Low Pulse Pressure After Acute Ischemic Stroke is Associated With Unfavorable Outcomes: The Taiwan Stroke Registry

Sung-Chun Tang, MD, PhD; Jiu-Haw Yin, MD; Chung-Hsiang Liu, MD; Ming-Hui Sun, MD; Jiunn-Tay Lee, MD; Yu Sun, MD, PhD; Chih-Shan Hsu, MD; Mu-Chien Sun, MD; Ching-Huang Lin, MD; Chih-Hung Chen, MD; Li-Ming Lien, MD, PhD; Chih-Hsin Muo, MS; Jiunn-Shing Jeng, MD, PhD; Chung Y. Hsu, MD, PhD; Taiwan Stroke Registry Investigators*

Background—Pulse pressure (PP) is related to cardiac function, arterial stiffness, fluid status, and vascular events. This study aimed to explore the prognostic role of PP upon admission in patients with acute ischemic stroke (AIS) based on a nation-wide stroke registry.

Methods and Results—We evaluated the association between PP upon admission and outcomes 3 months after a stroke in patients who had an AIS registered in the Taiwan Stroke Registry, including 56 academic and community hospitals between 2006 and 2013. Three months after the stroke, unfavorable outcomes were defined using a modified Rankin scale of 3 to 6. Of 33,530 patients (female, 40.6%; mean age, 68.8±13.3 years) who had an AIS, PP upon admission had a reverse J-curve association with an unfavorable outcome. After adjusting for clinical variables, including AIS subtypes, initial National Institutes of Health Stroke Scale, and systolic and diastolic blood pressure upon admission, a PP of 50 mm Hg was associated with unfavorable outcomes (P<0.0001). Compared with patients with a PP of 50 to 69 mm Hg, the odds ratios for unfavorable outcomes were 1.24 (95% CI, 1.14–1.36) with a PP of 30 to 49 mm Hg and 1.85 (95% CI, 1.50–2.28) with a PP of <30 mm Hg. Moreover, the prognostic impact of PP upon admission was similar across all AIS subtypes.

Conclusions—Low PP upon admission was associated with unfavorable patient outcomes in AIS. (J Am Heart Assoc. 2017;6:e005113. DOI: 10.1161/JAHA.116.005113.)

Key Words: blood pressure • ischemic stroke • outcome • pulse pressure • stroke registry

Stroke is a life-threatening disease, leading cause of death, and severe long-term disability worldwide. Among several factors that may increase the risk of stroke, hypertension is the single most important one. Uncontrolled blood pressure (BP) would lead to atherosclerosis and, in turn, harden and weaken the vessels in the brain, heart, and limbs, causing end-organ damage. However, the occurrence of stroke may directly lead to an acute increase in BP. Although the role of BP management after a stroke remains controversial, systolic, mean, or diastolic BP levels upon hospital arrival have demonstrated a U- or J-curve association with poststroke mortality and functional dependency.

In addition to the steady components of systolic and diastolic values, BP is also characterized by its pulsatile nature and is estimated using pulse pressure (PP). The difference between the systolic and diastolic BP can be conceptualized as being proportional to the stroke volume; and is inversely related to aortic compliance. However, it...
remained unclear whether a relationship between admission PP and clinical outcomes among patients with acute stroke existed.18–21 Thus, the present study aimed to explore the prognostic role of admission PP in patients with acute ischemic stroke (AIS) based on a nation-wide stroke registry.

Methods

Taiwan Stroke Registry

Since 2006, the Taiwan Stroke Registry (TSR) has been a nation-wide hospital-based prospective study engaging 56 academic and community hospitals and has 4 steps of quality control to ensure the reliability of the stroke database.22 The registry enrolls patients who had a stroke and who present to the hospital within 10 days of symptom onset. Study protocols were approved by the institutional review boards of all participating hospitals. Patients who signed the informed consent obtained follow-up 3 months after stroke onset during outpatient clinic visits and/or a telephone interview conducted by trained nurses who served as stroke case managers. Patients were excluded if they were aged <18 years, had a final diagnosis involving a condition other than a stroke, or were lost to follow-up. For patients who had multiple admissions because of a stroke, only the first stroke admission was included for analysis. In the present study, we retrieved the TSR registration data recorded between August 1, 2006 and August 31, 2013 that contained a total of 83,666 patients who had a stroke.

Data Collection and Measurements

Patient characteristics relevant to acute stroke, including stroke type, neurological deficit severity defined by the National Institute of Health Stroke Scale (NIHSS), systolic and diastolic BP upon admission, medical history, pre-existing comorbidities, and demographic data, were collected according to a predefined system. The definition of AIS in the TSR was acute onset of neurological deficit with signs or symptoms persisting longer than 24 hours with or without acute ischemic lesion(s) observed on brain computed tomogram or magnetic resonance imaging scans. Hypertension was considered if subjects were administered antihypertensive medicine before admission, documented to have hypertension in previous clinic visits, or had an average systolic BP of ≥140 mm Hg or diastolic BP of ≥90 mm Hg. Diabetes mellitus was considered if subjects were prescribed oral hypoglycemic agents or insulin for diabetes mellitus; if diabetes mellitus was documented in previous clinic visits or hospital admissions; or if patients had fasting glucose levels of ≥126 mg/dL. Past cerebrovascular events, including a stroke or transient ischemic attack, and a history of cardiovascular diseases, including coronary artery disease, atrial fibrillation, or congestive heart failure, were confirmed based on previous medical records during admission and at clinic visits.

Ischemic stroke was classified into 5 major subtypes according to the TOAST (Trial of ORG 10172 in Acute Stroke Treatment) criteria into large artery atherosclerosis, small vessel occlusion, cardioembolism, other specific etiologies, and undetermined etiology.23 As for the 3-month follow-up, patients were assessed upon admission and discharge, during follow-up clinic visits, or through phone calls. The main outcomes were modified Rankin Scale 3 months after stroke onset. Unfavorable outcomes were defined as a modified Rankin Scale of 3 to 6. Admission BP was obtained by nurses when patients were transferred to wards. Before the study, all designated nurses at the participating hospitals had obtained training on standardized procedures for BP measurement and TSR data entry. After the patients had lain down for 5 minutes, a BP monitor was used to measure systolic and diastolic BP from the arms of each enrolled patient. PP was defined as systolic BP minus diastolic BP.

Figure 1. Flow chart of the study subjects. DBP indicates diastolic blood pressure; mRS, modified Rankin Scale; NIHSS, National Institutes of Health Stroke Scale; SBP, systolic blood pressure; TOAST, Trial of ORG 10172 in Acute Stroke Treatment.

DOI: 10.1161/JAHA.116.005113
Statistical Analysis

All descriptive data are expressed as number of patients, percentage, and mean value with SD. Prognostic factors and poor outcome were determined using univariable and multivariable analyses. In the univariable analysis, unfavorable outcome rates for ischemic stroke in patients with different characteristics are expressed as percentages on a histogram. Distributions in age, sex, NIHSS level, and chronic medical conditions were also assessed using a chi-square or independent t test. In the multivariable analysis, a logistic regression method was used to adjust for known prognostic factors with univariable P values of <0.10, including age, sex, hypertension, diabetes mellitus, previous stroke, coronary artery disease, atrial fibrillation, dyslipidemia, current smoker, carotid stenosis, receiving thrombolytic therapy, initial NIHSS, and continuous systolic and diastolic BP at admission. Spearman’s correlation coefficient was used for the correlation between PP and systolic BP, and PP and diastolic BP. Data were analyzed using SAS software (version 9.2; SAS Institute Inc, Cary, NC). Statistical significance was considered at a P value of <0.05.

Results

Study Subject Demographics

Among 83 666 patients who had an acute stroke in the TSR, 23 487 had a hemorrhagic stroke; 18 865 were lost during the 3-month follow-up; and 7784 who had other specified conditions were excluded (Figure 1). The present study included 33 530 patients with AIS (mean age, 68.8±13.3 years; 59.4% males). Detailed demographic and clinical characteristics for this cohort are presented in Table 1.

Table 1. Three-Month Outcome of Acute Ischemic Stroke Patients

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Total (N=33 530)</th>
<th>Modified Rankin Scale</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0 to 2 (N=17 842)</td>
<td>3 to 6 (N=15 688)</td>
</tr>
<tr>
<td>Mean age, y</td>
<td>68.8±13.3</td>
<td>65.1±12.9</td>
<td>73.0±12.4</td>
</tr>
<tr>
<td>Age ≥65 y</td>
<td>21 425 (63.9%)</td>
<td>9423 (52.8%)</td>
<td>12 002 (76.5%)</td>
</tr>
<tr>
<td>Female sex</td>
<td>13 622 (40.6%)</td>
<td>6156 (34.5%)</td>
<td>7466 (47.6%)</td>
</tr>
<tr>
<td>Stroke risk factors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>24 640 (73.5%)</td>
<td>12 911 (72.4%)</td>
<td>11 729 (74.8%)</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>12 293 (36.7%)</td>
<td>6282 (35.2%)</td>
<td>6011 (38.3%)</td>
</tr>
<tr>
<td>Previous stroke or TIA</td>
<td>8782 (26.2%)</td>
<td>4090 (22.9%)</td>
<td>4692 (29.9%)</td>
</tr>
<tr>
<td>Coronary artery disease</td>
<td>4507 (13.4%)</td>
<td>1998 (11.2%)</td>
<td>2509 (16.0%)</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>4363 (13.0%)</td>
<td>1505 (8.4%)</td>
<td>2858 (18.2%)</td>
</tr>
<tr>
<td>Dyslipidemia</td>
<td>14 484 (43.2%)</td>
<td>7959 (44.6%)</td>
<td>6525 (41.6%)</td>
</tr>
<tr>
<td>Current smoker</td>
<td>8047 (24.0%)</td>
<td>4716 (26.4%)</td>
<td>3331 (21.2%)</td>
</tr>
<tr>
<td>Carotid stenosis</td>
<td>2937 (8.8%)</td>
<td>1287 (7.2%)</td>
<td>1650 (10.5%)</td>
</tr>
<tr>
<td>TOAST classification</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Large artery atherosclerosis</td>
<td>9315 (27.8%)</td>
<td>4376 (24.5%)</td>
<td>4939 (31.5%)</td>
</tr>
<tr>
<td>Small vessel occlusion</td>
<td>12 747 (38.0%)</td>
<td>8795 (49.1%)</td>
<td>3988 (25.4%)</td>
</tr>
<tr>
<td>Cardioembolism</td>
<td>4002 (11.9%)</td>
<td>1571 (8.8%)</td>
<td>2431 (15.5%)</td>
</tr>
<tr>
<td>Specific etiology</td>
<td>574 (1.7%)</td>
<td>257 (1.4%)</td>
<td>317 (2.0%)</td>
</tr>
<tr>
<td>Undetermined etiology</td>
<td>6892 (20.6%)</td>
<td>2879 (16.1%)</td>
<td>4013 (25.6%)</td>
</tr>
<tr>
<td>Characteristics on admission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NIHSS</td>
<td>6.2±8.1</td>
<td>4.6±6.7</td>
<td>7.9±9.1</td>
</tr>
<tr>
<td>Systolic blood pressure, mm Hg</td>
<td>160.2±31.1</td>
<td>160.8±30.1</td>
<td>159.6±32.1</td>
</tr>
<tr>
<td>Diastolic blood pressure, mm Hg</td>
<td>87.9±19.5</td>
<td>89.0±18.9</td>
<td>86.6±20.1</td>
</tr>
<tr>
<td>PP, mm Hg</td>
<td>72.4±23.8</td>
<td>71.8±22.8</td>
<td>73.0±24.8</td>
</tr>
<tr>
<td>Thrombolytic therapy</td>
<td>1070 (3.2%)</td>
<td>427 (2.4%)</td>
<td>643 (4.1%)</td>
</tr>
</tbody>
</table>

Values are number (percentage) or mean (SD). NIHSS indicates National Institutes of Health Stroke Scale; PP, pulse pressure; TIA, transient ischemic attack; TOAST, Trial of ORG 10172 in Acute Stroke Treatment.
Table 1. Mean values for systolic BP, diastolic BP, and PP upon admission were 160.2/87.9, 87.9/72.4, and 72.4/23.8 mm Hg, respectively. By the way, PP was strongly correlated with systolic BP ($r=0.78; P<0.0001$), but only very weakly correlated with diastolic BP ($r=0.02; P<0.0001$). The percentages of mortality and unfavorable outcomes 3 months poststroke were 8.7% and 46.8%, respectively. In addition, all clinical variables in Table 1 were significant between patients who had AIS with favorable and unfavorable outcomes in the univariable analysis. Besides, we compared subjects included in the present study with those who were excluded because of missing information on 3-month outcome ($n=18,865$). There were similar age and stroke severity (NIHSS at admission) between included ($N=33,530$) and excluded ($N=18,865$) populations. But there were different of sex and stroke risk factors containing coronary artery disease, atrial fibrillation, dyslipidemia, and current stenosis.

**Association of Admission PP With Outcome**

As shown in Figure 2, there is a reverse J-curve association between PP upon admission and unfavorable outcomes. After adjusting for clinical variables, including AIS subtypes, initial NIHSS, and systolic BP and diastolic BP upon admission, PP of <50 mm Hg remained a factor for unfavorable outcomes 3 months poststroke ($P<0.0001$). Compared with patients with a PP of 50 to 69 mm Hg, the adjusted odds ratio for unfavorable outcomes increased gradually with 1.24 (95% CI, 1.14–1.36) for PP of 30 to 49 mm Hg and 1.85 (95% CI, 1.50–2.28) for PP of <30 mm Hg (Table 2).

Furthermore, regarding ischemic stroke subtypes based on the TOAST classification, the prognostic impact of admission PP on unfavorable outcomes 3 months poststroke are shown in Table 3. There were significantly more unfavorable outcomes if the admission PP was <30 mm Hg across all ischemic stroke subtypes, and if the admission PP of 30 to 49 mm Hg in large artery atherosclerosis and other specific undetermined etiologies.

**Discussion**

The present study is a large nation-wide prospective registry of AIS patients who presented with wide-ranging BP levels that were used to derive the pathophysiological significance of PP upon admission. This study had 3 key findings. First, there is a nonlinear reverse J-curve association between the admission PP level and 3-month poststroke functional outcomes. Second, the impact of a low PP on unfavorable outcomes was persistent even after adjusting for some

Table 2. Relation Between Admission PP Levels and Poor Outcome in Acute Ischemic Stroke Patients

<table>
<thead>
<tr>
<th>PP (mm Hg)</th>
<th>mRS at 3 Months</th>
<th>mRS 3 to 6 vs 0 to 2</th>
<th>Odds Ratio (95% CIs)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 to 2 (N=17,842)</td>
<td>3 to 6 (N=15,688)</td>
<td></td>
</tr>
<tr>
<td>&lt;30</td>
<td>232</td>
<td>393</td>
<td>2.20 (1.86–2.60)</td>
</tr>
<tr>
<td>30 to 49</td>
<td>2496</td>
<td>2274</td>
<td>1.18 (1.10–1.27)</td>
</tr>
<tr>
<td>50 to 69</td>
<td>6106</td>
<td>4709</td>
<td>1.00</td>
</tr>
<tr>
<td>70 to 89</td>
<td>5353</td>
<td>4513</td>
<td>1.09 (1.04–1.16)</td>
</tr>
<tr>
<td>≥90</td>
<td>3655</td>
<td>242</td>
<td>1.35 (1.27–1.43)</td>
</tr>
</tbody>
</table>

PP of 50 to 69 mm Hg as a reference group. mRS indicates modified Rankin Scale; PP, pulse pressure.

*Adjusted for age, sex, hypertension, diabetes mellitus, previous stroke, coronary artery disease, atrial fibrillation, dyslipidemia, current smoker, carotid stenosis, thrombolytic therapy, and National Institutes of Health Stroke Scale at admission.

†Adjusted for age, sex, hypertension, diabetes mellitus, previous stroke, coronary artery disease, atrial fibrillation, dyslipidemia, current smoker, carotid stenosis, thrombolytic therapy, National Institutes of Health Stroke Scale at admission, and systolic and diastolic blood pressure.

Figure 2. Relationship between admission pulse pressure (PP) and poor outcome at 3 months after acute ischemic stroke reveals a “reversed J-curve” association using logistic regression.
well-known outcome parameters, including systolic and diastolic BP. Third, the findings fit all AIS subtypes. 

Previously, the relationship between early-stage PP level and stroke outcomes had been investigated only in a few studies. One study containing a total of 2178 patients who had AIS showed that admission PP was not associated with mortality during hospitalization or dependency upon discharge. Another study including 339 patients with first-ever acute stroke (20.6% intracerebral hemorrhage) underwent 24-hour BP monitoring during the first 24 hours of a stroke. The result showed that elevated 24-hour PP levels, but not systolic or diastolic BP, significantly associated with a high risk of long-term recurrence. Aslanyan et al analyzed 1455 cases of AIS with mostly moderate severity. An elevated weighted-average PP during the first 60 hours was associated with a poor stroke outcome at 3 months. Recently, Tien et al reported on 136 ischemic stroke patients with no >50% culprit artery stenosis. This study demonstrated that an elevated PP 24 hours after an emergency department visit for an acute stroke is independently associated with unfavorable 3-month poststroke outcomes. Overall, controversy exists regarding the prognostic role of PP in acute stroke from previous studies. 

Theoretically, PP is determined by both cardiac components (stroke volume, heart rate, and left ventricular ejection rate) and arterial circulation properties, such as aortic distensibility and peripheral vascular tone. Thus, an increase in PP may occur in patients with major artery stiffness, aortic regurgitation, old age, increased systolic hypertension, or decreased diastolic hypertension. In contrast, a decreased PP may be found with hypovolemia, cardiac failure, cardiac arrhythmia, valvular heart disease, an aortic dissection, or a low BP. Apparently, all the above-mentioned factors affecting PP can precipitate the occurrence of AIS; however, this may increase the risk of stroke in-evolution and poor outcomes in patients with AIS. 

Importantly, our study clearly demonstrated a detrimental effect on prognosis in patients with AIS who had a low PP, even after adjusting for systolic and diastolic BP. For every 20 mm Hg decrease in PP to the nadir, the hazard ratio for poor functional outcomes gradually increased to a maximum of around 200%, as compared with 50 to 69 mm Hg. These findings highlight the role of the pulsatile component of BP and the importance of maintaining adequate perfusion and cardiac function on poststroke outcomes. During the acute stage of an ischemic stroke, a low PP may reduce cerebral perfusion by disrupting the autoregulation of cerebral blood flow. Furthermore, concomitant severe cardiac disease may also be an important determinant. Upon review of previous medical literature, a low PP has been shown as an indicator of decreased cardiac function and poor outcomes in patients with myocardial infarction and a predictor of cardiovascular death in patients with mild to advanced heart failure. 

This study had several limitations. First, we did not have BP data that were recorded at multiple time points during the acute phase of a stroke. The present study was based on a single BP measurement upon admission. Fluctuations in BP following admission could also have a significant impact on the short-term mortality rate, but information on this important aspect was not available for the present study. Second, data on cardiac function and echocardiographic findings, including valvular dysfunction, which could have arthropometric effects on PP amplification that could impact stroke mortality, were also not available. Third, those with no consent or lost to follow-up were not included. This may likely bias the association of admission PP with outcome. Nevertheless, the novel finding of a reverse J-curve relationship between admission PP levels and poststroke outcomes drives the need for further studies.

**Conclusion**

The present study that was based on a large TSR cohort of ischemic stroke demonstrated that admission PP was associated with poststroke functional outcomes in patients with AIS.

![Table 3. Relation Between Admission PP Levels and Poor Outcome in Acute Ischemic Stroke Patients by Stroke Subtypes](image-url)
Sources of Funding
This study is supported, in part, by Taiwan Ministry of Health and Welfare Clinical Trial and Research Center of Excellence (MOHW105-TDU-B-212-133019), China Medical University Hospital, Academia Sinica Taipei Biobank Stroke Biosignature Project (BM 10501010037), NRPB Stroke Clinical Trial Consortium (MOST 105-2325-B-039-003), Tseng-Lien Lin Foundation, Taichung, Taiwan, Taiwan Brain Disease Foundation, Taipei, Taiwan, and Katsuyo and Kiyo Aoshima Memorial Funds, Japan.

Disclosures
None.

References
SUPPLEMENTAL MATERIAL
Taiwan Stroke Registry Investigators:

**China Medical University Hospital:** Chung-Hsiang Liu (Principal Investigator), Chon-Haw Tsai, Wei-Shih Huang, Chung-Ta Lu, Tzung-Chang Tsai, Chun-Hung Tseng, Kang-Hsu Lin, Woei-Cherng Shyn, Yu-Wan Yang, Yen-Liang Liu, Der-Yang Cho, Chun-Chung Chen

**National Taiwan University Hospital:** Jiann-Shing Jeng (Principal Investigator), Sung-Chun Tang, Li-Kai Tsai, Shin-Joe Yeh

**E-Da Hospital / I-Shou University:** Shih-Pin Hsu (Principal Investigator), Han-Jung Chen, Cheng-Sen Chang, Hung-Chang Kuo, Lian-Hui Lee, Huan-Wen Tsui, Jung-Chi Tsou, Yan-Tang Wang, Yi-Cheng Tai, Kun-Chang Tsai, Yen-Wen Chen, Kan Lu, Po-Chao Liliang, Yu-Tun Tsai, Cheng-Loong Liang, Kuo-Wei Wang, Hao-Kuang Wang, Jui-Sheng Chen, Po-Yuan Chen, Cien-Leong Chye, Wei-Jie Tseng, Pei-Hua Wu

**National Cheng Kung University Hospital:** Chih-Hung Chen (Principal Investigator), Pi-Shan Sung, Han-Chieh Hsieh, Hui-Chen Su

**Shin Kong WHS Memorial Hospital:** Hou-Chang Chiu (Principal Investigator), Li-Ming Lien, Wei-Hung Chen, Chyi-Huey Bai, Tzu-Hsuan Huang, Chi-Keong Lau, Ya-Ying Wu, Hsu-Ling Yeh, Anna Chang

**Kaohsiung Veterans General Hospital:** Ching-Huang Lin (Principal Investigator), Cheng-Chang Yen

**Kaohsiung Medical University Chung-Ho Memorial Hospital:** Ruey-Tay Lin (Principal Investigator), Chun-Hung Chen, Gim-Thean Khor, A-Ching Chao, Hsiu-Fen Lin, Poyin Huang

**Chi Mei Medical Center:** Huey-Juan Lin (Principal Investigator), Der-Shin Ke, Chia-Yu Chang, Poh-Shiow Yeh, Kao-Chang Lin, Tain-Junn Cheng, Chih-Ho Chou, Chun-Ming Yang, Hsiu-Chu Shen

**Chung Shan Medical University Hospital:** An-Chih Chen (Principal Investigator), Shih-Jei Tsai, Tsong-Ming Lu, Sheng-Ling Kung, Mei-Ju Lee, Hsi-Hsien Chou

**Show Chwan Memorial Hospital:** Hsin-Yi Chi (Principal Investigator), Chou-Hsiung Pan, Po-Chi Chan, Min-Hsien Hsu, Wei-Lun Chang, Ya-Ying Wu, Zhi-Zang Huang, Hai-Ming Shoung, Yi-Chen Lo, Fu-Hwa Wang

**Cheng Hsin General Hospital:** Ta-Chang Lai (Principal Investigator), Jiu-Haw Yin, Chung-Jen Wang, Kai-Chen Wang, Li-Mei Chen, Jong-Chyou Denq

**En Chu Kong Hospital:** Yu Sun (Principal Investigator), Chien-Jung Lu, Cheng-Huai Lin, Chieh-Cheng Huang, Chang-Hsiu Liu, Hoi-Fong Chan

**Far Eastern Memorial Hospital:** Siu-Pak Lee (Principal Investigator)

**Kuang Tien General Hospital:** Ming-Hui Sun (Principal Investigator), Li-Ying Ke

**Taichung Veterans General Hospital:** Po-Lin Chen (Principal Investigator), Yu-Shan Lee

**Ditmanson Medical Foundation Chia-Yi Christian Hospital:** Sheng-Feng Sung (Principal Investigator), Cheung-Ter Ong, Chi-Shun Wu, Yung-Chu Hsu, Yu-Hsiang Su, Ling-Chien
Hung

Tri-Service General Hospital: Jiunn-Tay Lee (Principal Investigator), Jiann-Chyun Lin, Yaw-Don Hsu, Jong-Chyou Denq, Giia-Sheun Peng, Chang-Hung Hsu, Chun-Chieh Lin, Che-Hung Yen, Chun-An Cheng, Yueh-Feng Sung, Yuan-Liang Chen, Ming-Tung Lien, Chung-Hsing Chou, Chia-Chen Liu, Fu-Chi Yang, Yi-Chung Wu, An-Chen Tso, Yu-Hua Lai, Chun-I Chiang, Chia-Kuang Tsai, Meng-Ta Liu, Ying-Che Lin, Yu-Chuan Hsu

Cathay General Hospital: Tsuey-Ru Chiang (Principal Investigator), Mei-Ching Lee, Pai-Hao Huang, Sian-King Lie, Pin-Wen Liao, Jen-Tse Chen


Taipei Tzuchi Hospital, Buddhist Tzuchi Medical Foundation: Shinn-Kuang Lin (Principal Investigator), Yu-Chin Su, Cheng-Lun Hsiao, Fu-Yi Yang, Chih-Yang Liu, Han-Lin Chiang, Ser-Chen Fu

Min Sheng General Hospital: Chun-Yuan Chang (Principal Investigator), I-sheng Lin, Chung-Hsien Chien, Yang-Chuang Chang

Lin Shin Hospital: Ping-Kun Chen (Principal Investigator), Pai-Yi Chiu

National Taiwan University Hospital Yunlin Branch: Yu-Jen Hsiao (Principal Investigator), Chen-Wen Fang

Landseed Hospital: Yu-Wei Chen (Principal Investigator), Kuo-Ying Lee, Yun-Yu Lin, Chen-Hua Li, Hui-Fen Tsai, Chuan-Fa Hsieh, Chih-Dong Yang, Shiumn-Jen Liaw, How-Chin Liao

Cheng Ching General Hospital: Shooou-Jeng Yeh (Principal Investigator), Ling-Li Wu, Liang-Po Hsieh, Yong-Hui Lee, Chung-Wen Chen

China Medical University Beigang Hospital: Chih-Shan Hsu (Principal Investigator), Ye-Jian-Jhih, Hao-Yu Zhuang, Yan-Hong Pan, Shin-An Shih

Taipei Medical University -Wan Fang Hospital: Chin-I Chen (Principal Investigator), Jia-Ying Sung, Hsing-Yu Weng, Hao-Wen Teng, Jing-Er Lee, Chih-Shan Huang, Shu-Ping Chao

Taipei Medical University Hospital: Rey-Yue Yuan (Principal Investigator), Jau- Jiuane Sheu, Jia-Ming Yu, Chun-Sum Ho, Ting-Chun Lin

Kuang Tien General Hospital Dajia Division: Shih-Chieh Yu (Principal Investigator)

Changhua Christian Hospital Yunlin Branch: Jiunn-Rong Chen (Principal Investigator), Song-Yen Tsai

Chang Bing Show Chwan Memorial Hospital: Cheng-Yu Wei (Principal Investigator), Tzu-Hsuan Huang, Chao-Nan Yang, Chao-Hsien Hung, Ian Shih

Lotung Poh Ai Hospital: Hung-Pin Tseng (Principal Investigator), Chin-Hsiung Liu, Chun-Liang Lin, Hung-Chih Lin, Pi-Tzu Chen
Taipei Medical University-Shuang Ho Hospital: Chaur-Jong Hu (Principal Investigator), Nai-Fang Chi, Lung Chan

Taipei Veterans General Hospital: Chang-Ming Chern (Principal Investigator), Chun-Jen Lin, Shuu-Jiuin Wang, Li-Chi Hsu, Wen-Jang Wong, I-Hui Lee, Der-Jen Yen, Ching-Piao Tsai, Shang-Yeong Kwan, BING-Wen Soong, Shih-Pin Chen, Kwong-Kum Liao, Kung-Ping Lin, Chien Chen, Din-E Shan, Jong-Ling Fuh, Pei-Ning Wang, Yi-Chung Lee, Yu-Hsiang Yu, Hui-Chi Huang, Jui-Yao Tsai

Chi Mei Medical Center, Liouying: Ming-Hsiu Wu (Principal Investigator), Shi-Cheng Chen, Szu-Yi Chiang, Chiung-Yao Wang

Buddhist Dalin Tzu Chi General Hospital: Ming-Chin Hsu (Principal Investigator)

St. MARTIN DE PORRES HOSPITAL: Chien-Chung Chen (Principal Investigator), Po-Yen Yeh, Yu-Taï Tsai, Ko-Yi Wang

Sin-Lau Hospital, Tainan, the Presbyterian Church in Taiwan: Tsang-Shan Chen (Principal Investigator)

Cardinal Tien Hospital: Ping-Keung Yip (Principal Investigator), Vinchi Wang, Kaw-Chen Wang, Chung-Fen Tsai, Chao-Ching Chen, Chih-Hao Chen, Yi-Chien Liu, Shao-Yuan Chen, Zi-Hao Zhao, Zhi-Peng Wei

Yumin Medical Corporation Yumin Hospital: Shey-Lin Wu (Principal Investigator)

Kaohsiung Municipal Hsiao-kung Hospital: Ching-Kuan Liu (Principal Investigator)

Wei Gong Memorial Hospital: Ryh-Huei Lin (Principal Investigator), Ching-Hua Chu

Taipei City Hospital Ren Ai Branch: Sui-Hing Yan (Principal Investigator), Yi-Chun Lin, Pei-Yun Chen, Sheng-Huang Hsiao

National Taiwan University Hospital Hsin-Chu Branch: Bak-Sau Yip (Principal Investigator), Pei-Chun Tsai, Ping-Chen Chou, Tsam-Ming Kuo, Yi-Chen Lee, Yi-Pin Chiu, Kun-Chang Tsai

Taichung Hospital Department of Health: Yi-Sheng Liao (Principal Investigator)

Tainan Municipal An-Nan Hospital-China Medical University: Ming-Jun Tsai (Principal Investigator), Hsin-Yi Kao
Low Pulse Pressure After Acute Ischemic Stroke is Associated With Unfavorable Outcomes: The Taiwan Stroke Registry
Sung-Chun Tang, Jiu-Haw Yin, Chung-Hsiang Liu, Ming-Hui Sun, Jiunn-Tay Lee, Yu Sun, Chih-Shan Hsu, Mu-Chien Sun, Ching-Huang Lin, Chih-Hung Chen, Li-Ming Liên, Chih-Hsin Muo, Jiann-Shing Jeng, Chung Y. Hsu and Taiwan Stroke Registry Investigators

*J Am Heart Assoc.* 2017;6:e005113; originally published June 22, 2017; doi: 10.1161/JAHA.116.005113
The *Journal of the American Heart Association* is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Online ISSN: 2047-9980

The online version of this article, along with updated information and services, is located on the World Wide Web at: http://jaha.ahajournals.org/content/6/6/e005113

Subscriptions, Permissions, and Reprints: The *Journal of the American Heart Association* is an online only Open Access publication. Visit the Journal at http://jaha.ahajournals.org for more information.