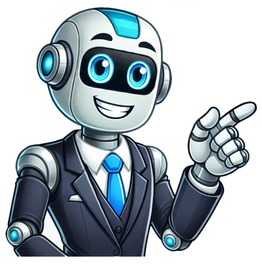
Click to prove you're human



Share copy and redistribute the material in any medium or format for any purpose, even commercially. Adapt remix, transform, and build upon the material for any purpose, even commercially. The licensor cannot revoke these freedoms as long as you follow the license terms. Attribution You must give appropriate credit , provide a link to the license, and indicate if changes were made . You may do so in any reasonable manner, but not in any way that suggests the licensor endorses you or your use. ShareAlike If you remix, transform, or build upon the material, you must distribute your contributions under the same license as the original. No additional restrictions You may not apply legal terms or technological measures that legally restrict others from doing anything the license permits. You do not have to comply with the license for elements of the material in the public domain or where your use is permitted by an applicable exception or limitation . No warranties are given. The license may not give you all of the permissions necessary for your intended use. For example, other rights such as publicity, privacy, or moral rights may limit how you use the material. Create your free account By continuing, you agree to Quizgecko's Terms of Service and Privacy Policy. Medical scoring systemThe National Institutes of Health Stroke Scale, or NIH Stroke Scale (NIHSS), is a tool used by healthcare providers to objectively quantify the impairment caused by a stroke and aid planning post-acute care disposition, though was intended to assess differences in interventions in clinical trials. The NIHSS was designed for the National Institute of Neurological Disorders and Stroke (NINDS) Recombinant Tissue Plasminogen Activator (rt-PA) for Acute Stroke Trial and was first published by neurologist Dr. Patrick Lyden and colleagues in 2001. Prior to the NIHSS, during the late 1980s, several stroke-deficit rating scales were in use (e.g., University of Cincinnati scale, Canadian neurological scale, the Edinburgh-2 coma scale, and the Oxbury initial severity scale).The NIHSS is composed of 11 items, each of which scores a specific ability between a 0 and 4. For each item, a score of 0 typically indicates normal function in that specific ability, while a higher score is indicative of some level of impairment.[1]The individual scores from each item are summed in order to calculate a patient's total NIHSS score. The maximum possible score is 42, with the minimum score being a 0.[2][3]Score [3]Stroke severity0No stroke symptoms14Minor stroke515Moderate stroke1620Moderate to severe stroke2142Severe strokeWhile administering the NIHSS, it is important that the examiner does not coach or help with the assigned task. The examiner may demonstrate the commands to patients that are unable to comprehend verbal instructions; however, the score should reflect the patient's own ability. It is acceptable for the examiner to physically help the patient get into position to begin the test, but the examiner must not provide further assistance while the patient is attempting to complete the task.For each item, the examiner should score the patient's first effort, and repeated attempts should not affect the patient's score. An exception to this rule exist in the language assessment (Item 9), in which the patient's best effort should be scored.[1]Some of the items contain "Default Coma Scores". These scores are automatically assigned to patients that scored a 3 in Item 1a. Note that the NIHSS may fluctuate depending on the time.[4]Level of consciousness (LOC) testing is divided into three sections. The first LOC items test for the patient's responsiveness. The second LOC item is based on the patient's ability to answer questions that are verbally presented by the examiner. The final LOC sub-section is based on the patient's ability to follow verbal commands to perform simple task.Although this item is broken into three parts, each sub-section is added to the final score as if it is its own item.[3]Scores for this item are assigned by a medical practitioner based on the stimuli required to arouse patient. The examiner should first assess if the patient is fully alert to his or her surroundings. If the patient is not completely alert, the examiner should attempt a verbal stimulus to arouse the patient. Failure of verbal stimuli indicates an attempt to arouse the patient via repeated physical stimuli. If none of these stimuli are successful in eliciting a response, the patient can be considered totally unresponsive.[3]ScoreTest results0Alert; Responsive1Not alert; Verbally arousable or aroused by minor stimulation to obey, answer, or respond.2Not alert; Only responsive to repeated or strong and painful stimuli3Totally unresponsive; Responds only with reflexes or is areflexicNotesIf patients scores a 3 in this factor, the default coma scores should be used when applicablePatient is verbally asked his or her age and for the name of the current month.[3]ScoreTest results0Correctly answers both questions1Correctly answers one question2Does not correctly answer either questionNotesDefault Coma Score: 2The patient must answer each question 100% correct without help to get creditPatients unable to speak are allowed to write the answerAphasic patients or patients in a stuporous state who are unable to understand the commands receive a score of 2Patients that are unable to talk due to trauma, dysarthria, language barrier, or intubation are given a score of 1The patient is instructed to first open and close his or her eyes and then grip and release his or her hand.[3]ScoreTest results0Correctly performs both tasks1Correctly performs 1 task2Does not correctly perform either taskNotesCommands can only be repeated once.The hand grip command can be replaced with any other simple one step command if the patient cannot use his or her hands.A patient's attempt is regarded as successful if an attempt is made but is incomplete due to weaknessIf the patient does not understand the command, the command can be visually demonstrated to him or her without an impact on his or her scorePatients with trauma, amputations, or other physical impediments can be given other simple one-step commands if these commands are not appropriateAssesses ability for patient to track a pen or finger from side to side only using his or her eyes. This is designed to assess motor ability to gaze towards the hemisphere opposite of injury. This item is tested because conjugated eye deviation (CED) is present in approximately 20% of stroke cases. CED is more common in right hemispheric strokes and typically in lesions affecting the basal ganglia and temporoparietal cortex. Damage to these areas can result in decreased spatial attention and reduced control of eye movements.[5]ScoreTest results0Normal; Able to follow pen or finger to both sides1Partial gaze palsy; gaze is abnormal in one or both eyes, but gaze is not totally paralyzed. Patient can gaze towards hemisphere of infarct, but cannot go past midline2Total gaze paresis; gaze is fixed to one sideNotesIf patient is unable to follow the command to track an object, the investigator can make eye contact with the patient and then move side to side. The patient's gaze palsy can then be assessed by his or her ability to maintain eye contact.If patient is unable to follow any commands, assess the horizontal eye movement via the oculocephalic maneuver. This is done by manually turning the patient's head from midline to one side and assessing the eye's reflex to return to a midline position.If the patient has isolated peripheral nerve paresis assign a score of 1Assess the patient's vision in each visual fields. Each eye is tested individually, by covering one eye and then the other. Each upper and lower quadrant is tested by asking the patient to indicate how many fingers the investigator is presenting in each quadrant. The investigator should instruct the patient to maintain eye contact throughout this test, and not allow the patient to realign focus towards each stimulus. With the first eye covered, place a random number of fingers in each quadrant and ask the patient how many fingers are being presented. Repeat this testing for the opposite eye.[3]ScoreTest results0No vision loss1Partial hemianopia or complete quadrantanopia; patient recognizes no visual stimulus in one specific quadrant2Complete hemianopia; patient recognizes no visual stimulus in one half of the visual field3Bilateral blindness, including blindness from any causeNotesIf patient is non-verbal, he or she can be allowed to respond by holding up the number of fingers the investigator is presentingIf patient is not responsive the visual fields can be tested by visual threat (the investigator moving an object towards the eye and observing the patient's response, being careful not to trigger the corneal reflex with air movement).Facial palsy is partial or complete paralysis of portions of the face. Typically this paralysis is most pronounced in the lower half of one facial side. However, depending on lesion location the paralysis may be present in other facial regions. While inspecting the symmetry of each facial expression the examiner should first instruct patient to show his or her teeth (or gums). Second, the patient should be asked to squeeze his or her eyes closed as hard as possible. After reopening his or her eyes, the patient is then instructed to raise his or her eyebrows.[6]ScoreTest results0Normal and symmetrical movement1Minor paralysis; function is less than clearly normal, such as flattened nasolabial fold or minor asymmetry in smile2Partial paralysis; particularly paralysis in lower face3Complete facial Hemiparesis, total paralysis in upper and lower portions of one face sideNotesIf the patient is unable to understand verbal commands, the instructions should be demonstrated to the patient.Patients incapable of comprehending any commands may be tested by applying a noxious stimulus and observing for any paralysis in the resulting grimace.With palm facing downwards, have the patient extend one arm 90 degrees out in front if the patient is sitting, and 45 degrees out in front if the patient is lying down. If necessary, help the patient get into the correct position. As soon as the patient's arm is in position the investigator should begin verbally counting down from 10 while simultaneously counting down on his or her fingers in full view of the patient. Observe to detect any downward arm drift prior to the end of the 10 seconds. Downward movement that occurs directly after the investigator places the patient's arm in position should not be considered downward drift. Repeat this test for the opposite arm. This item should be scored for the right and left arm individually, denoted as item 5a and 5b.[3]ScoreTest results0No arm drift; the arm remains in the initial position for the full 10 seconds1Drift; the arm drifts to an intermediate position prior to the end of the full 10 seconds, but not at any point relies on a support2Limited effort against gravity; the arm is able to obtain the starting position, but drifts down from the initial position to a physical support prior to the end of the 10 seconds3No effort against gravity; the arm falls immediately after being helped to the initial position, however the patient is able to move the arm in some form (e.g. shoulder shrug)4No movement; patient has no ability to enact voluntary movement in this armNotesDefault coma score: 8Test the non paralyzed arm first if applicableScore should be recorded for each arm separately, resulting in a maximum potential score of 8.Motor Arm assessment should be skipped in the case of an amputee, however a note should be made in the scoring of the amputation.If patient is unable to understand commands, the investigator should deliver the instructions via demonstrationWith the patient in the supine position, one leg is placed 30 degrees above horizontal. As soon as the patient's leg is in position the investigator should begin verbally counting down from 5 while simultaneously counting down on his or her fingers in full view of the patient. Observe any downward leg drift prior to the end of the 5 seconds. Downward movement that occurs directly after the investigator places the patient's leg in position should not be considered downward drift. Repeat this test for the opposite leg. Scores for this section should be recorded separately as 6a and 6b for the left and right legs respectively.[3]ScoreTest results0No leg drift; the leg remains in the initial position for the full 5 seconds1Drift; the leg drifts to an intermediate position prior to the end of the full 5 seconds, but at no point touches the bed for support2Limited effort against gravity; the leg is able to obtain the starting position, but drifts down from the initial position to physical support prior to the end of the 5 seconds3No effort against gravity; the leg falls immediately after being helped to the initial position, however, the patient is able to move the leg in some form (e.g. hip flex)4No movement; patient has no ability to enact voluntary movement in this legNotesDefault coma score: 8This is performed for each leg, indicating a maximum possible score of 8Test the non paralyzed leg first if applicableMotor leg assessment should be skipped in the case of an amputee, however a note should be made in the score recordsIf patient is unable to understand commands, the investigator should deliver the instructions via demonstrationThis test for the presence of a unilateral cerebellar lesion, and distinguishes a difference between general weakness and incoordination. The patient should be instructed to first touch his or her finger to the examiner's finger then move that finger back to his or her nose, repeat this movement 3-4 times for each hand. Next the patient should be instructed to move his or her heel up and down the shin of his or her opposite leg. This test should be repeated for the other leg as well.[3]ScoreTest results0Normal coordination; smooth and accurate movement1Ataxia present in 1 limb; rigid and inaccurate movement in one limb2Ataxia present in 2 or more limbs: rigid and inaccurate movement in both limbs on one sideNotesIf significant weakness is present, score 0If patient is unable to understand commands or move limbs, score is 0Patient's eyes should remain open throughout this sectionIf applicable, test the un-paretic side firstSensory testing is performed via pinpricks in the proximal portion of all four limbs. While applying pinpricks, the investigator should ask whether or not the patient feels the pricks, and if he or she feels the pricks differently on one side when compared to the other side.[3]ScoreTest results0No evidence of sensory loss1Mild-to-Moderate sensory loss; patient feels the pinprick, however he or she feels as if it is duller on one side2Severe to total sensory loss on one side; patient is not aware he or she is being touched in all unilateral extremitiesNotesDefault coma score: 2The investigator should insure that the sensory loss being detected is a result of the stroke, and should therefore test multiple spots on the body.For patients unable to understand the instructions, the pinprick can be replaced by a noxious stimulus and the grimace can be judged to determine sensory score.This item measures the patient's language skills. After completing items 1-8, it is likely the investigator has gained an approximation of the patient's language skills; however, it is important to confirm this measurement at this time. The stroke scale includes a picture of a scenario, a list of simple sentences, a figure of assorted random objects, and a list of words. The patient should be asked to explain the scenario depicted in the first figure.Next, the patient should read the list of sentences and name each of the objects depicted in the next figure. The scoring for this item should be based on both the results from the test performed in this item in addition to the language skills demonstrated up to this point in the stroke scale.[3]ScoreTest results0Normal; no obvious speech deficit1Mild-to-moderate aphasia; detectable loss in fluency, however, the examiner should still be able to extract information from patient's speech2Severe aphasia; all speech is fragmented, and examiner is unable to extract the figure's content from the patients speech.3Unable to speak or understand speechNotesDefault coma score: 3Patients with visual loss should be asked to identify objects placed in his or her handsThis is an exception to recording only the patients first attempt. In this item, the patients best language skills should be recordedDysarthria is the lack of motor skills required to produce understandable speech. Dysarthria is strictly a motor problem, and is not related to the patient's ability to comprehend speech. Strokes that cause dysarthria typically affect areas such as the anterior opercular, medial prefrontal and premotor, and anterior cingulate regions. These brain regions are vital in coordinating motor control of the tongue, throat, lips, and lungs.[7] To perform this item the patient is asked to read from the list of words provided with the stroke scale while the examiner observes the patient's articulation and clarity of speech.[3]ScoreTest results0Normal; clear and smooth speech1Mild-to-moderate dysarthria; some slurring of speech, however the patient can be understood2Severe dysarthria; speech is so slurred that he or she cannot be understood, or patients that cannot produce any speechNotesDefault coma score:2An intubated patient should not be rated on this item, instead make note of the situation in the scoring documents.Sufficient information regarding this item may have been obtained by the examiner in items 110 to properly score the patient. However, if any ambiguity exist the examiner should test this item via a technique referred to as "double simultaneous stimulation".Double simultaneous stimulation is performed by having the patient close his or her eyes and asking him or her to identify the side on which they are being touched by the examiner. During this time, the examiner is alternating between touching the patient on the right and left side. Next, the examiner touches the patient on both sides at the same time. This should be repeated on the patients face, arms, and legs.To test extinction in vision, the examiner should hold up one finger in front of each of the patient's eyes and ask the patient to determine which finger is wiggling or if both are wiggling. The examiner should then alternate between wiggling each finger and wiggling both fingers at the same time.[3]ScoreTest results0Normal; patient correctly answers all questions1Inattention on one side in one modality; visual, tactile, auditory, or spatial2Hemi-inattention; does not recognize stimuli in more than one modality on the same side.NotesDefault coma score: 2Patient with severe vision loss that correctly identifies all other stimulations scores a 0The NIHSS was designed to be a standardized and repeatable assessment of stroke patients utilized by large multi-center clinical trials.[8] Clinical researchers have widely accepted this scale due to its high scoring consistency, which has been demonstrated in inter-examiner and in test-retest scenarios.[9] Clinical research use of the NIHSS typically involves obtaining a baseline NIHSS score as soon as possible after onset of stroke symptoms[10][11] The NIHSS is then repeated at regular intervals or after significant changes in patient condition. This history of scores can then be utilized to monitor the effectiveness of treatment methods and quantify a patient's improvement or decline.[12][13] The NIHSS has also been used in a prospective observational study, to predict 3 month outcomes of patients with undernutrition during hospital stays directly after a stroke.[14]NIHSS has gained popularity as a clinical tool utilized in treatment planning. Tissue plasminogen activator (tPA), a type of thrombolysis, is one of the main options for treatment of acute ischemic strokes (the type of stroke caused by blood clots that are preventing blood flow within a cerebral artery).The effectiveness and risk of tPA is strongly correlated with the delay between stroke onset and tPA delivery ("door-to-needle time"). Current standards recommend for tPA to be delivered within 4,5 hours of onset, while best results occur when treatment is delivered within 90 minutes of onset.[15] Since the NIHSS has been established as a quick and consistent quantifier of stroke severity, many physicians have looked to NIHSS scores as indicators for tPA treatment.[16] This rapid assessment of stroke severity is targeted to reduce delay of tPA treatment. While some clinical trials have used minimum and maximum NIHSS scores to determine eligibility for acute treatment such as tPA,[10][11] guidelines such as those from the American Heart Association / American Stroke Association urge against NIHSS scores being used as the sole reason for declaring a patient as ineligible for tPA treatment.[17]In an effort to produce a complete neurological assessment the NIHSS was developed after extensive research and multiple iterations. The goal of the NIHSS was to accurately measure holistic neurological function by individually testing specific abilities. NIHSS total score is based on the summation of 4 factors. These factors are left and right motor function and left and right cortical function. The NIHSS assesses each of these specific functions by the stroke scale item listed in the chart below.[18]Left corticalRight corticalRight motorLeft motorLOC questionsHorizontal eye movementRight arm motorLeft arm motorLOC commandsVisual fieldsRight legLeft legLanguageExtinction and inattentionDysarthriaSensoryThe Modified NIH Stroke Scale (mNIHSS) is a shortened, validated version of the mNIHSS. It has been shown to be equally, if not more, accurate than the longer, older NIHSS. It removes questions 1A, 4, and 7. This makes the mNIHSS shorter and easier to use.The mNIHSS predicts patients at high risk of hemorrhage if given tissue plasminogen activator (tPA) and which patients are likely to have good clinical outcomes.[19] The mNIHSS has also recently been shown to be taken without seeing the patient, and only using medical records. This potentially improves care while in the emergency room and the hospital, but also facilitates retrospective research.[20]The National Institutes of Health Stroke Scale has been repeatedly validated as a tool for assessing stroke severity and as an excellent predictor for patient outcomes.[21][22][23] Severity of a stroke is heavily correlated with the volume of brain affected by the stroke; strokes affecting larger portions of the brain tend to have more detrimental effects.[24] NIHSS scores have been found to be reliable predictors of damaged brain volume, with a smaller NIHSS score indicating a smaller lesion volume.[25]The NIHSS places 7 of the possible 42 points on abilities that require verbal skills; 2 points from the LOC questions, 2 points from LOC commands, and 3 points from the Language item. The NIHSS only awards 2 points for extinction and inattention.[26] Approximately 98% of humans have verbal processing take place in the left hemisphere, indicating that the NIHSS places more value on deficits in the left hemisphere. This results in lesions receiving a higher (worse) score when occurring in the left hemisphere, compared to lesions of equal size in the right hemisphere. Due to this emphasis, the NIHSS is a better predictor of lesion volume in the strokes occurring within the left cerebral hemisphere.[17]The NIHSS has been found to be an excellent predictor of patient outcomes. A baseline NIHSS score greater than 16 indicates a strong probability of patient death, while a baseline NIHSS score less than 6 indicates a strong probability of a good recovery. On average, an increase of 1 point in a patient's NIHSS score decreases the likelihood of an excellent outcome by 17%.[27] However, correlation between functional recovery and NIHSS scores was weaker when the stroke was isolated to the cortex.[25]ABCD scoreCHADS2 score^ a b National Institutes of Health, National Institute of Neurological Disorders and Stroke. Stroke Scale. NIH Stroke Scale Training, Part 2. Basic Instruction. Department of Health and Human Services, National Institute of Neurological Disorders and Stroke. The National Institute of Neurological Disorders and Stroke (NINDS) Version 2.0^ a b c d e f g h i j k l m n Hage V (2011). "The NIH stroke scale: a window into neurological status". Nursing Spectrum. 24 (15): 4449.^ Costalat, Doctor (13 October 2021) [13 October 2021]. "SLICE Worldwide 2021 - Failed Thrombectomy". Master & Fellows.{{cite web}}: CS1 maint: date and year (link)^ Singer O, Humpich M, Laufs H, Lanfermann H, Steinmetz H, Neumann-Haefelin T (2006). "Conjugate eye deviation in acute stroke: incidence, hemispheric asymmetry, and lesion pattern". Stroke. 37 (11): 27262732. doi:10.1161/01.str.0000244809.67376.10. PMID17008621.^ Schimmel M, Leemann B, Christou P, Kiliaridis S, Herrmann F, Muller F. Quantitative assessment of facial muscle impairment in patients with hemispheric stroke. Journal of Oral Rehabilitation [serial online]. n.d.;NOV, 2011, 38.11, p800-p809, 10p.^ Okuda B, Kawabata K, Tachibana H, Sugita M (1999). "Cerebral blood flow in pure dysarthria: role of frontal cortical hypoperfusion". Stroke. 30 (1): 109113. doi:10.1161/01.str.30.1.109. PMID9880397.^ Brott T, Adams HP, Olinger CP, etal. (1989). "Measurements of acute cerebral infarctiona clinical examination scale". Stroke. 20 (7): 86470. doi:10.1161/01.str.20.7.864. PMID2749846.^ Goldstein LB, Bartels C, Davis JN (1989). "Interrater reliability of the NIH Stroke Scale". Arch Neurol. 46 (6): 660662. doi:10.1001/archneur.1989.00520420080026. PMID2730378.^ a b Clark WM, Wissman S, Albers GW, Jhamandas JH, Madden KP, Hamilton S (1999). "Recombinant tissue-type plasminogen activator (alteplase) for ischemic stroke 3 to 5 hours after symptom onset: the ATLANTIS study: a randomized con- trolled trial". JAMA. 282 (21): 20192026. doi:10.1001/jama.282.21.2019. PMID10591384.^ a b Del Zoppo GJ, Higashida RT, Furlan AJ, Pessin MS, Rowley HA, Gent M (1998). "PROACT: a phase II randomized trial of recombinant pro-urokinase by direct arterial delivery in acute middle cerebral artery stroke". Stroke. 29 (1): 411. doi:10.1161/01.str.29.1.4. PMID9445320.^ Furlan A, Higashida R, Wechsler L, Gent M, Rowley H, Kase C, Pessin M, Ahuja A, Callahan F, Clark WM, Silver F, Rivera F (1999). "Intra-arterial prourokinase for ischemic stroke: the PROACT II study: a randomized controlled trial". JAMA. 282 (21): 20032011. doi:10.1001/jama.282.21.2003. PMID10591382.^ Lewandowski CA, Frankel M, Tomsick TA, Broderick J, Frey J, Clark W, Starkman S, Grotta J, Spilker J, Khoury J, Brott T (1999). "Combined intra- venous and intra-arterial r-TPA versus intra-arterial therapy of acute ischemic stroke. Emergency Management of Stroke (EMS) Bridging Trial". Stroke. 30 (12): 25982605. doi:10.1161/01.str.30.12.2598. PMID10582984.^ Yoo, SH; Kim, JS; Kwon, SU; Yun, SC; Koh, JY; Kang, DW (2008). "Undernutrition as a Predictor of Poor Clinical Outcomes in Acute Ischemic Stroke Patients". Archives of Neurology. 65 (1): 3943. doi:10.1001/archneurol.2007.12. PMID18195138.^ Eissa A, Krass I, Bajorek B. "Optimizing the management of acute ischaemic stroke: a review of the utilization of intravenous recombinant tissue plasminogen activator (tPA). Journal of Clinical Pharmacy & Therapeutics December 2012;37(6):620-629.^ Mishra, NK; Lyden, P; Grotta, JC; Lees, KR (2010). "Thrombolysis Is Associated With Consistent Functional Improvement Across Baseline Stroke Severity: A Comparison of Outcomes in Patients From the Virtual International Stroke Trials Archive (VISTA)". Stroke. 41 (6): 26122617. doi:10.1161/strokeaha.110.589317. PMID20947852.^ a b Fink JN, Selim MH, Kumar S, etal. (2002). "Is the association of National Institutes of Health Stroke Scale scores and acute magnetic resonance imaging stroke volume equal for pa- tients with right- and left-hemisphere ischemic stroke?". Stroke. 33 (4): 9548. doi:10.1161/01.str.0000013069.24300.1d. PMID11935043.^ Lyden P, Lu M, Jackson C, Marler J, Kothari R, Brott T, Zivin J (1999). "Underlying structure of the National Institutes of Health Stroke Scale: results of a factor analysis". Stroke. 30 (11): 23472354. doi:10.1161/01.str.30.11.2347. PMID10548669.^ Lyden PD, Lu M, Levine SR, Brott TG, Broderick J, NINDS rtPA Stroke Study Group. (2001). "A modified National Institutes of Health Stroke Scale for use in stroke clinical trials: preliminary reliability and validity". Stroke. 32 (6): 13107. doi:10.1161/01.str.32.6.1310. PMID11387492.{{cite journal}}: CS1 maint: multiple names: authors list (link)^ Kasner SE, Cucchiara BL, McGarvey ML, Luciano JM, Liebeskind DS, Chalela JA (2003). "Modified National Institutes of Health Stroke Scale can be estimated from medical records". Stroke. 34 (2): 56870. doi:10.1161/01.str.0000052630.11159.25. PMID12574577.^ Muir KW, Weir CJ, Murray GD, Povey C, Lees KR (1996). "Comparison of neurological scales and scoring systems for acute stroke prognosis". Stroke. 27 (10): 18171820. doi:10.1161/01.str.27.10.1817. PMID8841337.^ Frankel MR, Morgenstern LB, Kwiatkowski T, Lu M, Tilley BC, Broderick JP, Libman R, Levine SR, Brott T (2000). "Predicting prognosis after stroke: a placebo group analysis from the National Institute of Neurological Disorders and Stroke rt-PA Stroke Trial". Neurology. 55 (7): 952959. doi:10.1212/wnl.55.7.952. PMID11061250. S2CID39939549.^ Dehaan R, Horn J, Limburg M, etal. (1993). "A comparison of 5 stroke scales with measures of disability, handicap, and quality-of-life". Stroke. 24 (8): 117881. doi:10.1161/01.str.24.8.1178. PMID8342193.^ Weimar C, Konig I, Kraywinkel K, Ziegler A, Diener H (2004). "Age and national institutes of health stroke scale score within 6 hours after onset are accurate predictors of outcome after cerebral ischemia - Development and external validation of prognostic models". Stroke. 35 (1): 158162. doi:10.1161/01.str.0000106761.94985.8b. PMID14684776.^ a b Glymour M, Berkman L, Ertel K, Fay M, Glass T, Furie K (2007). "Lesion characteristics, NIH Stroke Scale, and functional recovery after stroke". American Journal of Physical Medicine & Rehabilitation. 86 (9): 725733. doi:10.1097/phm.0b013e31813e0a32. PMID17709996. S2CID29378035.^ Woo D, Broderick JP, Kothari RU, Lu M, Brott T, Lyden PD, Marler JR, Grotta JC (1999). "Does the National Institutes of Health Stroke Scale favor left hemisphere strokes?". Stroke. 30 (11): 23552359. doi:10.1161/01.str.30.11.2355. PMID10548670.^ Adams H, Davis P, Hansen M, etal. (1999). "Baseline NIH Stroke Scale score strongly predicts outcome after stroke - A report of the Trial of Org 10172 in Acute Stroke Treatment (TOAST)". Neurology. 53 (1): 126131. doi:10.1212/wnl.53.1.126. PMID10408548. S2CID20176582.[1]^ Martin-Schild S, Albright KC, Tanksley J, Pandav V, Jones EB, Grotta JC, Savitz SI (2011). "Zero on the NIHSS does not equal the absence of stroke". Ann Emerg Med. 57 (1): 425. doi:10.1016/j.annemergmed.2010.06.564. PMC3426834. PMID20828876.Retrieved from " found this document useful (24 votes)220K views1. The document reports clinical findings for 6 patients divided into 3 groups (A, B, C). 2. For each patient, results are shown for 11 tests assessing factors like alertness, language skilSaveSave NIHSS Answer Key For Later79%79% found this document useful, undefined79%(24)79% found this document useful (24 votes)220K views1. The document reports clinical findings for 6 patients divided into 3 groups (A, B, C). 2. For each patient, results are shown for 11 tests assessing factors like alertness, language skil,the free encyclopedia that anyone can edit.117,937 active editors 7,001,369 articles in EnglishThe English-language Wikipedia thanks its contributors for creating more than seven million articles! Learn how you can take part in the encyclopedia's continued improvement.GL Mk.II transmitter vanRadar, Gun Laying, MarkI, or GL Mk.I for short, was an early World WarII radar system developed by the British Army to provide information for anti-aircraft artillery. There were two upgrades, GL/EF (elevation finder) and GL Mk.II (pictured), both improving the ability to determine a target's bearing and elevation. GL refers to the radar's ability to direct the guns onto a target, known as gun laying. The first GL sets were developed in 1936 using separate transmitters and receivers mounted on gun carriages. Several were captured in 1940, leading the Germans to believe falsely that British radar was much less advanced than theirs. The GL/EF attachment provided bearing and elevation measurements accurate to about a degree: this caused the number of rounds needed to destroy an aircraft to fall to 4,100, a tenfold improvement over early-war results. The Mk.II, which was able to directly guide the guns, lowered the rounds-per-kill to 2,750. About 410 Mk.Is and 1,679 Mk.IIs were produced. (Fullarticle...)Recently featured: Andrea NavageroNosy KombaMcDonnell Douglas Phantom in UK serviceArchiveBy emailMore featured articlesAboutLieke Klaver ahead in the women's 400 metres final... that a 400-metre race in 2025 (pictured) was won by Lieke Klaver, who pretended that an absent competitor was running in front of her?... that the land snail Drymaeus poecilus is notable for the striking variety of colors and patterns on its shell?... that a forensic investigation of Signalgate has determined how a journalist was included in a group chat about Operation Rough Rider?... that two of the players involved in the 2005 Vietnamese football match-fixing scandal did not accept payment because they felt ashamed?... that a rebellion against a peace treaty with the Yuan dynasty operated out of the Historic Site of Anti-Mongolian Struggle on Jeju Island?... that Nathan Frink fled the United States with enslaved children to settle in Canada, where he was elected as a Member of the Legislative Assembly and caught in a smuggling conspiracy?... that Seattle's women's ice hockey team has an expected rival, despite not even having played their first game?... that Cave Johnson Couts was separately acquitted for shooting his foreman, firing on funeral mourners, and whipping a native laborer to death?... that characters' scars in an episode of The Last of Us were made with a paste-based appliance and a food mixer?ArchiveStart a new articleNominate an articleNgg wa Thiong'oKenyan writer and activist Ngg wa Thiong'o (pictured) dies at the age of 87.In sumo, nosato Daiki is promoted to yokozuna.In association football, Liverpool win the Premier League title.In motor racing, lex Palou wins the Indianapolis 500.Ongoing: Gaza warM23 campaignRussian invasion of UkrainetimelineSudanese civil wartimelineRecent deaths: Phil RobertsonMary K. GaillardPeter DavidAlan YentobGerry ConnollySebastio SalgadoNominate an articleMay 30: Statehood Day in Croatia (1990)Johann Sebastian Bach1431 Hundred Years' War: After being convicted of heresy, Joan of Arc was burned at the stake in Rouen, France.1723 Johann Sebastian Bach (pictured) assumed the office of Thomaskantor in Leipzig, presenting the cantata Die Elenden sollen essen in St.Nicholas Church.1922 The Lincoln Memorial in Washington, D.C., featuring a sculpture of the sixteenth U.S. president Abraham Lincoln by Daniel Chester French, opened.1963 Buddhist crisis: A protest against pro-Catholic discrimination was held outside the National Assembly of South Vietnam in Saigon, the first open demonstration against President Ng nh Dim.2008 The Convention on Cluster Munitions, prohibiting the use, transfer, and stockpiling of cluster bombs, was adopted.Ma Xifan (d.947)Colin Blythe (b.1879)Norris Bradbury (b.1909)Wynonna Judd (b.1964)More anniversaries: May 29May 30May 31ArchiveBy emailList of days of the yearAboutSeventeen performing "Oh My!" in 2018South Korean boy band Seventeen made their debut on May 26, 2015, when they performed a showcase for their debut EP 17 Carat in front of a crowd of 1,000 people. Since then, the group have held 9 concert tours, 13 fan meetings, and have performed at a number of music festivals and awards shows. Their concert tours include the Right Here World Tour, which sold over one million tickets, and the Follow Tour, which was noted by Billboard as being the top grossing K-pop tour of 2023. In 2024, Seventeen made their first appearances at festivals in Europe, when they were the first South Korean act to perform at Glastonbury Festival's Pyramid Stage and as headliners for Lollapalooza Berlin. Seventeen's live performances are well regarded by fans and critics alike, and garnered them the award for Top K-pop Touring Artist at the 2024 Billboard Music Awards. (Fulllist...)Recently featured: Accolades received by Top Gun: MaverickNational preserve76th Primetime Emmy AwardsArchiveMore featured listsIgnace Tonen (1840 or 1841 15 March 1916), also known as Nias or by his Ojibwe name Maiagizis ('right/correct sun'), was a Teme-Augama Anishnabai chief, fur trader, and gold prospector in Upper Canada. He was a prominent employee of the Hudson's Bay Company. Tonen was the elected deputy chief before being the lead chief and later the life chief of his community. In his role as deputy, he negotiated with the Canadian federal government and the Ontario provincial government, advocating for his community to receive annual financial support from both. His attempts to secure land reserves for his community were thwarted by the Ontario premier Oliver Mowat. Tonen's prospecting triggered a 1906 gold rush and the creation of Kerr Addison Mines Ltd., although one of his claims was stolen from him by white Canadian prospectors. This photograph shows Tonen in 1909.Photograph credit: William John Winter; restored by Adam CuerdenRecently featured: Australian white ibisHell Gate BridgeAnemonoides blandaArchiveMore featured picturesCommunity portal The central hub for editors, with resources, links, tasks, and announcements.Village pump Forum for discussions about Wikipedia itself, including policies and technical issues.Site news Sources of news about Wikipedia and the broader Wikimedia movement.Teahouse Ask basic questions about using or editing Wikipedia.Help desk Ask questions about using or editing Wikipedia.Reference desk Ask research questions about encyclopedic topics.Content portals A unique way to navigate the encyclopedia.Wikipedia is written by volunteer editors and hosted by the Wikimedia Foundation, a non-profit organization that also hosts a range of other volunteer projects: CommonsFree media repository MediaWikiWiki software development Meta-WikiWikimedia project coordination WikibooksFree textbooks and manuals WikidataFree knowledge base WikinewsFree-content news WikiquoteCollection of quotations WikisourceFree-content library WikiversityFree learning tools WikivoyageFree travel guide WiktionaryDictionary and thesaurusThis Wikipedia is written in English. Many other Wikipedias are available; some of the largest are listed below. 1,000,000+ articles DeutschEspaolFranaisItalianoNederlandsPolskiPortugusSvenskaTing Vit 250,000+ articles Bahasa IndonesiaBahasa MelayuBn-lm-gCataletinaDanskEestiEsperantoEuskaraMagyarNorsk bokmlRomnSimple EnglishSloveninaSrpskiSrpskohrvatskiSuomiTrkeOzbekcha 50,000+ articles AsturianuAzrbaycancaBosanskiFryskGaeilgeGalegoHrvatskiKurdLatvieuLietuviNorsk nynorskShqipSlovenina Retrieved from " 2EP by Seventeen17 CaratEP by SeventeenReleasedMay29,2015(2015-05-29)GenreK-popdance-pophip hopLength16:48LanguageKoreanLabelPledis EntertainmentLOEN EntertainmentSeventeen chronology17 Carat(2015)Boys Be(2015)Singles from 17 Carat "Adore U"Released: May 29, 201517 Carat is the debut extended play (EP) by South Korean boy group Seventeen. It was released on May 29, 2015, by Pledis Entertainment and distributed by LOEN Entertainment. "Adore U" serves as the lead single for the EP.17 Carat features five tracks written, co-written, and co-produced by Seventeen's group members. "Adore U" was chosen as the lead single for the EP and was performed on multiple music shows by the group. "Shining Diamond" was used as a pre-single on the group's reality debut show. The group stated that the tracklist was chosen to reflect Seventeen's core concept of "boys' passion".[1] The album has two physical versions: one with a "black" themed photo card set, and the other with a "white" themed photo card set. All copies include a CD containing the songs and a fold-up poster/lyric sheet."Adore U" is the lead single of the extended play. It was written by Woozi, S.Coups, and Yeon Dong-geon.[2] The Korea Herald states "'Adore U' is a funky pop song about a teenage boy trying to navigate through puppy love."[3] It marks the beginning of the group's trilogy composed of the singles Adore U, Mansae, and Pretty U about a boy meeting, falling in love and asking out a girl. The track was composed and arranged by Woozi, Bumzu, and Yeon Dong-geon. The music video for the single was released on May 29, 2015, and was directed by Dee Shin. The dance choreography accompaniment to the song was choreographed by Hoshi and focuses on "storytelling, and on highlighting each member's strengths onstage".[4] The single has sold more than 38,000 digital copies and peaked at number 13 on the Billboard US World Chart.The EP has sold over 82,972 copies in South Korea.[5] It peaked at number 4 on the Korean Gaon Album Chart[6] and number 8 on the US World Billboard Chart.[7]Year-end listsCritic/publicationListRankRef.BillboardThe 10 Best K-pop Album of 2015Placed[8]Hoshi participated in the choreography of "Adore U" and "Shining Diamond", Dino choreographed "Jam Jam".[9]Official track list[10]No.TitleLyricsMusicArrangementsLength1."Shining Diamond"WooziVernonS.CoupsKim Min-jeongWooziMasterKeyRishiMasterKeyRishi3:242.""Adore U"" (; Akkinda)WooziVernonS.CoupsBumzuWooziBumzuYeon Dong-geonWooziBumzuYeon Dong-geon3:073."Ah Yeah" (Hip-Hop unit)S. CoupsVernonWonwooMingyuCream DoughnutRishiCream DoughnutRishi3:294."Jam Jam" (Performance unit + Vernon)WooziHoshiDinoVernonWooziCream DoughnutCream Doughnut3:255."20" (Vocal unit)WooziWooziWon Yeong-heonWon Yeong-heonDong Ne-hyeong3:23Weekly chart performance for 17 CaratChart (2015-2023)PeakpositionJapanese Albums (Oricon)[11]46South Korean Albums (Gaon)[12]4US World Albums (Billboard)[13]8Year-end chart performance for 17 CaratChart (2015)PeakpositionSouth Korean Albums (Gaon)[14]47^ "Seventeen hopes to shine like diamonds with '17 Carat'". The Korea Herald. 26 May 2015. Retrieved 30 November 2016.^ "Adore U". Color Coded Lyrics. 29 May 2015. Retrieved 29 November 2016.^ "Seventeen hopes to shine like diamonds with '17 Carat". The Korea Herald. 26 May 2015. Retrieved 30 November 2016.^ "Seventeen hopes to shine like diamonds with '17 Carat'". The Korea Herald. 26 May 2015. Retrieved 30 November 2016.^ Cumulative sales of 17 Carat:"2015 Album Chart"."2016 12 Album Chart"."2017