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The study assessed brain infarction for the subsequent classification of Aspect TS. Tran Kong Tange, BS. Lu Hong Minhyo Ho Chi Minh Urban University of Medicine and Pharmacy-Tien Giang Medical College HYUNDAIS Research Goal: Assess the relationship between the aspect of scale and results in 3 months. Compare the forerant of the ASPECT result with NIHSS. Study method: The system describes progress by getting successive patients with acute brain infarction hospitalized in the first 48 hours. All patients received GCS, NIHSS rating at the time of admission, discharge, mRS and BI rating at the time of 3 months. The assessment aspect is read on CT images using 2 independent doctors images and neuropsychics. We divide individual points into 2 groups: good group: 8-10 points, bad group: 0-7 points, from a bad group divided into 2 groups: Group 5-7 points and 0-4 points. Results: A total of 100 patients with a brain infarction due to obstruction of the middle cerebral artery, the average age is 54.89; 62 per cent of men. The average ASPECT is 0.818. GCS, NIHSS during discharge, mRS and BI 3 months are associated with ASPECTS when comparing aspects good and bad. Patients with short hospital stays correspond to good ASPECTS. Optimal sensitivity and specificity with a total ASPECT score is 7 (sensitivity 94%, specific 95%) and a total NIHSS score of 10 (sensitivity 86.7%, specific 88.8%). Conclusion: In patients with acute brain infarction caused by the obstruction of the middle cerebral artery, ASPECTS is a strong progression factor in the pre-emption of acute cerebral infarction. The ASPECT score is better than the NIHSS scale. Keywords: ASPECT scale, mRS scale, NIHSS scale, and brain infarction (NMN) is a common clinical stroke organ that accounts for 80-85%. According to the American Heart and Stroke Society in 2006, 565,000 NMN patients are hospitalized annually, with monthly deaths accounting for 16%, treatment worth \$58 billion and being the main cause of severe and long-term disability. Increasing disability, reducing mortality is a medical problem. The issue for doctors and relatives of patients is the pre-installation of a brain infarction (NMN) Once you're hospitalized? Previous studies have used the NIHSS, Glasgow to pre-set stroke weight to assess NMN prefings, using the mRS or BI scale for targeted functional results. Today, many imaging techniques are born, such as CT scans, MRIs... helps to show specific images of the location and size of the area of brain infarction, as well as the influence of surrounding brain tissues serving the diagnosis of cause, treatment and thegnoscture. Many studies around the world are studying NMN fore-related photology, such as Tei and her partner 47 finding fore-quality clinical factors and CT in the sediments of cyehor attack recovery. Puest's research shows that CT scans the volume of a heart attack and is clinically associated with the outcome of a heart attack in the middle cerebral artery. The Alberta Stroke Program's Early CT Assessment has so far been used for semi-dosing assessments based on the location of lesions on CT scans on cases of an average brain infarction and to assess the extent of early ischemic changes in CT scans in patients with acute ischemic stroke. One study noted the EVALUATION score, which had a good forerunner hemorrhhex after intravenous thrombolytic treatment and was closely related to other advanced imaging techniques such as CTA, CTP, MRI. As part of numerous studies, we have recorded an ASPECT score commonly used in nmN treatments, and assessed the extent of the damage on CT. Therefore, in order to contribute to assessing the necessary role of ASPECT assessment in patients with acute brain infarction, we conducted this study with the following specific goal: Characteristics of aspectal scale in patients with acute brain infarction. The link between the ASPECT scale and the population, clinical factors and the outcomes of brain infarction.II. METHOD OF RESEARCH Target population includes patients with an acute brain infarction due to a blockage of the middle cerebral artery in the first 48 hours. The population selects samples of NMN patients admitted to the emergency room who meet the criteria for the selection and elimination of diseases during the study period at the Central General Hospital Jiang.Cross-section research describes, promotes research. Independent variables are population, risk factors, scale of clinical evaluation, death, complications, length of hospital stay, start time, time of CT scan of dependent variables is the ASPECT assessment during the study period. We get patients with acute onset of NMN in the first 48 hours and 18 years and older. The criteria for exclusion in the study of NMN patients are related to cerebral artery anemia and lateral cerebral artery, after circulatory NMN, NMN due to intravenous thrombosis and stroke anemia. After recording patient information, all patients are evaluated at the time of admission, the time of discharge, and monitored after 3 months. Detailed patient records include: Age, gender, risk factors, stroke onset time before hospitalization, CT time. All patients are styding in medical examinations, neurological and other examinations. Rate GCS and NIHSS scores at the time of receipt and discharge. Patients are tested for blood glucose levels, electrocardi cardiac measurements, ultrasound of the heart, lipid blood tests. The results of the CT are independently evaluated by the diagnostic doctor and neurosis. Both doctors were trained to read a CT. Finally evaluate mRS and BI scores on three months by calling a relative interview. The collected data are recorded in the medical reports of the studies and then included in the data entry section of the statistical software SPSS 16.0 to survey the intercommunality of variables with an aspect scale. In one variable analysis, calculated variables are analyzed using a validation, dosing variables analyzed by ANOVA 1-dimensional ertcholysis analysis if 3 variations are homogeneous, according to the Kruskal-Wallis test, if Levene Stats is 0.05, relies on the Bonferroni test in this post or compare each group. Aspects and NIHSS variables are evaluated using operational analysis of receivers to determine sensitivity, specificity, and areas below the ROC curve, thus comparing ASPECT and NIHSS. STUDY 1. Study of Selective Characteristics Study of 100 Patients, Including 38 Women 38%, average age 54.89; the youngest is 21 years old, the 90-year-old is the youngest. 90% of patients have at least one risk factor. Hypertension was 50%, then in descending order, smoking (46%), diabetes (28%), coronary heart disease (20%), heart valve disease (18%), alcoholism (14%), atrial fibrillation (8%), TIA (7%), lipid disorders (6%) and family history of stroke (1%). 56% of patients with right paralysis and 44% of left paralyzed patients with or without facial paralysis. THE ASPECTS intermediate score is 8 based on the results of the doctor's imaging reading, the AVERAGE score of ASPECTS is 7 if the CT-based results of the reading are neurosis. The correlation is 0.818. Based on aspects divided into 3 groups: Group 0 with ASPECTS 8 to 10, group 1 from 5 to 7, and group 3 from 0 to 4. With regard to the relationship between the scale of aspects with variables, based on statistical analysis, recognition of age, gender, all risk factors, TIME of CT, there are no statistical differences (except p-0.037 smoking). ASPECT is associated with GCS, NIHSS, mRS, BI and hospital stays, statistically significant differences. Roc curve survey, ASPECTS has a higher sensitivity and specificity than NIHSS. Figure 1. Correlation of CT scan results between neuroscialistic and BS scanning. Group 1. The results of one variable analysis between aspects and related variables. From the results of the inter-variable mediation study to the ASPECTS subgroup, age, gender, risk factors (excluding smoking), hospital time, CT time, mortality, acute complications not related to the aspect scale in the study (p. qgt; 0.05). Variables: Smoking, NIHSS scale, GCS, mRS, BI, hospital stay, is associated with a scale aspect in a statistically significant study (p zlt; 0.05).2. Compare the aspect scales with NIHSS, which are close to the ROCIV curve. DISCUSSED In this study, we had a photo-based NMN score on nmN patients starting in the first 48 hours. The correlation of our study was 0.82. This is consistent with many other studies ranging from 0.71 to 0.85 (3.11). Through this is the correlational effects we see as calculating the ASPECT scale, which estimates accurately and better than the calculation of the 33% rule. In addition, the ASPECT scale is easier to use for less experienced physicians, and the ASPECT scale is a unit of measurement of heart attack in CT. As a result of the study, we noted that ASPECTS is not related to the time of operation of the hospital terminal, but to the time of CT. ASPECTS is associated with NIHSS, GCS and functional results after 3 months. We chose a good mRS score: 0 - 2, bad: zgt;2 to score based on the results of research by Nguyen Ba Tang and author Gonzalez. The results of the ROC curve study showed that the area below the curve was 98%, with a high sensitivity of 94%, a specificity of 95% according to the results of the study of Gonzalez and his partner. Thus, the ASPECT scale is a good assessment of the functional result. The predictive predictive outcome of the projected outcome of the ASPECT scale has a positive value of 96%, a negative value of 93%, which proves that the predictive value of functional results is high. Our study did not include a NIHSS assessment when discharged for evaluation, as the NIHSS assessment at the time of admission was earlier, so we do not include it. Our ASPECT assessment is based on the doctor's visualization readings at the time of admission. When comparing the sensitivity between the ASPECT scale and the NIHSS scale, the ASPECTS scale is more sensitive (93.3% vs. 86.7%), so functional results have a higher value, in the study of Gonzalez and his partner, using NIHSS assessments and aspect scales of equal sensitivity of 86%-94.5% (p<0.0001), which differed from our results, which may also explain whether we rated the NIHSS score as probable. but only one variable analysis shows that ASPECTS has a higher value than the NIHSS scores while author Gonzalez and his partner, multi-variable analysis combining NIHSS and ASPECTS have a strong value in predicting results.V. Conclusion Through this study, we conclude that the ASPECTS scale has a stronger clinical outcome premise than NIHSS during admission. However, we must do An gye NIHSS két hóp aspects để cho kết quả tốt nhất. Purpose: Assess the correlation of Alberta's Stroke Program Early CT Assessment (ASPECTS) and forecast results for 3 months. Methods: In a prospective cohort study, we recruited successive patients with acute medium cerebral (MCA) ischemic stroke, which was presented within 48 hours of the onset of stroke. All patients were assessed at admission (Glasgow Coma Scale - GCS and NationalInstitute of Health Stroke Scale - NIHSS) at discharge (GCS, NIHSS, BarthelIndex - BI and modified Rankin-mRS scale) and in 3months (BlandmRS). THE ENT ASPECTS was calculated by two observers on their own. We divided patients into three ASPECTS groups with scores of 8 - 10, 5 - 7 and 0 - 4.Results: Among 100 patients with acute MCA heart attack (average age 55yrs, 62 men), average ASPECTS scores were inter-reliability course 0.82. Mortality, GCS and NIHSS at discharge, and MRS and BI in 3 months are significantly better among patients with 'Better' compared to 'Worse' APSECTS. The hospital stay was shorter than inpatients with better ASPECTS. The amount of sensitivity and specificity was maximised on the overall ASPECTS score 7 (sensitivity 94%; specificity 95%) and NIHSS total score 10 (sensitivity 86.7%; specificity 88.8%). Conclusion: In acute stroke, ASPECTS is a strong predictor of outcome in acute ischemic stroke. ASPECTS is a valid predictor better than NIHSS. Keywords: Alberta Stroke Program Early CT Assessment, National Institute of Health Stroke Scale, Modified Rankin Scale, Forecast Results. TLM LIÊU THAM KHÃOAppelosP, TerentA.Characteristics of the National Institutes of Health Stroke Scale: Results from the population - based on the cohort of stroke at a baseline and after one year. CerebrovascDis 2004;17:21-7.Barber PA, Demchuk AM, ChangJ, et al.(2000). For the ASPECTS study group. The reliability and reliability of quantitative computed tomography in predicting the outcome of hyperacute stroke before thrombolytic therapy. Lancet 355, p.1670 - 4.BatemanB, Schumacher, Boden-AlbalaB, Ethal (2006). 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