Research Article Volume X, Issue No. X. 2024

The Medical Journal of Neurology and Rehabilitation Medicine



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Article History :
Received date : YYMMDD
Revised date : YYMMDD
Accepted date : YYMMDD
Published date : YYMMDD

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ABSTRACT

A well-prepared abstract allows readers to quickly and accurately identify the basic content of a document, determine its relevance to their interests, and thereby decide whether to read the document in its entirety. The abstract must be informative and clear enough, written clearly, and provide a clear statement of the problem, research objectives, research methods, findings, and conclusions. Abstracts should consist of 100 to 200 words. The abstract must be written in the past tense. Standard nomenclature should be used, and abbreviations should be avoided. No literature may be cited. Keyword lists provide the opportunity to add keywords used by indexing and abstracting services in addition to the keywords already present in the title. Wise use of keywords can increase the ease with

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INTRODUCTION

This section explains the three main components. First, to describe the phenomenon being studied, the introduction must contain the research background and research context. Second, the author explains the relationship between the phenomenon and existing theories (at least the journal cited must be less than ten years old), along with gap analysis and the novelty of the research, and finally explains the research objectives. All introductions should be presented in paragraph form, not pointers, with a proportion of 15-20% of the overall length of the article.

The introduction should not be divided into background sub-chapters, problem formulation, and objectives. Beginning of paragraph once tab. Citations are written in bodynote format and are relevant to the bibliography (recommended using the Mendeley application or other reference management application programs such as EndNote, Reference Manager, or Zotero) (12pt, spacing 1.5, spacing after paragraph 6pt).

The manuscript should be written as concisely, consistently, and as directly as possible. The number of pages consists of 10–20 (twenty) pages (including figures and tables). Manuscripts are written single-spaced on one side of A4-sized paper (210 x 297 mm). Manuscripts must have normal margins, or top, bottom, right, and left margins, namely 2.54 cm. The font used is Times New Roman. 12pt. Manuscripts must be written in English.

METHODS

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The Methods section must be short but must include sufficient technical information and contain the type of research, research population, research samples or subjects, and data analysis techniques. Only new methods have to be described in detail. Cite previously published procedures in References.

Table 1. Search Strategy

Database	**Search Strategy**	***Hits***
Pubmed	*("endovascular thrombectomy" OR " ischemic stroke " AND "treatment")*	3233
Science Direct	*("endovascular thrombectomy" OR " ischemic stroke " AND "treatment")*	1139
Sagepub	*("endovascular thrombectomy" OR " ischemic stroke " AND "treatment")*	1003

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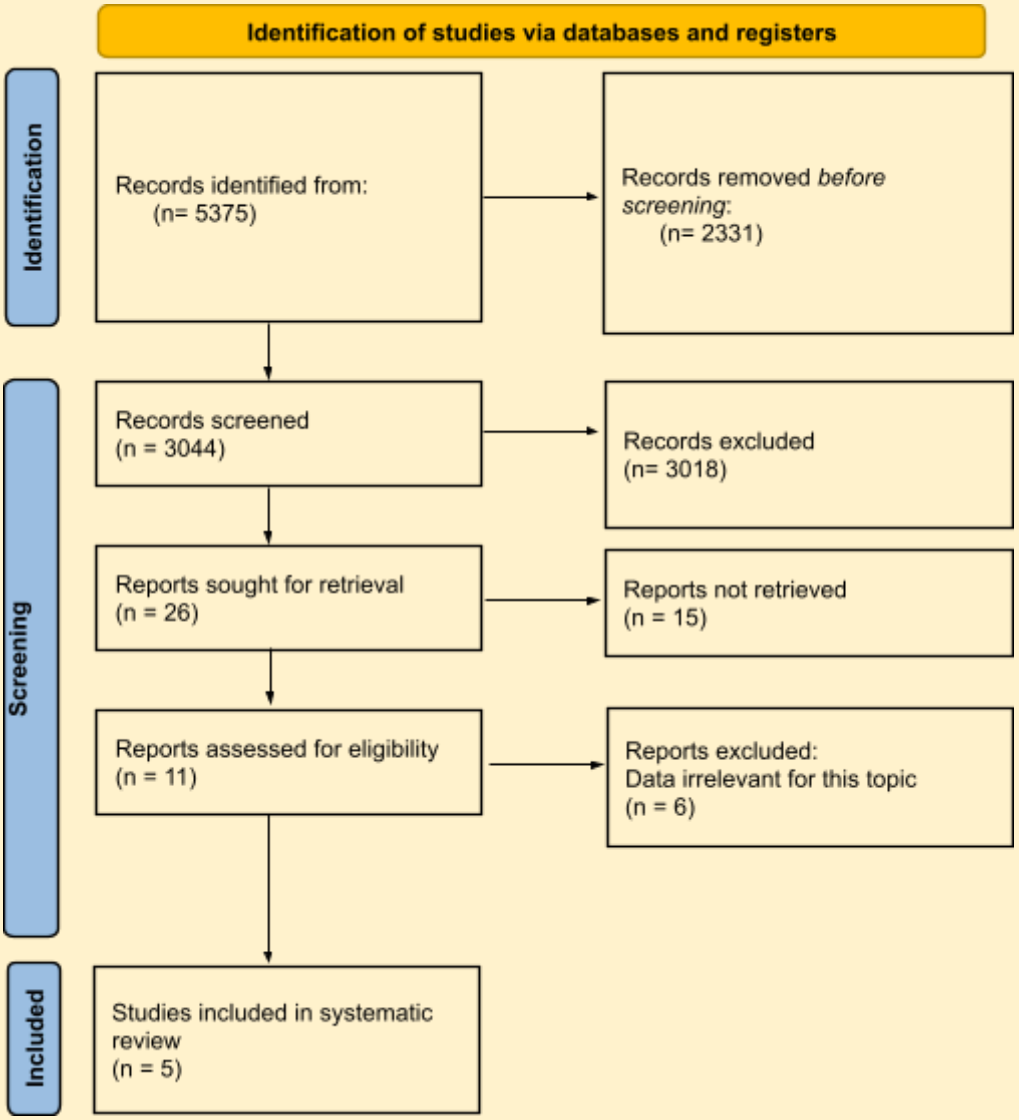


Figure 1. Article search flow chart

RESULT

Results should include the rationale or design of the experiment as well as the results of the experiment. Results can be presented in the form of images, tables, and text. Research findings must be supported by adequate data. This section must answer the research hypothesis.

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Table

The table is in the middle. Use Times New Roman and font sizes 8 to 11. Horizontal lines in the middle of the table do not need to be displayed; only display the heading and the very end, and there should also be no vertical lines. Make sure you create the table correctly via the Insert Table menu. Tables should be referenced in the text by writing something like: '... (Tables are written with a capital 'T').

Table 3. The literature included in this study

Yoshimura, S et al., 2022[5]	Japan	We conducted a multicenter, open-label, randomized clinical trial in Japan involving patients with occlusion of large cerebral vessels and sizable strokes on imaging, as indicated by an Alberta Stroke Program Early Computed Tomographic Score (ASPECTS) value of 3 to 5 (on a scale	203	A total of 203 patients underwent randomization; 101 patients were assigned to the endovascular-therapy group and 102 to the medical-care group. Approximately 27% of patients in each group received alteplase. The percentage of patients with a modified Rankin scale score of 0 to 3 at 90 days was 31.0% in the endovascular-therapy group and 12.7% in the medical-care group (relative risk, 2.43; 95% confidence interval [CI], 1.35 to 4.37; P=0.002). The ordinal shift across the range of modified Rankin scale scores generally favored endovascular therapy. An improvement of at least 8 points on the NIHSS score at 48 hours

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		from 0 to 10, with lower values indicating larger infarction).		was observed in 31.0% of the patients in the endovascular-therapy group and 8.8% of those in the medical-care group (relative risk, 3.51; 95% CI, 1.76 to 7.00), and any intracranial hemorrhage occurred in 58.0% and 31.4%, respectively (P<0.001).
Sarraj, A et al., 2023[6]	Spain	We performed a prospective, randomized, open-label, adaptive, international trial involving patients with stroke due to occlusion of the internal carotid artery or the first segment of the middle cerebral artery to assess endovascular thrombectomy within 24 hours after onset.	178	The trial was stopped early for efficacy; 178 patients had been assigned to thrombectomy and 174 to medical care. The median ischemic-core volumes were 74 ml and 77 ml in the two groups, respectively. The generalized odds ratio for a shift in the distribution of modified Rankin scale scores toward better outcomes in favor of thrombectomy was 1.51 (95% confidence interval [CI], 1.20 to 1.89; P<0.001). A total of 20% of the patients in the thrombectomy group and 7% in the medical-care group had functional independence (relative risk, 2.97; 95% CI, 1.60 to 5.51). Mortality was similar in the two groups. In the thrombectomy group, arterial access-site complications occurred in 5 patients, dissection in 10, cerebral-vessel perforation in 7, and transient vasospasm in 11. Symptomatic intracranial hemorrhage occurred in 1 patient in the thrombectomy group and in 2 in the medical-care group.

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Sarraj, A et al., 2024[7]	USA	An exploratory analysis of the SELECT2 trial, which randomized 352 adults (18-85 years) with acute ischemic stroke due to occlusion of the internal carotid or middle cerebral artery (M1 segment) and large ischemic core to EVT vs medical management (MM), across 31 global centers between October 2019 and September 2022.	352	Among 352 patients randomized, 336 were analyzed (median age, 67 years; 139 [41.4%] female); of these, 168 (50%) were randomized to EVT, and 2 additional crossover MM patients received EVT. In an ordinal analysis of mRS at 90 days, EVT improved functional outcomes compared with MM within ASPECTS categories of 3 (aGenOR, 1.71 [95% CI, 1.04-2.81]), 4 (aGenOR, 2.01 [95% CI, 1.19-3.40]), and 5 (aGenOR, 1.85 [95% CI, 1.22-2.79]). Across strata for CT perfusion/MRI ischemic core volumes, aGenOR for EVT vs MM was 1.63 (95% CI, 1.23-2.16) for volumes ≥70 mL, 1.41 (95% CI, 0.99-2.02) for ≥100 mL, and 1.47 (95% CI, 0.84-2.56) for ≥150 mL. In the EVT group, outcomes worsened as ASPECTS decreased (aGenOR, 0.91 [95% CI, 0.82-1.00] per 1-point decrease) and as CT perfusion/MRI ischemic core volume increased (aGenOR, 0.92 [95% CI, 0.89-0.95] per 10-mL increase). No heterogeneity of EVT treatment effect was observed with or without mismatch, although few patients without mismatch were enrolled.
Wilkelmeier, L et al., 2024[4]	Germany	We conducted a systematic review and meta-analysis of RCTs	4	Literature research identified four RCTs which evaluated the treatment effect of endovascular thrombectomy for large

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		comparing endovascular thrombectomy versus medical treatment alone in acute ischemic anterior circulation stroke with very large infarct, defined as ASPECTS of 0–2. The primary outcome was the shift toward better functional outcomes on the 90-day modified Rankin Scale (mRS).		infarcts and provided a subgroup analysis of the mRS shift in patients with ASPECTS of 0–2. The pooled analysis showed a significant shift toward better 90-day mRS scores in favor of endovascular thrombectomy (pooled odds ratio, 1.62, 95% confidence interval, 1.29–2.04, $P < 0.001$).
Morsi, RZ et al., 2023[8]	USA	We searched MEDLINE, Embase, and the Cochrane Library to identify randomized controlled trials (RCTs) comparing EVT versus medical management alone in AIS patients with large ischemic regions.	14513	Of 14,513 citations, we included 3 RCTs with a total of 1,010 participants. We found low-certainty evidence of possibly a large increase in the proportion of patients with functional independence (risk difference [RD] 30.3%, 95% CI 15.0% to 52.3%), low-certainty evidence of possibly a small non-significant decrease in mortality (RD -0.7%, 95% CI -3.8% to 3.5%), and low-certainty evidence of possibly a small non-significant

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				increase in sICH (RD 3.1%, 95% CI -0.3% to 9.8%) for AIS patients with large infarcts who underwent EVT compared to medical management only.

DISCUSSION

The discussion should be an interpretation of the results, not a repetition of the results. This discussion includes at least: an explanation of the meaning of the findings and why the findings are important; Support the answer with the results. Explain how your results relate to expectations and the literature; state clearly why the results are acceptable and whether there is any agreement or conflict with previous research results; consider alternative explanations for the findings; consider research implications; study limitations; and provide suggestions for further research.

Avoid writing in the form of bullet numbering or item list style; it is best to write it in the form of a descriptive paragraph, even though it is a list item. If it contains tables and figures, the numbering is a continuation of the previous number. Each table and figure must be given a title.

CONCLUSION

The conclusion must contain confirmation of the problems that have been analyzed in the results and discussion sections. Write a conclusion concisely and clearly. It is not recommended that the conclusion be written in several parts or points. The conclusion is intended to help readers understand why your research is important to them after they have finished reading the manuscript. A conclusion is not simply a summary of the main topics discussed or a restatement of your

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research problem, but rather a synthesis of the important points. It is important that the conclusion does not leave any questions unanswered.

DISCLOSURE STATEMENT

Disclosure Statement : The authors have no conflicts of Interest to declare.

REFERENCES

References should be listed in the order of their appearance in the text. Each cited source must include the author's name, article title, journal name, year of publication, volume, issue number, page numbers, and DOI (if available). Example of reference format:

1. Abuelazm M, Ahmad U, Abu Suilik H, Seri A, Mahmoud A, Abdelazeem B. Endovascular Thrombectomy for Acute Stroke with a Large Ischemic Core: A Systematic Review and Meta-Analysis of Randomized Controlled Trials. Clin Neuroradiol [Internet]. 2023 Sep 26;33(3):625–34. Available from: https://link.springer.com/10.1007/s00062-023-01306-x
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