

An investigation of the outcomes of Stroke patients in the community: Is it possible to recovery well after golden rehabilitation period

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Stroke is the fourth leading cause of death in Taiwan and is the main cause of disability globally. Yang, et al. (2011) address most of the stroke people whose aged 65 and over are cared for at home, but the frequency of rehabilitation care for these elderlies is the lowest. Community-based care is another way to look after stroke patients in long-term condition. Currently, little is known about community clinic care of stroke patients when the patients returned home from the hospital.

Purpose: The purpose of this study is to analyze the patient data of a community clinic to understand the outcome of the care of stroke patients.

Method: A retrospective study which reviewed the stroke patients' charts in a community clinic was adopted. Data were collected from 2011 to 2016. 388 patients' data were showed in this study.

Result: The result showed that the improvement of stroke patients in the upper limbs and lower limbs is the most significant, and its progress can reach nearly 75~80%. Moreover, the slurred speech of this group can be improved by about 20%. Although the symptoms of drooling and choking were also improved, the progress is about 10~15%.

Conclusion: The community clinic care may be another way to facilitate the progress of stroke patients after transition from the hospital to the home.

Background:

Acute stroke syndrome clinical methods have advanced dramatically in recent years, outpacing advances in successful stroke care. Thus, the clinician faces a number of assessments, each with specific cost effects, and each to a greater or lesser degree, altering management. This review will focus on the basic tests for all strokes (full blood count, ESR, biochemical screen, blood glucose, cholesterol, syphilis serology, chest X-ray and electrocardiogram) to be performed.

In selected cases, additional tests may be required: CT scans to diagnose 'non-stroke' lesions, to exclude cerebral hemorrhage if anti-haemostatic therapy is planned, and to detect strokes that may require emergency intervention (such as cerebellar stroke with hydrocephalus); echocardiography to detect cardiac sources of embolization; and in a few cases, lumbar puncture and specialized haematological tests; Certain tests which are currently research instruments could be suitable for potential widespread use including NMR, SPECT and PET scanning.

There is scant information about predictors of stroke severity and long-term mortality for first-ever ischemic strokes based on the population. The purpose of this study was to determine the characteristics of patients who first presented with an ischemic stroke and to identify predictors of severity and long-term mortality. Includes 1057 patients with first-ever ischemic stroke between 2004 and 2008. Analyzed variables

included co-morbidities, socio-demographic causes, risk factors prior to the stroke, admission treatment, and pathophysiological and metabolic factors.

The Cerebrovascular Aosta Registry (CARE) is a population-based registry that records strokes in all age groups for the first time. The overall design for the study has been previously published. We surveyed all diagnostic cases prospectively from similar sources. No patient selection was conducted prior to admission in terms of age, severity of the stroke or comorbid medical conditions. It excluded patients with recurrent stroke, intracerebral or subarachnoid hemorrhage, subdural hematoma, or other causes that mimic the stroke. Hospital treatment is safe, and a very high percentage of stroke patients have been admitted to hospital (92.5 per cent).

The aims of this study were to determine the characteristics of patients who initially presented with ischemic stroke, and to identify predictors of stroke severity and long-term mortality (all causes).

Stroke has been identified according to guidelines from the World Health Organization (WHO). Clinical criteria and brain imaging combined to diagnose ischemic stroke. Both patients underwent brain CT scan with no contrast to remove intracerebral haemorrhage after admission.

Annually, the discharged patients were followed up by neurological assessment and record analysis for further hospitalization. Both reports have been followed up; last follow-up was in December 2012. The Ufficio Anagrafe (UA) has obtained data on the vital status. Mortality data were cross-checked with the Office of Legal Medicine list of stroke death ICD-9 codes registered. Case fatality for all causes was defined within 28 days, 1 year, and 5 years as the proportion of cases for which death occurred from the onset of stroke.

The variables analyzed were age, gender, body mass index (BMI), life conditions, prestroke dependence, comorbidities, NIHSS at admission, vascular risk factors, therapy prior to stroke, pathophysiologic and metabolic factors.

Multivariate logistic regression models were used to estimate the effect of potential determinants of stroke severity at entry. Using Chi-square test, differences between groups and effect of patient characteristics on clinical outcome were assessed. The model of Cox Regression has been used to estimate the impact of possible survival determinants.

Most patients admitted with a stroke who had never had an AF diagnosis were sub optimally anticoagulated before their stroke and only 10 per cent of patients with an AF history received sufficient antithrombotic care before the stroke. Treatment for anticoagulation is highly dependent on single-patient factors such as age, comorbidities, lifestyle of the patient and the efficacy of appropriate therapy monitoring. The high proportion of nontreated patients is likely to be due to our population's older age,

becoming difficult to monitor and administer anticoagulant care.

Several factors affected long-term mortality, including prestroke dependence and comorbidities, which are more prevalent among the elderly. Prestroke mRS score 3–5 and a CI score > 2 were found to be statistically important, independent long-term mortality factors in patients with ischemic first-time stroke.

Many of the long-term mortality predictors identified have already been reported in preceding studies but hypertension, diabetes, or smoking.

Hyperglycaemia did not associate with a worse outcome at the time of the index stroke.

The study indicates that very old age in ischemic stroke patients was a major risk factor for poor prognosis. Severe stroke was associated with the involvement of AF and cardio embolism, and decreased long-term survival. In addition, the presence of prestroke dependency, comorbidity or at least a history of ischemic heart disease may be accounted for in long-term mortality after ischemic stroke.