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# Letters to the Editor

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## A Prospective Study Using the ABCD2 Score in Screening for Minor Stroke or Transient Ischaemic Attack in Referrals to a Fast Track Clinic

To the Editor:

We have read the impressive article recently published by Quinn et al<sup>1</sup> regarding the prediction of noncerebrovascular diagnosis in the outpatient clinic using ABCD2 scores. The authors have demonstrated that there was a positive association between increasing ABCD2 score and cerebrovascular diagnosis. Although the ABCD2 score has been developed as a prognostic tool and to aid risk stratification after a transient ischaemic attack (TIA),<sup>2</sup> it has been suggested that part of its value is diagnostic. This was a retrospective study with a large number of patients. The authors have suggested that prospective studies examining diagnosis and outcomes of patients triaged with ABCD2 score could help better define the use of the scale in clinical practice.

We performed a prospective audit of 75 consecutive new patients attending the weekly fast track TIA clinic in the Glasgow Royal Infirmary. All had their ABCD2 scores checked and calculated on first clinic visit. A final diagnosis of stroke or TIA was made on clinical grounds (supported by neuroimaging) by independent physicians. The mean age of the patients was 62.1 years (standard deviation 12.3) and there were 30 males. Referrals were from General Practitioners (n=56), Emergency Department (n=11) and other sources (n=8); Forty three of 75 patients (57.3%) were confirmed to have a diagnosis of stroke or TIA. The median ABCD2 score for diagnosis of stroke or TIA was 4 and for noncerebrovascular diagnosis was 2. The area under the receiver operating characteristic curve for the ABCD2 score for diagnosis of a cerebrovascular event was 0.80 (95% confidence interval=0.69 to 0.91). The sensitivity of ABCD2 score of greater than 2 for stroke or TIA diagnosis was 88% with an odds ratio of 16.7 (confidence interval=5.1 to 55.2).

Our fast track TIA clinic has a high number of referral rate for noncerebrovascular pathologies. Approximately 43% (n=32) of our patients had a noncerebrovascular diagnosis. This has a

knock on effect on the waiting time of those patients who have a true stroke or TIA diagnosis. There is evidence that minimizing delay to specialist assessment and commencement of secondary prevention is the key to prevent further stroke or TIA.<sup>3</sup> Patients with high ABCD2 scores could be targeted for rapid assessment and treatment if there are limited clinical resources. We are increasingly using ABCD2 score to triage new referrals as referenced in the article.<sup>4</sup> However, it should be noted with caution that 1 in 5 of our patients with low ABCD2 score (0–2) had a final diagnosis of stroke or TIA and a third of our patients with ABCD2 score of greater than 2 had a noncerebrovascular diagnosis. We agree with the authors that these results need validation in larger prospective studies and also in different populations.

### Disclosures

None.

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