Sir,
We thank Vidale and Agostoni (2014) for their very thoughtful suggestions as to how one might select patients that derive benefit from thrombolysis, especially in the grey areas. In the absence of randomized evidence based on metrics, patient selection does still rely very much on the art and not the science of clinical medicine.

‘Practice and thought might gradually forge many an art.’ Virgil (70–19 BC).

At best, what has been suggested is empirically strong but experimentally weak and above all, not evidence-based. We agree that it is not an exhaustive catalogue of potential indications and contraindications to thrombolysis. As further results from trials and case reports accumulate, the inclusion and exclusion criteria can be further honed to optimize selection of the patients most likely to benefit.

Isolated deficits suggestive of posterior circulation insults may be relative contraindications to intravenous thrombolysis, but if they are indicative of serious circulatory compromise, as determined by imaging, targeted intra-arterial interventions may be more appropriate.

We acknowledged in the paper that radiological recanalization does not necessarily correlate with clinical recovery, although it can be useful as an outcome measure in clinical trials. The evidence regarding the prognostic value of statin use as an indication or contraindication for thrombolysis is still conflicting (Meseguer et al., 2012; Rocco et al., 2012). The lipid profile is not directly addressed under the current guidelines, but these guidelines may be revised once sufficient evidence resolves this conflict.

References