Question 2 evidence tables

Question 2: Does the use of risk stratified prediction tools (using clinical parameters) in patients with suspected TIA compared to not using risk stratified prediction tools accurately identify patients who are at high early stroke risk?

NB Any discrepancies between reviewers in evidence quality and comment were discussed at the corresponding evidence review meeting

AUC = area under curve, TIA = transient ischaemic attack, SR = systematic review, MA = meta-analysis, RCT = randomised controlled trial, IPDMA = individual patient data meta-analysis, MDT = multidisciplinary team, PICO = patient/population, intervention, comparison and outcomes, OR = odds ratio, CI = confidence interval, QoL = quality of life, ADL = activities of daily living, OR = odds ratio, RR = relative risk, aOR = adjusted odds ratio, cOR = crude odds ratio, CI = confidence interval, RoB = risk of bias, I2 = heterogeneity statistic.

Ref ID	Source	Setting, design and subjects	Intervention	Outcomes	Results	Evidence quality (SIGN checklist score) and comment
15	F. Ildstad et al. (2021). ABCD3-I and ABCD2 Scores in a TIA Population with Low Stroke Risk. *Stroke Research and Treatment,* 2021: 8845898	Prospective multicentre study in Norway examining the predictive value of two scoring systems (ABCD3-I and ABCD2 tool on recurrent stroke in the short and long term for patients with TIA diagnosis. Outcome measured by telephone assessment.	Two tools ABCD2 ABCD3-I	Area under curve (AUC) for both scoring systems with comparison between each tool for each time point (1 week, 3 months and 1 year).	591 in initial sample but with exclusions resulted in 305 patients with complete data for analysis Data between included and exclude patients varied in case mix AUC for ABCD2 0.55 (0.24 to 0.86) at 1 week, 0.55 (0.42 to 0.68) at 3 months and 0.63 (0.5 to 0.76) AUC for ABCD3-I 0.72 (0.54 to 0.89) at 1 week, 0.66 (0.53 to 0.80) at 3 months and .68 (0.56 to 0.79) at 1 year	Low discriminatory value for both ABCD2 and ABCD3-1 from TIA score judged on AUC scores and wide CI.

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					Only significant difference between AUC using both tools was at week 1.	
15	F. Ildstad et al. (2021). ABCD3-I and ABCD2 Scores in a TIA Population with Low Stroke Risk. *Stroke Research and Treatment,* 2021: 8845898	Nested, retrospective study in a prospective TIA cohort, MIDNOR TIA. They included 305 patients and excluded 272.	Compared ABCD2 and ABCD3-I.	They compared the area under the curve for each cohort against recurrent stroke.	No useful difference.	This is retrospective. Any potential benefit in ABCD3-I would need the be evaluated in a proper prospective study.
	P. Amarenco et al, 2012. Patients with transient ischemic attack with ABCD2 <4 can have similar 90-day stroke risk as patients with transient ischemic attack with ABCD2 ≥4. Stroke. 43:3. 863-865.	SOS TIA registry (observational study, clinic population in Paris), evaluating patients with a diagnosis of TIA from 2003 to 2008 with 90 day stroke risk stratified according to ABCD2 tool.	Patients were stratified into 3 group according to a risk stratified tool using the ABCD2 score 1.ABCD2 ≥4 2.ABCD2 < 4 (criteria for emergency intervention based on carotid disease or cardiac embolic aetiology ABCD2 < 4 with no criteria for emergency treatment.	90 day stroke risk for all patients with TIA and patients (seen within 24 hours)	2398 patients evaluated 42% ABCD2 ≥4 28% ABCD2 ≥4 (criteria for emergency treatment) 18% ABCD <4 (criteria for emergency treatment 90 day outcomes [stroke] Compared to patients with ABCD2 ≥4 (3.4%) Patients with ABCD2 < 4 with no criteria for emergency treatment (0.4%), significant P<0.0001 ABCD2 < 4 (criteria for emergency intervention) (3.9%) P=0.82 Higher rates of stroke risk at 90 days with patients with low ABCD2 scores (criteria for emergency treatment) compared with higher scores (ABCD2≥4) Similar results in sensitivity analysis (<24 hrs)	Observational study over 5 years Large numbers Single site experience only
	P. Amarenco et al, 2012. Patients with transient ischemic attack with ABCD2 <4	Observational data from a prospective registry of 2398 patients evaluated for TIA over five years between 2003 and 2008. Patients were unusually	The intervention was hospital evaluation (or admission, not always clear which) and emergency	Detection of angiographic or echocardiographic abnormalities warranting 'emergency treatment'	The researchers observed that if they had allocated priority of investigations purely by ABCD2 score, then similar proportions of	Reasonable quality observational cohort data, although some key data not reported at least in this paper. Non-randomised (as was the

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	can have similar 90-day stroke risk as patients with transient ischemic attack with ABCD2 ≥4. Stroke. 43:3. 863-865.	young (mean age 64 years) and a higher proportion were smokers than would be typical in the UK/Ireland (21%). No data given in this report as to what proportion were anti-platelet naïve or the extent of risk factor intervention in high-risk or low-risk patients.	investigations for high-risk vascular features, including CT cerebral angiography for intracranial stenosis, and echocardiography, with subsequent risk factor interventions (antiplatelets, statins, antihypertensives).	(not otherwise specified); 90-day stroke rate and death.	angiographic and echocardiographic abnormalities would have been detected between those with ABCD2 below 4 (19%) and 4 or above (22%). There was no difference in stroke rate between those with ABCD2 above 4 (with or without angio/echo abnormalities) and those below 4 with angio/echo abnormalities.	original ABCD and ABCD2 evidence). Vulnerable to various biases, including a lack of data in this report regarding risk in patients not diagnosed with TIA (71% of the registry were ultimately diagnosed with TIA), and confirmation bias if investigations were completed before the diagnosis of TIA was made.