

**ANNEXE 2 : OUTILS DE DÉPISTAGE PRÉHOSPITALIER DE L'AVC**
**Tableau 2A : Outils normalisés de dépistage préhospitalier de l'AVC en phase aiguë**

Assessment Tool Author	Items/Scoring	Sample	Reference Standard	Results (validity & reliability)
<b>Cincinnati Pre-Hospital Stroke Scale (CPSS)</b>  <b>Kothari et al. 1999</b>	3 items : presence/absence of facial palsy; unilateral arm weakness; and speech impairment. Items simplified versions from the NIHSS.  Abnormality demonstrated on one or more items is indicative of suspected stroke	171 patients with suspected stroke recruited through ED and inpatient neurology units. Mean age was 57.8 years, 58% male.  Stroke/TIA prevalence: 49 (28.7%)  Patients were assessed by 24 prehospital care providers (17 paramedics and 7 EMTs) and 2 NIH certified physicians, resulting in 860 total assessments.	Final discharge diagnosis of stroke	<b>Validity</b> Physicians: Sensitivity 1 abnormality 66%, 95% CI 49-80% 2 abnormalities 26%, 95% CI 14-43 % 3 abnormalities 11%, 95% CI 3-26%  Physicians: Specificity 1 abnormality 87%, 95% CI 80-92% 2 abnormalities 95%, 95% CI 90-98% 3 abnormalities 99%, 95% CI 95-100%  Prehospital care workers: Sensitivity 1 abnormality 59%, 95% CI 51-67% 2 abnormalities 27%, 95% CI 21-35% 3 abnormalities 13%, 95% CI 8-20%  Prehospital care workers: Specificity 1 abnormality 88%, 95% CI 86-91% 2 abnormalities 96%, 95% CI 94-97% 3 abnormalities 98%, 95% CI 96-99%  The validity of this scale has been evaluated further, by both the scale developers and independent researchers.  <b>Reliability</b> ICC for total scores among all prehospital workers was 0.92, 95% CI 0.89-0.93  ICC for total scores between prehospital workers and physicians was 0.92, 95% CI 0.89-0.93
<b>Face Arm Speech Test (FAST)</b>	3 items derived from the CPSS: facial palsy, arm weakness, speech disturbance. Assessment of speech is not dependent on the repetition	487 patients admitted by ambulance, primary care physicians and ED referrals with suspected	WHO criteria	<b>Validity</b> Sensitivity: Diagnostic sensitivity of FAST associated with paramedic use was estimated to be 79%. PPV (arrival by ambulance): 78%, 95% CI 72-84%

Assessment Tool Author	Items/Scoring	Sample	Reference Standard	Results (validity & reliability)
<b>Harbinson et al 2003</b>	<p>of a stock phrase, as per CPSS, but assessed during by EMS during normal conversation with the patient.</p> <p>Abnormality demonstrated on one or more items is indicative of suspected stroke</p>	<p>stroke. Mean age was 72 years, 52% were female</p> <p>Stroke/TIA prevalence: 356 (73.1%).</p> <p>FAST was completed by paramedics over a 6-month period</p>		<p>The validity of this scale has been evaluated further, by independent researchers.</p> <p><b>Reliability</b> Not assessed in this publication, but has been subsequently <b>evaluated</b>.</p>
<p><b>Los Angeles Prehospital Stroke Screen (LAPSS)</b></p> <p><b>Kidwell et al. 2000 (Prospective validation study)</b></p>	<p>6 items : 4 screening/history items (age&gt;45 years, no history of seizures, symptom duration &lt;24 hours, ambulation status at baseline not bedridden or wheelchair bound), blood glucose (between 60 and 400) level, a clinical assessment (of 3 items to identify obvious asymmetry: facial palsy, grip, arm strength).</p> <p>If the patient has positive criteria, a blood glucose level within the specified range and unilateral weakness on the clinical exam items, they are a positive screen for stroke.</p>	<p>206 patients (of 1,298 total runs) with neurological symptoms, who were noncomatose, with nontraumatic cause, who had a LAPSS screen conducted. Mean age was 67 years, 52% were male.</p> <p>Stroke/TIA prevalence: 36 (17.5%)</p> <p>LAPSS was completed by 18 paramedics over a 7-month period.</p>	Hospitalized patients with final diagnosis of stroke	<p><b>Validity</b> Sensitivity: 91%, 95% CI 76-98% Specificity: 97%, 95% CI 93-99% PPV: 86%, 95% CI 70-95% NPV: 98%, 95% CI 95-99% Accuracy: 96%, 95% CI 92-98% + LR : 31, 95% CI 16-147 - LR : 0.09, 95% CI 0-0.21</p> <p>This validity of this scale has been evaluated further, by both the scale developers and independent researchers.</p> <p><b>Reliability</b> Not assessed</p>
<p><b>Ontario Prehospital Stroke Screen (OPSS)</b></p> <p><b>Chenkin et al. 2009</b></p>	<p>At least one of the following symptoms must be present: unilateral leg/arm weakness or drift; slurred speech or muteness; unilateral facial droop), and the patient can be transported to arrive at a stroke centre within 3.5 hours of symptom onset.</p>	<p>325 patients transported to a stroke centre, who had been screened as positive by paramedics using the OPSS. Patients were identified through a National Stroke Registry. Mean age was 73.7 years, 47.4% were male.</p> <p>Stroke prevalence: 187 (58%)</p> <p>An unknown number of</p>	Final discharge diagnosis	<p><b>Validity</b> Since all patients included in the sample, were screened as positive, sensitivity and specificity could not be calculated.</p> <p>PPV for acute stroke (1,2, or 3 positive signs): 89.5%, 95% CI 85.7-92.7% No additional validation studies have been conducted on this scale.</p> <p><b>Reliability</b> Not assessed</p>

Assessment Tool Author	Items/Scoring	Sample	Reference Standard	Results (validity & reliability)
<b>Melbourne Ambulance Stroke Screen (MASS)</b>  <b>Bray et al. 2005</b>	Combination of items from CPSS and LAPSS.  The presence of any physical assessment item + a response of "yes" to all history items indicates a positive screen	EMS workers conducted OPSS over a one-year period  100 MASS assessments were conducted on patients with suspected stroke (total of 5,957 paramedic calls during the study period)  Stroke/TIA prevalence: 73 (73%)  18 paramedics conducted MASS assessments over a one-year period	Final discharge diagnosis	<b>Validity</b> Sensitivity: 90%, 95% CI 81-96% Specificity: 74%, 95% CI 53-88% PPV: 90%, 95% CI 81-96% NPV : 745, 95% CI 53-88% +LR : 3.49, 95% CI 1.83-6.63 -LR : 0.13, 95% CI 0.06-0.27 Accuracy: 86%  (Validity of LAPSS and CPSS was also assessed. CPSS had highest sensitivity at 95%, LAPSS had highest specificity at 85%)  This validity of this scale has been evaluated further, by the scale developers.  <b>Reliability</b> Not assessed
<b>Medic Prehospital Assessment for Code Stroke (MedPACS)</b>  <b>Studneck et al. 2013</b>	The scale was developed by combining the strongest elements of CPSS and LAPSS and included: eligibility criteria-no prior history of seizure; onset of symptoms ≤25 hours, blood glucose 60-400 mg/mL and a physical exam (facial droop, arm/leg weakness; speech difficulty; and gaze preference)  The presence of any physical assessment item + a response of "yes" to at least one eligibility criterion item indicates a positive screen	416 patients with suspected stroke, transported to one of 7 hospitals. Mean age was 66.8 years, 45.7% were male.  Stroke prevalence: 186 (44.7%)  EMS reports and stroke GWTG-S registries were reviewed over a 6-month period	Final discharge diagnosis	<b>Validity</b> Sensitivity: 74.2%, 95% CI 67.2-80.2% Specificity: 732.6%, 95% CI 26.7-39.1% PPV: 47.1%, 95% CI 41.3-53.0% NPV : 61.0, 95% CI 51.8-69.6% + LR : 1.10, 95% CI 0.973-1.24 - LR : 0.791, 95% CI 0.582-1.07 The validity of the CPSS was also assessed (SN : 79%, SP : 24%)  No additional validation studies have been conducted on this scale.  <b>Reliability</b> Not assessed
<b>Recognition of Stroke in the Emergency Room Scale (ROSIER)</b>	7-items : 2 clinical history items (loss of consciousness, convulsive fits/syncope) and 5 neurological signs of stroke (facial palsy/weakness, arm weakness,	160 consecutive patients with suspected stroke presenting to the Emergency Department (ED)	Final diagnosis made by stroke consultant after review of symptoms and	<b>Validity</b> (Prospective validation study) Sensitivity: 93%, 95% CI 89-97% Specificity: 83%, 95% CI 77-89% PPV: 90%, 95% CI 85-98% NPV: 88%, 95% CI 83-93%

Assessment Tool Author	Items/Scoring	Sample	Reference Standard	Results (validity & reliability)
<b>Nor et al. 2005</b>	<p>leg weakness, speech disturbance and visual field defect).</p> <p>A -1 is awarded for each clinical history item present and a +1 for each neurological sign. Total scores range from -2 to +5. A score &gt;0 is associated with possible stroke.</p>	<p>Stroke/TIA prevalence: 101 (63.1%)</p> <p>Assessments were conducted by ED physicians during a one-year period</p>	imaging findings	<p>(Validity of LAPSS, FAST and CPSS was also assessed. CPSS had highest sensitivity at 85%, LAPSS had highest specificity at 85%).</p> <p>The validity of this scale has been evaluated further by independent researchers.</p> <p><b>Reliability</b> Not assessed</p>

PPV: Positive Predictive Value; NPV : Negative Predictive Value; LR Likelihood Ratio

**Tableau 2B : Autres outils de dépistage : Échelle de coma de Glasgow**

Assessment Tool	Number and description of Items	Time to Administer	Reliability/validity	Interpretation of Scores	Sensitivity and Specificity	Training Required
<b>Glasgow Coma Scale (GCS)</b> <b>Teasdale &amp; Jennett 1974<sup>1</sup></b>	15 items in 3 categories: motor response (6 items), verbal response (5 items), and eye opening (4 items). Points are awarded for the best response in each category. Categories are summed to provide a total score.	Approximately 1 minute.	<p><b>Interobserver reliability:</b> Scale authors reported low rates of disagreement, but noted variations in motor responses based on stimulus used <sup>2</sup>. Reported agreements ranged 0.48 (verbal) to 0.72 (eye opening)<sup>3</sup> and from 0.39 – 0.79.<sup>4</sup> Percentage agreements have been reported as 90% overall, and as ranging from 83.8% (eye opening, right) to 98.7% (best motor response – left).<sup>5</sup> In addition, similar rates of between observer agreement have been reported in groups of experienced nurses (98.6% - 100%), newly graduated nurses (94.3%-96.2%) and student nurses (77.3% - 100%).<sup>6</sup></p> <p><b>Construct Validity:</b> In review of GCS, evidence supports</p>	GCS scores range from 3 – 15, where 3 represents total unresponsiveness and 15 represents alert and fully responsive. Scores may be divided into categories by severity: 13-15 = mild; 9-12=moderate and ≤8 represents severe injury. <sup>21</sup>	Not reported	Yes.

Assessment Tool	Number and description of Items	Time to Administer	Reliability/validity	Interpretation of Scores	Sensitivity and Specificity	Training Required
			association between extent of brain damage and depth of coma as assessed on GCS. GCS scores significantly associated with length of coma ( $p < 0.0001$ ). <sup>7</sup> <b>Predictive Validity:</b> GCS score is a significant predictor of death following stroke <sup>8,9</sup> or traumatic brain injury (modified by age and mechanism of injury) <sup>10</sup> , though eye-opening may be less strongly associated than either the motor or verbal score components <sup>11</sup> . GCS scores are also predictive of survival (AUC=0.89), though eye-opening may not add to predictive accuracy <sup>12</sup> . GCS scores have been demonstrated to be predictive of Glasgow Outcome scores at 6 months to 1 year post injury <sup>7,13-16</sup> , Disability Rating Scale scores at discharge <sup>17</sup> and at 6 months <sup>18</sup> , FIM scores at discharge <sup>17,19</sup> and employment status at one-year <sup>20</sup> .			

**Tableau 2C : Échelles de gravité de l'AVC en milieu préhospitalier**

Assessment Tool Author	Items/Scoring	Sample	Reference Standard	Results
<b>Field Assessment Stroke Triage for Emergency Destination (FAST-ED)</b>	6-items, 5 based on NIHSS 1. Facial palsy (0-1) 2. Arm weakness (0-2) 3. Speech changes (0-2) 4. Eye deviation (0-2)	741 consecutive patients enrolled in the STOPStroke study, who were admitted to 2 university-based hospitals with unilateral,	CTA	A cut-point of $\geq 4$ on FAST-ED had best performance  Sensitivity: 0.61 Specificity: 0.83 PPV: 0.72 NPV: 0.82

Assessment Tool Author	Items/Scoring	Sample	Reference Standard	Results
<b>Lima et al. 2016</b>	5. Denial/neglect (0-2) 6. Time (documentation for decision making) not scored  Total possible score : 9	complete occlusion of the M1 and M2 segments of the MCA or basilar artery, with onset of symptoms within 24 hours.  Prevalence of LVO: 240 (33%)		Accuracy: 0.79 AUC:0.813  Performance of FAST-ED was also compared with NIHSS, RACE and CPSS scale
<b>FAST-VAN</b> <b>Wasyliw et al. 2018</b>	FAST + VAN (see description below)	172 consecutive stroke patients recruited from a single centre.	CTA	80 patients were positive for LVO, 58 were negative, based on CTA.  PPV was 58%
<b>Vision, Aphasia, and Neglect (VAN)</b> <b>Teleb et al. 2016</b>	Patients are asked to raise both arms up and hold them up for 10 s. If the patient demonstrates any level of drift, weakness or paralysis, the assessment continues. Otherwise, patient is VAN -ve and screen ends.  <b>Items</b> Visual disturbances: field cut, double vision, new-onset blindness (present/absent)  Aphasia: Expressive, receptive, mixed (present/absent)  Neglect: Forced gaze, unable to feel both sides at same time or doesn't recognize arm, ignoring one side (present/absent)  Scoring : None If weakness present + ≥1 positive finding =VAN +ve	62 acute stroke codes at a single facility  Prevalence of LVO: 19 (30.6%)	CTA	Performance of VAN was also compared with NIHSS ≥6  For VAN +ve patients Sensitivity: 1.00 Specificity: 0.90 PPV: 0.74 NPV: 1.00 Accuracy: 0.92  NIHSS≥6 Sensitivity: 1.00 Specificity: 0.79 PPV: 0.58 NPV: 1.00 Accuracy: 0.84
<b>Prehospital Acute Stroke Severity Scale (PASS)</b>	3 NIHSS items :  1. Incorrect month and/or age? (Level of consciousness (NIHSS item >0) 1 point	3,127 patients included in the Danish Stroke Registry (2010-2015) who were treated with t-PA. 2/3 of sample was	CTA/MRA	A cut-point of ≥2 on the PASS had the best predictive value:  Using the Derivation cohort Sensitivity 0.66, 95% CI 0.62-0.66

Assessment Tool Author	Items/Scoring	Sample	Reference Standard	Results
<b>Hastrup et al. 2016</b>	2. Gaze palsy and/or deviation (NIHSS item gaze>0) 1 point 3. Arm weakness (NIHSS item arm weakness >0) 1 point  Total possible score : 3	used for scale development and 1/3 for validation  Prevalence of LVO: 35%		Specificity: 0.83, 95% CI 0.81-0.85 AUC: 0.74, 95% CI 0.72-0.76 OR=9.22, 95% CI 7.5-11.40 PPV/NPV : 0.68/0.81 +LR/-LR : 3.84/0.42  The values were similar when using the validation cohort
<b>The Los Angeles Motor Scale (LAMS)</b>  <b>Nazliel et al. 2008</b>	3 items : 1. Facial droop (absent=0, present=1) 2. Arm drift (absent=0, drifts down=1, falls rapidly=2) 3. Grip strength (normal=0, weak=1, no grip=2)  Total possible score 5	119 patients included in a clinical trials registry at a stroke centre from 1996-2003, and patients included in the Get with the Guidelines Registry in 2005. Patients were included if they were last known well within 12 hours of presentation to the ED and had a final diagnosis of ischemic stroke in the anterior circulation  Prevalence of LVO: 74 (62%)	MRA/CTA, or catheter angiography	AUC: 0.854  A cut point of $\geq 4$ had the best predictive value for detecting LVO Sensitivity: 81% Specificity: 89% Accuracy: 85% +LR : 7.36 -LR : 0.21
<b>Cincinnati Prehospital Stroke Severity Scale (CPSSS)</b>  <b>Katz et al. 2015</b>	3 NIHSS items: 1. Conjugate gaze deviation ( $\geq 1$ on NIHSS item for gaze) 2 points 2. Incorrectly answers to at least 1 of 2 LOC questions (NIHSS age or current month) and does not follow at least 1 of 2 commands (close eyes, open and close hand) $\geq 1$ NIHSS items LOC 1b and 1c. 1 point 3. Cannot hold arm (left, right or both) up for 10 seconds ( $\geq 2$ NIHSS motor arm). 1 point  Total possible score 4	Derivation cohort-624 patients with mild to severe stroke from 2 NINDS t-PA trials. Validation cohort-650 patients from the IMS-III trial  Prevalence of LVO: 34% (validation cohort)	CTA	<b>Severe stroke</b> AUC: 0.89 A cut point of $\geq 2$ had the best predictive value for severe stroke Using the derivation cohort Sensitivity: 89% Specificity: 73% + LR/-LR : 3.30/0.15  Using the validation cohort: Sensitivity: 92% Specificity: 51% + LR/-LR : 1.89/0.1

Assessment Tool Author	Items/Scoring	Sample	Reference Standard	Results
<b>Pérez de la Ossa et al. 2014</b>  <b>Rapid Arterial Occlusion Evaluation Scale (RACE)</b>	5 NIHSS items : 1. Facial palsy (absent=0, mild=1, mod/severe=2) 2. Arm motor function (normal/mild=0, moderate=1, severe=2) 3. Leg motor function (normal/mild=0, moderate=1, severe=2) 4. Head and gaze deviation (absent=0, present=1) 5. Aphasia (R hemiparesis: performs both tasks correctly=0, performs 1 task correctly=1, performs neither tasks=2); Agnosia (Left hemiparesis: patient recognizes arm/impairment=0, does not recognize arm or impairment=1, does not recognize arm and impairment=2)	Derivation cohort-654 patients with acute stroke or stroke mimic for whom a stroke code had been activated by EMS or a community hospital. Validation cohort-357 patients transferred by EMS to a stroke centre  Prevalence of LVO: 178 patients (27%) had a LVO in derivation cohort vs. 76 (21.3%) in the validation cohort.	Transcranial Doppler, CT or MRA	In the derivation cohort, there was a strong correlation between RACE and NIHSS ( $r=0.76$ , $p<0.01$ )  In the validation cohort, a cut point of $\geq 5$ had the best predictive value for detecting LVO Sensitivity: 85% Specificity: 68% PPV: 42% NPV: 94%  The AUC for the RACE scale was 0.82, 95% CI 0.77-0.87 for the detection of LVO
<b>3-Item Stroke Scale (3ISS)</b>  <b>Singer et al. 2005</b>	3 items : Disturbance of consciousness (no=0, mild =1, severe= 2) Gaze and head deviation (absent= 0, incomplete gaze/head deviation=1, forced gaze/head deviation= 2) Hemiparesis (absent=0, moderate=1, severe= 2)	180 patients presenting to a stroke unit in 2002 with symptoms of stroke within $\leq 6$ hours (28 patients had ICH).  Prevalence of LVO: 27 (15%)	MRI/MRA/CT	A cut point of $\geq 4$ had the best predictive value for detecting MCA occlusions Sensitivity: 67% Specificity: 92% PPV: 74% NPV: 89% Accuracy: 86%  Inter-rater reliability : Intraclass correlation coefficient was 0.947; K for individual items were 0.77, 0.77 and 0.84

PPV: Positive Predictive Value; NPV: Negative Predictive Value; LR Likelihood Ratio; AUC Area under curve



#### Références du tableau A

1. Teasdale G and Jennett B. Assessment of coma and impaired consciousness. A practical scale. *Lancet (London, England)*. 1974;2:81-4.
2. Teasdale G, Knill-Jones R and van der Sande J. Observer variability in assessing impaired consciousness and coma. *Journal of neurology, neurosurgery, and psychiatry*. 1978;41:603-10.
3. Gill MR, Reiley DG and Green SM. Interrater reliability of Glasgow Coma Scale scores in the emergency department. *Annals of emergency medicine*. 2004;43:215-23.
4. Juarez VJ and Lyons M. Interrater reliability of the Glasgow Coma Scale. *The Journal of neuroscience nursing : journal of the American Association of Neuroscience Nurses*. 1995;27:283-6.
5. Fielding K and Rowley G. Reliability of assessments by skilled observers using the Glasgow Coma Scale. *The Australian journal of advanced nursing : a quarterly publication of the Royal Australian Nursing Federation*. 1990;7:13-7.
6. Rowley G and Fielding K. Reliability and accuracy of the Glasgow Coma Scale with experienced and inexperienced users. *Lancet*. 1991;337:535-8.
7. Katz DI and Alexander MP. Traumatic brain injury. Predicting course of recovery and outcome for patients admitted to rehabilitation. *Archives of neurology*. 1994;51:661-70.
8. Weingarten S, Bolus R, Riedinger MS, Maldonado L, Stein S and Ellrodt AG. The principle of parsimony: Glasgow Coma Scale score predicts mortality as well as the APACHE II score for stroke patients. *Stroke; a journal of cerebral circulation*. 1990;21:1280-2.
9. Weir CJ, Bradford AP and Lees KR. The prognostic value of the components of the Glasgow Coma Scale following acute stroke. *QJM : monthly journal of the Association of Physicians*. 2003;96:67-74.
10. Demetriades D, Kuncir E, Murray J, Velmahos GC, Rhee P and Chan L. Mortality prediction of head Abbreviated Injury Score and Glasgow Coma Scale: analysis of 7,764 head injuries. *Journal of the American College of Surgeons*. 2004;199:216-22.
11. Teoh LS, Gowardman JR, Larsen PD, Green R and Galletly DC. Glasgow Coma Scale : variation in mortality among permutations of specific total scores. *Intensive care medicine*. 2000;26:157-61.
12. Healey C, Osler TM, Rogers FB, Healey MA, Glance LG, Kilgo PD, Shackford SR and Meredith JW. Improving the Glasgow Coma Scale score: motor score alone is a better predictor. *The Journal of trauma*. 2003;54:671-8; discussion 678-80.
13. Waxman K, Sundine MJ and Young RF. Is early prediction of outcome in severe head injury possible? *Archives of surgery*. 1991;126:1237-41; discussion 1242.
14. Balestreri M, Czosnyka M, Chatfield DA, Steiner LA, Schmidt EA, Smielewski P, Matta B and Pickard JD. Predictive value of Glasgow Coma Scale after brain trauma: change in trend over the past ten years. *Journal of neurology, neurosurgery, and psychiatry*. 2004;75:161-2.
15. Satz P, Zaucha K, Forney DL, McCleary C, Asarnow RF, Light R, Levin H, Kelly D, Bergsneider M, Hovda D, Martin N, Caron MJ, Namerow N and Becker D. Neuropsychological, psychosocial and vocational correlates of the Glasgow Outcome Scale at 6 months post-injury: a study of moderate to severe traumatic brain injury patients. *Brain injury : [BI]*. 1998;12:555-67.
16. Young B, Rapp RP, Norton JA, Haack D, Tibbs PA and Bean JR. Early prediction of outcome in head-injured patients. *Journal of neurosurgery*. 1981;54:300-3.
17. Zafonte RD, Hammond FM, Mann NR, Wood DL, Black KL and Millis SR. Relationship between Glasgow coma scale and functional outcome. *American journal of physical medicine & rehabilitation / Association of Academic Physiatrists*. 1996;75:364-9.
18. Pastorek NJ, Hannay HJ and Contant CS. Prediction of global outcome with acute neuropsychological testing following closed-head injury. *Journal of the International Neuropsychological Society : JINS*. 2004;10:807-17.
19. Udekwu P, Kromhout-Schiro S, Vaslef S, Baker C and Oller D. Glasgow Coma Scale score, mortality, and functional outcome in head-injured patients. *The Journal of trauma*. 2004;56:1084-9.
20. Cifu DX, Keyser-Marcus L, Lopez E, Wehman P, Kreutzer JS, Englander J and High W. Acute predictors of successful return to work 1 year after traumatic brain injury: a multicenter analysis. *Archives of physical medicine and rehabilitation*. 1997;78:125-31.
21. Sternbach GL. The Glasgow coma scale. *The Journal of emergency medicine*. 2000;19:67-71.

### Références du tableau 2B

- Bray JE, Coughlan K, Barger B, Bladin C. Paramedic diagnosis of stroke: examining long-term use of the Melbourne Ambulance Stroke Screen (MASS) in the field. *Stroke* 2010;41(7):1363-1366.
- Chenkin J, Gladstone DJ, Verbeek PR, et al. Predictive value of the Ontario prehospital stroke screening tool for the identification of patients with acute stroke. *Prehosp Emerg Care* 2009;13(2):153-159.
- Harbison J, Hossain O, Jenkinson D, Davis J, Louw SJ, Ford GA. Diagnostic accuracy of stroke referrals from primary care, emergency room physicians, and ambulance staff using the face arm speech test. *Stroke* 2003;34(1):71-76.
- Kidwell CS, Starkman S, Eckstein M, Weems K, Saver JL. Identifying stroke in the field. Prospective validation of the Los Angeles prehospital stroke screen (LAPSS). *Stroke* 2000;31(1):71-76.
- Kothari RU, Pancioli A, Liu T, Brott T, Broderick J. Cincinnati Prehospital Stroke Scale: reproducibility and validity. *Ann Emerg Med* 1999;33(4):373-378.
- Nor AM, Davis J, Sen B, et al. The Recognition of Stroke in the Emergency Room (ROSIER) scale: development and validation of a stroke recognition instrument. *Lancet Neurol* 2005;4(11):727-734.
- Studnek JR, Asimos A, Dodds J, Swanson D. Assessing the validity of the Cincinnati prehospital stroke scale and the medic prehospital assessment for code stroke in an urban emergency medical services agency. *Prehosp Emerg Care* 2013;17(3):348-353.

### Références du tableau 2C

- Hastrup S, Damgaard D, Johnsen SP, Andersen G. Prehospital Acute Stroke Severity Scale to Predict Large Artery Occlusion: Design and comparison with other scales. *Stroke* 2016;47(7):1772-1776.
- Katz BS, McMullan JT, Sucharew H, Adeoye O, Broderick JP. Design and validation of a prehospital scale to predict stroke severity: Cincinnati Prehospital Stroke Severity Scale. *Stroke*. 2015;46(6):1508-1512.
- Lima FO, Silva GS, Furie KL, et al. Field Assessment Stroke Triage for Emergency Destination: A Simple and Accurate Prehospital Scale to Detect Large Vessel Occlusion Strokes. *Stroke* 2016;47(8):1997-2002.
- Nazliel B, Starkman S, Liebeskind DS, et al. A brief prehospital stroke severity scale identifies ischemic stroke patients harboring persisting large arterial occlusions. *Stroke* 2008;39(8):2264-2267.
- Perez de la Ossa N, Carrera D, Gorchs M, et al. Design and validation of a prehospital stroke scale to predict large arterial occlusion: the rapid arterial occlusion evaluation scale *Stroke*. 2014;45(1):87-91.
- Singer OC, Dvorak F, du Mesnil de Rochemont R, Lanfermann H, Sitzer M, Neumann-Haefelin T. A simple 3-item stroke scale: comparison with the National Institutes of Health Stroke Scale and prediction of middle cerebral artery occlusion. *Stroke* 2005;36(4):773-776.
- Teleb MS, Ver Hage A, Carter J, Jayaraman MV, McTaggart RA. Stroke vision, aphasia, neglect (VAN) assessment-a novel emergent large vessel occlusion screening tool: pilot study and comparison with current clinical severity indices. *J Neurointerv Surg* 2016. doi: 10.1136/neurintsurg-2015-012131.
- Sanchea Wasyliw, K. Ruth Whelan, Michael Kelly, Kimberly Davy, Gary Hunter. The FAST VAN Tool for Identifying Large Vessel Occlusion in Acute Stroke: American Academy of Neurology annual meeting; April 21-27 2018; Los Angeles CA. Abstract P4.

**Liens utiles :**

- 1) Cincinnati Prehospital Stroke Scale (CPSS) <http://www.strokecenter.org/wp-content/uploads/2011/08/cincinnati.pdf> Lien direct pour consulter l'échelle.
- 2) [http://www.strokeassociation.org/idc/groups/stroke-public/@wcm/@private/@hcm/@gwtg/documents/downloadable/ucm\\_428607.pdf](http://www.strokeassociation.org/idc/groups/stroke-public/@wcm/@private/@hcm/@gwtg/documents/downloadable/ucm_428607.pdf) Lien de l'American Stroke Association. Il s'agit d'instructions pour permettre d'évaluer l'AVC à l'aide de l'échelle CPSS.
- 3) [http://www.acep.org/uploadedFiles/ACEP/Practice\\_Resources/disater\\_and\\_EMS/EMS\\_week/ems\\_week\\_materials/08factsheets.pdf](http://www.acep.org/uploadedFiles/ACEP/Practice_Resources/disater_and_EMS/EMS_week/ems_week_materials/08factsheets.pdf) Des cartes au sujet des échelles CPSS et Los Angeles Prehospital Stroke Screen (LAPSS) se trouvent à la deuxième page.
- 4) <http://www.strokecenter.org/wp-content/uploads/2011/08/LAPSS.pdf> Un lien pour consulter l'échelle LAPSS.
- 5) Une évaluation de l'échelle Glasgow Coma Scale (GCS) se trouve sur le site [www.abiebr.com](http://www.abiebr.com). Une autre évaluation de l'échelle GCS se trouve au [www.strokengine.ca](http://www.strokengine.ca).