Introduction

Because of economic constraints, identification of patients at high risk for ischemic stroke who may benefit from further evaluation and aggressive control of their risk factors carries a special importance in low-resources settings. Given its reasonable sensitivity and specificity to predict ischemic stroke, P-terminal force in lead V1(PTFV1) greater than or equal to 40mm-ms could be used as a risk stratification tool to discriminate between patients at high and low risk of ischemic stroke, and subsequently identify patients who may benefit from further evaluation and aggressive control of their risk factors *(Soliman et al., 2010).*

Left Atrial (LA)anteroposterior diameter by 2 dimensional (2D)echocardiography is commonly used for evaluating the left atrial size but has limitations related to the LA irregular geometry and physical constraints imposed by the spine and sternum. For chronic atrial fibrillation(AF), echocardiographic left atrial enlargement (Echo-LAE) was of no value for predicting thromboembolism, whereas LA size was a main predictor of stroke. Reasons for these conflicting data remains unclear *(Petersen et al., 1990).*

The electrocardiographic left atrial abnormality (ECG-LAA) estimation is a noninvasive and universally available method. It is known to reflect increases in left ventricular (LV)filling pressure and the consequent remodeling process in hypertensive heart disease. This fact can be utilized in investigating every stroke patient received at the emergency room in order to identify each particular patient's risk factors .Reliable ECG-LAA criteria might offer a simple and inexpensive way to predict the risk of ischemic stroke in addition to echocardiographic LA assessment *(Kohsaka et al., 2005)*.