LATE-MT explained: thrombectomy 24 to 72 hours after large-vessel stroke

23 November 2026 · 6 min read · blogs.iictp.org/late-mt-thrombectomy-24-to-72-hours-stroke-trial-explained

Short answer: LATE-MT is a randomised trial published in the New England Journal of Medicine on 19 November 2026 (online 23 October) that tested endovascular thrombectomy in patients who reached hospital 24 to 72 hours after a large-vessel ischaemic stroke and had imaging-identified salvageable brain tissue. In 336 patients in China, thrombectomy plus standard care gave a better 90-day functional outcome than standard care alone, but with more symptomatic haemorrhage and a higher 90-day case fatality. This is a summary for readers, not medical advice.

TL;DR The short version

- LATE-MT, published in NEJM, tested thrombectomy 24 to 72 hours after a large-vessel stroke in 336 patients in China with salvageable brain tissue on imaging.
- Thrombectomy plus standard care gave better 90-day function, but with more symptomatic haemorrhage and higher 90-day case fatality.
- Imaging selection is central and all sites were in China; this is a summary for readers, not medical advice.

Read online, listen to it, or change the text size: https://blogs.iictp.org/late-mt-thrombectomy-24-to-72-hours-stroke-trial-explained

What is LATE-MT?

Endovascular thrombectomy is an established treatment for acute ischaemic stroke. The question here was whether benefit extends past 24 hours from symptom onset, or from when the patient was last known well, when imaging still shows salvageable tissue. The first author is affiliated with Changhai Hospital in Shanghai, and the LATE-MT Investigators group includes international collaborators, per the PubMed record.

How the trial was designed

- Open-label, randomised, with blinded outcome assessment, at comprehensive stroke centres in China.
- Patients had anterior-circulation large-vessel occlusion and imaging-identified salvageable tissue at 24 to 72 hours.
- Intervention: endovascular therapy plus standard medical care. Control: standard medical care alone.
- Primary outcome: the modified Rankin scale (0 to 6, higher is worse) at 90 days, analysed as a distribution across scores.

Results reported in the abstract

- 336 patients in the intention-to-treat population, 168 per group; median time from onset or last known well to randomisation 38.5 hours.
- Common odds ratio for a better functional outcome 1.74 (95% CI 1.19 to 2.55).
- Symptomatic intracranial haemorrhage in 4.8% of the intervention group and none in controls; 90-day case fatality 6.0% against 1.8%.

How to read these results

- The benefit and the harms are both real: the authors conclude better outcomes with a higher risk of intracranial haemorrhage and death.
- Imaging selection matters, since only patients with salvageable tissue were included, which is why the imaging pipeline is part of the intervention.
- Open-label designs rely on blinded outcome assessment to limit bias.

Limitations and open questions

- All sites were in China, so generalisation to other health systems is uncertain.
- We read the PubMed abstract, not the full paper or the accompanying NEJM editorial.
- The trial did not settle which patients benefit most; subgroups need more data.

What it means for stroke pathways and stroke-imaging teams

Late-window decisions depend on perfusion or tissue imaging being available quickly and read reliably. Teams should review how their imaging protocol, transfer rules and consent processes would apply if guidelines move, and wait for guideline bodies before changing practice.

Frequently asked questions

- **Is this peer reviewed?** Yes, it was published in NEJM, volume 395, issue 20.
- **What was the main benefit?** A more favourable distribution of 90-day modified Rankin scores, common odds ratio 1.74.
- **What were the risks?** Symptomatic intracranial haemorrhage in 4.8% and 90-day case fatality of 6.0% in the intervention group, per the abstract.
- **Should patients ask for thrombectomy at 48 hours?** That is a clinical decision for treating teams and guidelines, not this article.

Related reading

- MILD-MT: thrombectomy in mild stroke
- Blind sweep ultrasound AI
- Responsible AI in practice
- Certified Technical Practitioner

Sources and currency

Sources were read on 23 November 2026. Products, rules and standards change, so check the linked originals before you rely on any detail.

Related credential: Certified Technical Practitioner. Explore the exam facts and syllabus.

Sources and further reading

1. Yang P, et al., LATE-MT Investigators. Mechanical Thrombectomy 24 to 72 Hours after Large-Vessel Ischemic Stroke. N Engl J Med 2026;395(20):2004-2014. doi:10.1056/NEJMoa2609362. pubmed.ncbi.nlm.nih.gov/42929656.

Published by IICTP, an independent technical credential body, on 23 November 2026. The current version of this post is at https://blogs.iictp.org/late-mt-thrombectomy-24-to-72-hours-stroke-trial-explained. More guides: blogs.iictp.org.