**Background** Hemorrhagic stroke accounts for 10–15% of all types of strokes. It carries higher mortality and morbidity in comparison to ischemic stroke. Evidence suggests that inflammatory mechanisms are involved in the pathophysiology of brain injury due to intracranial hemorrhage. Peripheral blood neutrophil to lymphocyte ratio (NLR) has recently emerged as a reliable marker of subclinical systemic inflammation. The aim of this study was to explore the significance of Neutrophil to Lymphocyte ratio in the functional outcome of patients with hemorrhagic stroke.

**Methods** Patients who presented to the Emergency Department with symptoms suggestive of stroke were evaluated with CT brain to identify hemorrhagic stroke. Patients with history of trauma, coagulopathy, fever or prior cerebrovascular accidents were excluded. The Modified ICH score and NLR were estimated at the time of admission. Functional outcome was assessed with Modified Rankin score after 3 months of initial presentation by telephonic conversation. A Modified Rankin score equal to or more than 3 was categorized as poor outcome group. Receiver operating curve (ROC) was used with NLR and Modified ICH score to analyze their influence in predicting poor functional outcome.

**Results** A total of 158 patients were recruited for the study. After 3 months, 107 patients were identified as the poor outcome group as per their Modified Rankin score. The mean NLR and Modified ICH score at presentation were significantly higher for the poor outcome group (6.577 and 2.83) compared to the good outcome group (2.754 and 1.49) respectively with a p value of 0.001. The cut off value of 3.2 for NLR has a sensitivity of 75% and specificity of 70% to predict poor outcome.

**Conclusion** In patients with hemorrhagic stroke, a higher Neutrophil to Lymphocyte ratio at presentation is associated with poor functional outcomes at 3 months.
A review shows that more CVT extension & earlier presentation (<2 weeks) were correlated with higher D-dime levels. Unfortunately, most of the studies are not high-quality studies, with variable designs, population, and reference standard tests. The studies showed that D dimer could help predict CVT in combination with risk factors and clinical presentation.

We concluded that the normal D-dimer only should not be used to exclude CVT. There is a probability of using D-dimer in CVT risk scoring and pre-imaging negotiation, and for that purpose, larger and higher-quality studies are needed.

REFERENCES
3. Dentali F, Squizzato A, Marchesi C, Bonzini M, Ferro JM, Ageno W. D-dimer test purpose, larger and higher-quality studies are needed.

Abstract 798 Figure 1
STROBE flow diagram of study population selection

Abstract 798 Table 1
Performance of binary NHS 111 triage (ambulance or urgent assessment 4 hours or less) for composite outcome (death or organ support)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>N=40, 261</th>
<th>Adverse</th>
<th>No Adverse</th>
<th>Sensitivity</th>
<th>Specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance/urgent assessment</td>
<td>890</td>
<td>15, 035</td>
<td>90%</td>
<td>74.2% (71.6-76.6%)</td>
<td>5.6% (52-6%)</td>
</tr>
<tr>
<td>Self-care/non-urgent assessment</td>
<td>310</td>
<td>24, 025</td>
<td>100%</td>
<td>61.5% (61-62%)</td>
<td>98.7% (98.6-98.9%)</td>
</tr>
</tbody>
</table>