk of all major vascular events was similar for non-consensus and classic TIAs.

The OXVASC study is a prospective population-based study of all cerebrovascular, cardiovascular and peripheral vascular events in a population of 92,728 people registered with nine practices in Oxfordshire, UK. As part of the study, all participants who sought medical attention in primary or secondary care with sudden onset neurological symptoms, over a 16-year period from 2002 to 2018, were investigated.

Patients were classified at baseline with minor ischaemic stroke, classic TIA, or non-consensus TIA, and treated according to secondary prevention guidelines. Risks of stroke (seven-day, 90-day, and ten-year risks) and risks of all major vascular events (from the time of the first event, and from the time of seeking medical attention) were established by follow-up visits and were compared with the risk expected from age- and sex-specific stroke incidence in the underlying study population. Patients were followed up for a median 5·2 years.

A total of 1,287 patients were identified with minor ischaemic stroke, 1,021 with classic TIA and 570 with non-consensus TIA. Patients with non-consensus TIA were younger than those with classic TIA, mean age 68·5 vs 72·9 years; P < 0.0001, and had fewer vascular risk factors.

Of the 570 cases of non-consensus TIA:
- 210 reported isolated vertigo or isolated ataxia
- 157 isolated sensory loss
- 99 bilateral decreased vision without positive symptoms
- 57 isolated dysarthria
- 47 isolated diplopia

The 90-day stroke risk from time of index event after a non-consensus TIA was similar to that after a classic TIA: 10·6% (95% CI: 7·8-12·9%) vs 11·6% (95% CI: 9·6-13·6%); hazard ratio (HR) 0·87 (95% CI: 0·64-1·19; P = 0·43).

Patients with non-consensus TIA were less likely to seek medical attention on the day of the event than those with classic TIA; 336 of 570 (59%) vs 768 of 1,021 (75%); odds ratio (OR) 0·47 (95% CI: 0·38-0·59; P < 0·0001). They were also more likely to have recurrent strokes before seeking attention; 45 of 570 (8%) vs 47 of 1,021 (5%); OR 1·77 (95% CI: 1·16-2·71; P = 0·007).

After excluding recurrent strokes, seven-day stroke risk after seeking medical attention for non-consensus TIA was still much higher than the expected background risk, particularly if the patient sought attention on the day of the index event. Ten-year risk of all major vascular events was similar for non-consensus and classic TIAs at 27·1% (95% CI: 22·8-31·4%) vs 30·9% (95% CI: 27·2-33·7%); P = 0·12.

The baseline prevalence of atrial fibrillation, patent foramen ovale, and arterial stenoses were also similar for non-consensus TIA and classic TIA, although stenoses in the posterior circulation were more frequent with non-consensus TIA.

Symptoms of classic TIA such as motor weakness, dysphasia, hemianopia and monocular visual loss are often easy to detect.

However, monosymptomatic events in non-consensus TIA, with sudden onset, non-progressive, focal negative symptoms such as isolated diplopia, dysarthria, vertigo, ataxia, sensory loss, and bilateral visual disturbance are often more difficult to detect. There can be significant variation in the investigation and treatment of such patients.

Up to 25% of strokes are preceded by a TIA and prompt treatment with antiplatelet agents can substantially reduce the risk of recurrent stroke.

The study authors state: 'Our findings have several implications for clinical practice. First, they should help to improve reproducibility of clinical diagnoses of TIA and inform guidelines on diagnostic criteria. Second, patients with non-consensus TIAs should not be falsely reassured about the nature of their symptoms or about a benign prognosis but should be treated similarly to patients with classic TIA.'

They add: 'In conclusion, our findings show that several common, sudden onset, transient, isolated, negative, focal neurological symptoms (i.e. non-consensus TIAs) are associated with high short-term and long-term risks of stroke and other acute vascular events, have similar rates of vascular pathological findings on baseline investigation to classic TIAs, and should be treated in the same way as are classic TIAs.'

DR PETER SAVILL

Tuna MA, Rothwell PM on behalf of the Oxford Vascular Study. Diagnosis of non-consensus transient ischaemic attacks with focal, negative, and non-progressive symptoms: population-based validation by investigation and prognosis. *Lancet* 2021;397(10277):902-12