

components and five animals components ⁽⁷⁾, trials of [MLC 601] in China found that patients receiving [MLC 601] were 2.4 times more likely to be independent at 1 month after stroke than the control group ⁽⁶⁾. The neuroproliferative and neuroprotective effects of [MLC 601] (and hence its potential role in neuroplasticity after stroke) have been recently established in animal models of stroke and ischemia ⁽⁸⁾. MLC601 (NeuroAid) were provided by Moleac (Singapore). The composition of MLC601 (0.4 g per capsule) was the following: 0.57 g Radix astragali, 0.114 g Radix salvia miltiorrhizae, 0.114 g Radix paeoniae rubra, 0.114 g Rhizoma chuanxiong, 0.114 g Radix angelicae sinensis, 0.114 g Carthamus tinctorius, 0.114 g Prunus persica, 0.114 g Radix polygalae, 0.114 g Rhizoma acori tatarinowii, 0.095 g Buthus martensii, 0.0665 Hirudo, 0.0665 g Eupolyphaga seu steleophaga, 0.0285 g Calculus bovisartifactus, 0.0285 g Cornu saigae tataricae ⁽⁸⁾.

In our study we summarize reported neurological improvements in Iraqi stroke patients who used Neuraid as part of their treatment.

Methods

Two hundred and seventeen patients with stroke were admitted into Al-Kadhimiya Teaching Hospital and Hospital of Neurosciences from January 2007 to January 2011 was included in the study. The patients and their companions' written consent were taken before participating in this study and the study was approved by ethical committees of Alkindy College of Medicine.

We excluded unconscious patients and those with minor stroke at the onset of the disease.

The [MLC 601] dose received was 4 tablets, 3 times per day ⁽⁸⁾ for 3 months [MLC 601] was given in addition to the patients other treatment like antiplatelet, anticoagulant, lipid-lowering, antihypertensive, hypoglycemic drugs and other medications.

The patients were assessed medically and neurologically at time of admission and thereafter

monthly for 3 months after discharge from the hospital. All patients were sent for brain CT scan, the residual disability was assessed according to modified Rankin scale [mRs] ⁽⁹⁾ at onset and monthly thereafter.

Six speech domains were assessed: fluency, comprehension, naming, repetition, writing and readings (if the patient could read and write prior to the stroke). Visual field was assessed only for the patients with field defects using perimetry at onset and at first and third months post stroke. For the homonymous heminopia, we considered any enlargement in the visual field using perimetry as an improvement.

We lost contact with 25 patients for unknown reasons mainly because of the unstable security state in Iraq which prevent them to maintaining follow up.

Results

Two hundred patients had ischemic stroke, and 17 had intracerebral hemorrhage. We had 133 male participants out of the 200 ischemic stroke patients, and 11 males out of the 17 intracerebral hemorrhage patients. Their age ranged between 24-83 years (Table 1). Seventy three patients were females, while 144 were males, majority are between 40-69 years of age. Age and gender distribution of patients is present in tables 1 and 2.

Table 3 showed that only one out of 17 intracerebral hemorrhage patient in the group with mRs below grade 2; and 12 out of 17 in the first and third month.

We considered G2-5 mRs score to reflect patients' dependence, while G0-1 was equivalent to the patient being independent. Table 4 shows that zero out of 159 ischemic stroke patients group with mRs score of G2-5; 89 out of 155 in the first month and 98 out of 134 in the third month were had such mRs score 2 of treated group.

Out of the 21 aphasic patients, 9 improved and 12 did not after 3 months. Also, 18 out of the 37