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In reply to ''Mechanical thrombectomy in acute ischemic stroke, knowing our results''☆

En respuesta a «Trombectomía mecánica en el ictus isquémico agudo, conociendo nuestros resultados»

Dear Editor,

We wish to thank the authors for their interest and comments on our paper ''Results and functional outcomes of acute ischemic stroke patients who underwent mechanical thrombectomy'' (''*Resultados y evolución funcional de pacientes críticos con ictus isquémico sometidos a trombectomía mecánica*'' in Spanish), and would like to make a few comments too:

We completely share the authors' view in their letter on the importance of intensive care units (ICU) and intensivists in the good management of neuro-critically ill patients. As intensivists we should always keep a proactive attitude during the hospital admission of patients with strokes. And not only with the most critically ill patients who require the full support ICUs can provide, but also with patients who are not so critical, in whose referring hospitals there are no stroke units, but could achieve better functional outcomes with good management of the neuro-physiological variables. Taking into consideration that cerebrovascular disease is one of the leading causes of mortality and disability, its management should be multidisciplinary (neurology, interventional neuro-radiology and neurosurgery), which poses an interesting challenge for healthcare today.

There is no doubt about it. The management of ischemic strokes has evolved during the last few years and so has our team from early IV-only fibrinolysis to intra-arterial fibrinolysis,[1] endovascular treatment (EVT) and combined therapies. The comment that the actual indication for EVT is up to 24 h after symptom onset is less strict than the indication of our series is right too. We have been expanding the window of opportunity to implement EVT, but we shouldn't forget that our study patients date back to 2012–2014 and were under more restrictive criteria on the implementation of EVT.

It is also true that the low rate of patients with systemic fibrinolysis of our series is actually lower than that of other studies published, but we should remember that it was a cohort biased towards more clinical severity and, therefore, more proximal arterial occlusions. We have been prescribing alteplase to patients with acute strokes for nearly 20 years and we know that its effects are scarce[2] and that the use of mechanical thrombectomy in these patients has better outcomes. In our hospital, interventional neuro-radiologists on call have a very fast response. That is why in this subgroup of patients we normally omit the previous step of IV fibrinolysis in the light of the immediate availability of this option and how time-consuming it is in patients who won't probably have an effective response. On the other hand, the superiority of combined therapies has been put into question by some recent studies.[3,4]

We wish to congratulate the authors for their experience and good outcomes. Also, we agree on the need to conduct multicenter studies to know more on the outcomes of endovascular treatment. Our hospital will soon participate in the international multicenter randomized trial SWIFT DIRECT[5] that will be comparing the clinical outcomes between two therapeutic strategies: EVT and EVT plus IV fibrinolysis.

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