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Recurrent Ischemic Stroke: Strategies for Prevention

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Recurrent strokes make up almost 25% of the nearly 800,000 strokes that occur annually in the United States. Risk factors for ischemic stroke include hypertension, diabetes mellitus, hyperlipidemia, sleep apnea, and obesity. Lifestyle modifications, including tobacco cessation, decreased alcohol use, and increased physical activity, are also important in the management of patients with a history of stroke or transient ischemic attack. Antiplatelet therapy is recommended to reduce the risk of recurrent ischemic stroke. The selection of antiplatelet therapy should be based on timing, safety, effectiveness, cost, patient characteristics, and patient preference. Aspirin is recommended as initial treatment to prevent recurrent ischemic stroke. Clopidogrel is recommended as an alternative monotherapy and in patients allergic to aspirin. The combination of clopidogrel and aspirin is not recommended for long-term use (more than two to three years) because of increased bleeding risk. Aspirin/dipyridamole is at least as effective as aspirin alone, but it is not as well tolerated. Warfarin should not be used for prevention of recurrent ischemic stroke. (*Am Fam Physician*. 2017;96(7):436-440. Copyright © 2017 American Academy of Family Physicians.)

CME This clinical content conforms to AAFP criteria for continuing medical education (CME). See CME Quiz on page 431. Author disclosure: No relevant financial affiliations.

► Patient Information: A handout on this topic is available at <http://www.aafp.org/afp/2007/0801/p389.html>.

Stroke is the fifth-leading cause of death in the United States.¹ The total cost of direct stroke-related medical care is projected to rise from \$71.6 billion in 2012 to \$184.1 billion by 2030.¹ Out of the 795,000 strokes each year in the United States, 691,000 are ischemic, and 185,000 are recurrent events.¹ The American Heart Association (AHA) and the American Stroke Association (ASA) define a transient ischemic attack (TIA) as a transient episode of neurologic dysfunction caused by focal brain, spinal cord, or retinal ischemia without acute infarction.² They define an ischemic stroke as brain, spinal cord, or retinal cell death due to ischemia based on neuropathology, neuroimaging, or clinical evidence of permanent injury.³

About one-half of patients who survive an ischemic stroke or TIA are at increased risk of recurrent stroke within a few days or weeks of the initial event, with the greatest risk during the first week.⁴ Patients who have a TIA have a 10-year stroke risk of 19% and a combined 10-year risk of stroke, myocardial infarction, and vascular death of 43%.¹ Recurrent events lead to prolonged hospitalization, worsened functional outcome, and increased mortality.

This article discusses current recommendations for risk factor management and

antithrombotic therapy for the prevention of recurrent ischemic stroke based on the AHA/ASA guidelines, with a focus on non-cardioembolic stroke management. Preventing a TIA and preventing an ischemic stroke are equally important, and the current AHA/ASA guidelines apply to both.⁵

Risk Factors for Recurrent Stroke

HYPERTENSION

Hypertension is a major risk factor for ischemic stroke, and its treatment can drastically reduce the risk of recurrent ischemic stroke.⁶ Two major trials—PATS (Post-stroke Antihypertensive Treatment Study), which studied a diuretic, and PROGRESS (Perindopril Protection Against Recurrent Stroke Study), which studied an angiotensin-converting enzyme inhibitor alone or in combination with a diuretic—demonstrated that lowering blood pressure was associated with marked reduction in recurrent stroke risk.^{6,7}

The AHA/ASA guidelines recommend lifestyle interventions, such as weight loss, a Mediterranean-style diet, reduced sodium intake, regular aerobic physical activity, and limited alcohol consumption, to lower blood pressure.^{5,8} The guidelines also recommend initiating blood pressure therapy in untreated patients with a recurrent ischemic

Lifestyle Modification in Secondary Prevention: Beyond Pharmacotherapy

Abstract: *Despite significant advances in medical technology and pharmacology, cardiovascular disease (CVD) remains a major contributor to health care expenses and the leading cause of death in the United States. Patients with established CVD and their health care providers are challenged with achieving cardiovascular risk reduction to decrease the likelihood of recurrent cardiovascular events. This "secondary prevention" can be achieved, in part, through adherence to prescribed pharmacotherapies that favorably modify major coronary risk factors (ie, hypertension, hypercholesterolemia, diabetes, and obesity). However, lifestyle modification can also be helpful in this regard, providing independent and additive benefits to the associated reductions in cardiovascular morbidity and mortality. Accordingly, physicians and other health care providers should routinely counsel their coronary patients to engage in structured exercise and increased lifestyle physical activity, consume a heart-healthy diet, quit smoking and avoid*

secondhand smoke, and purposefully address psychosocial stressors that may elevate cardiovascular risk. These lifestyle interventions, either as an adjunct to medication therapy or independently in those patients where medications may be poorly tolerated, cost prohibitive, or ineffective, can significantly decrease cardiovascular

Despite a 51% decline in cardiovascular disease (CVD) death rates from 2000 to 2010,¹ heart disease remains the leading cause of death in the United States, followed by cancer, respiratory disease, accidents, and stroke.² In 2010, US\$193.4 billion was spent on direct medical costs associated with stroke and heart disease,

“... adjunctive lifestyle modification in the setting of established CVD is arguably of equal importance in reducing the risk of recurrent cardiovascular events.”

mortality and the risk of recurrent cardiac events.

Keywords: secondary prevention; risk factor reduction; cardiovascular mortality; lifestyle modification

excluding associated nursing home care expenses.¹ For those experiencing nonfatal cardiovascular events, coronary revascularization procedures and/or new cardiac diagnoses, patients and their health care providers are challenged with

DOI: 10.1177/155827616651402. Manuscript received February 8, 2016; revised April 19, 2016; accepted May 4, 2016. From Preventive Cardiology and Cardiac Rehabilitation, William Beaumont Hospital, Royal Oak, Michigan (JB, AF, BAF); Internal Medicine and Biomedical Engineering, Oakland University William Beaumont School of Medicine, Rochester, Michigan (BAF); and Drug Information Pharmacy Specialist, William Beaumont Hospital, Royal Oak, Michigan (JD). Address correspondence to: Jenna Brinks, MS, Manager, Preventive Cardiology and Cardiac Rehabilitation, William Beaumont Hospital, Beaumont Health Center, Cardiac Rehabilitation, 4949 Coolidge Highway, Royal Oak, MI 48073, USA; e-mail: jenna.brinks@beaumont.org.

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Article in *British Journal of Neuroscience Nursing* · October 2009

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Relationship of Inter-Individual Blood Pressure Variability and the Risk for Recurrent Stroke

Bum Joon Kim, MD; Sun U. Kwon, MD, PhD; Dalia Wajsbrodt, MSc; Jaseong Koo, MD; Jong Moo Park, MD; Barrett W. Jeffers, PhD

Background—Evidence suggests that patients with higher blood pressure variability (BPV) have a higher risk for stroke, but any link between BPV and stroke recurrence is unknown among those who had a stroke or transient ischemic attack (TIA).

Methods and Results—Data for patients with a history of stroke or TIA at enrollment were extracted from the ASCOT (Anglo Scandinavian Cardiac Outcomes Trial) and the ALLHAT (Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial). BPV was defined as the within-subject standard deviation or coefficient of variation of systolic blood pressure across visits from 12 weeks poststroke or TIA onward. BPV was significantly higher in patients with a history of stroke or TIA than those without. BPV was a predictor of recurrent stroke in the pooled analysis. In the ASCOT study, 252 patients (12.3%) had a recurrent stroke among 2046 with a history of stroke. Incidence of recurrent stroke was significantly higher in the highest BPV quartile (17.8%) compared with the lowest quartile (10.5%); by treatment arm, this reached significance for the amlodipine-arm only (high-BPV: 18.7% versus low-BPV: 12.9%; $P=0.029$). Of the 2173 patients from the ALLHAT with a history of stroke or TIA, patients with the highest quartile of BPV had a higher incidence of recurrent stroke (9.6%) compared with the lowest quartile BPV (5.5%); by treatment arm, this reached significance for the chlorthalidone-arm only (high-BPV: 12.1% versus low-BPV: 5.4%; $P=0.007$).

Conclusions—Visit-to-visit BPV is a predictor of recurrent stroke in patients with a history of stroke or TIA on antihypertensive treatment. Considering BPV following a stroke may be important to reduce the risk for a recurrent stroke. (*J Am Heart Assoc.* 2018;7:e009480. DOI: 10.1161/JAHA.118.009480.)

Key Words: blood pressure • calcium channel blocker • secondary prevention • stroke • blood pressure variability

Fluctuations in blood pressure (BP) are attributed physiologically to complex interactions of the autonomic nervous system, which ultimately ensure that physical demands are met.¹ However, autonomic and cardiac dysfunction may occur after vascular brain injury, which affects BP control.² Alteration of BP control is evident in the acute stage and sustains for several months after stroke.³ However, there are no data demonstrating the effect of

previous stroke on long-term alteration of BP control, to our knowledge.

Variability in blood pressure (BPV) is becoming increasingly recognized as an important predictor for future cardiovascular events.^{4–8} High BPV is also predictive of stroke independent from high mean BP.^{5,9–13} Observations linking BPV to stroke have been supported by analyses in previous clinical trials and a cohort study.^{8,14} However, the specific relationship between BPV and risk for patients having a recurrent (secondary) stroke is less clear. Stroke patients have various angiopathies in their cerebrovascular structures, such as atherosclerosis, arteriosclerosis, and microangiopathy.^{15,16} High BPV may affect diseased vessels, which may be more or less significant following, compared with preceding, a stroke. How these pathological changes influence a recurrent stroke is unknown. Knowing whether or not BPV is of importance in the risk of recurrent stroke would help physicians to select the most appropriate antihypertensive(s) for these high-risk individuals.

This post hoc analysis of 2, large-scale cardiovascular end point studies sought to determine whether there are differences in BPV between patients who have a history of previous stroke or transient ischemic attack (TIA) compared with

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**Knowledge About High Risk Stroke Relationship With Lifestyle In Post-Stroke Patients In
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Indonesia, stroke patients have increased every year. Stroke is a disease characterized by brain tissue death. This disease can occur due to reduced blood flow and oxygen to the brain due to blockage, narrowing, or rupture of blood vessels and have an impact on decreased bodily functions and disability. This study aims to determine the relationship between knowledge of high risk of stroke and

lifestyle in post stroke patients in the working area of the health center Tanggul in Jember. Analytic correlation with cross sectional is the research design and the sample technique uses total sampling with a sample of 28 people, then the data collection using questionnaires and analyzed using Spearman Rank. The results showed that respondents had a low level of knowledge of 26 people (89%) and a bad lifestyle of 16 people (58%). Statistical test results show that the p value of 0.030 and the value of R 0.04 which indicates a moderate and positive (+) relationship the higher the knowledge, the better the lifestyle and the lower the knowledge, the worse the lifestyle. Health workers must emphasize the provision of health education to the community to provide knowledge about the risk of stroke and implement a healthy lifestyle

Key words : level of knowledge, high risk of stroke, lifestyle, post stroke**To cite this article :**

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Healthy lifestyle behaviors among individuals with chronic obstructive pulmonary disease in urban and rural communities in China: a large community-based epidemiological study

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Background: Lifestyle modification is one of the most cost-effective strategies in self-management and secondary prevention of chronic obstructive pulmonary disease (COPD). However, the prevalence of healthy lifestyle behaviors in COPD patients in China remains unclear. The objective of this study was to examine the rates of healthy lifestyle behaviors including smoking cessation, regular exercise, and healthy diet in community population with COPD in China.

Methods: We recruited 46,285 individuals aged 35–70 years from 115 urban and rural communities in 12 provinces of China from 2005 to 2009. We recorded the smoking status, physical activity intensity, and quality of diet for all spirometry-diagnosed COPD patients by standardized questionnaires.

Results: Among 3,690 individuals with COPD, 18.2% (95% confidence interval [CI], 13.0–24.9) quit smoking, 27.1% (95% CI, 24.7–29.7) exercised often, and 34.8% (95% CI, 31.8–38.0) ate high-quality diet. More than half of the individuals followed one or less key healthy lifestyle, and only 8.4% (95% CI, 7.0–10.0) followed all of the three healthy behaviors. Urban residents had significant higher rates of smoking cessation (23.5% [95% CI, 17.3–31.1] vs 14.4% [95% CI, 9.9–20.5], $p=0.0008$), regular exercise (45.6% [95% CI, 42.4–48.8] vs 14.0% [95% CI, 12.1–16.2], $p<0.0001$), and healthy diet (38.5% [95% CI, 35.5–41.6] vs 32.2% [95% CI, 29.2–35.4], $p=0.0013$) than rural residents. Age, sex, education level, body mass index, respiratory symptoms, and family income were associated with healthy living, and the strength of associations varied between urban and rural areas.

Conclusion: There is a large gap between the anticipated rate and the real participation in healthy lifestyle behaviors in Chinese adults with COPD, especially in rural communities. Simple and effective strategies are warranted to improve patients' lifestyle in China.

Keywords: COPD, lifestyle, smoking cessation, physical activity, diet

Introduction


Chronic obstructive pulmonary disease (COPD) is the third leading cause of mortality and the ninth leading cause of disability in the world.^{1,2} More than 75% of the COPD deaths are attributed to tobacco smoking.³ Smoking cessation, as an essential treatment for COPD, can not only decrease respiratory symptoms and hospitalizations, but also decline acute exacerbation and overall mortality.⁴ Besides smoking cessation, proper physical activity and high-quality diet also play important roles in delaying disease process, improving quality of life, and reducing COPD-related outcomes.^{5–7} Therefore, adoption of healthy lifestyle behaviors including smoking cessation, regular exercise,

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Stroke Risk Factors, Genetics, and Prevention

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Keywords

cerebrovascular disorders; stroke; transient ischemic attack; risk factors; epidemiology

Stroke is the leading cause of long-term adult disability and the fifth leading cause of death in the US, with approximately 795,000 stroke events in the US each year.^{1, 2} The aging of the population, coupled with the reduction in case fatality after stroke, is expected to increase the prevalence of stroke by 3.4 million people between 2012 and 2030.^{3, 4} While stroke mortality had decreased in the US over the past two decades, recent trends in mortality indicate that these decreases may have leveled off, and that stroke mortality may even be rising again. Reasons for this remain uncertain, but could reflect the consequences of the obesity epidemic, and associated diabetes. The morbidity associated with stroke remains high, with costs estimated at \$34 billion per year for healthcare services, medications and missed days of work.^{3, 5} It is likely that estimates of morbidity and cost burden, moreover, based on studies of clinical stroke and using traditional measures such as physical disability and healthcare costs, underestimate the burden of cerebrovascular disease. It is increasingly appreciated, for example, that subclinical cerebrovascular disease—including so-called “silent infarction” identified on brain imaging in up to 28% of the population over age 65⁶, and ischemic white matter disease—is associated with memory loss, dementia, gait impairment, and other functional disability. Furthermore, the global burden of stroke is high, with stroke remaining the fourth leading cause of death worldwide, with a particularly large impact in developing nations.^{7, 8}

Stroke Risk Factors

Unlike myocardial infarction, which is almost always due to large vessel atherosclerotic disease affecting the coronary arteries, identification of risk factors for stroke is complicated

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Lifestyle Factors and Early Clinical Outcome in Patients With Acute Stroke

A Population-Based Study

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Heidi H. Hundborg, PhD; Henrik H. Rasmussen, PhD; Søren P. Johnsen, PhD

Background and Purpose—We examined the associations of individual and combined lifestyle factors with early adverse stroke outcomes.

Methods—A total of 82 597 patients were identified from nationwide registries. Lifestyle factors at the time of stroke admission included body mass index (kg/m²), smoking habits, and alcohol intake, which were grouped (healthy, moderately healthy, moderately unhealthy, and unhealthy). The associations between lifestyle and outcomes were examined using multivariable regression.

Results—A total of 18.3% had a severe stroke, 7.8% pneumonia, 12.5% urinary tract infection, and 9.9% died within 30 days. The association between lifestyle, stroke severity, and mortality, respectively, differed according to sex. Unhealthy lifestyle was associated with lower risk of severe stroke (adjusted odds ratio [OR], 0.73; 95% confidence interval [CI], 0.63–0.84) and 30-day mortality among men (adjusted OR, 0.71; 95% CI, 0.58–0.87), but not among women (severe stroke: adjusted OR, 1.14; 95% CI, 0.85–1.55, and mortality: adjusted OR, 1.34; 95% CI, 0.90–1.99). No sex differences were found for pneumonia and urinary tract infection. Unhealthy lifestyle was not associated with a statistically significant increased risk of developing in-hospital pneumonia (adjusted OR, 1.30; 95% CI, 0.98–1.73) or urinary tract infection (adjusted OR, 0.98; 95% CI, 0.72–1.33). Underweight was associated with a higher 30-day mortality (men: adjusted OR, 1.71; 95% CI, 1.50–1.96, and women: adjusted OR, 1.46; 95% CI, 1.34–1.60).

Conclusions—Healthy lifestyle was not associated with a lower risk of adverse stroke outcomes, in particular among men. However, underweight may be a particular concern being associated with an increased risk of adverse outcomes among both sexes. (*Stroke*. 2017;48:611–617. DOI: 10.1161/STROKEAHA.116.015784.)

Key Words: body mass index ■ healthy lifestyle ■ pneumonia ■ registries ■ stroke

Obesity, high alcohol intake, and smoking are all well-established modifiable risk factors for stroke, and they all play a central role for global stroke incidence and mortality.¹ In contrast, there are still significant gaps in the understanding of the prognostic role of lifestyle factors in patients with stroke, including how the potential prognostic effects are mediated and how they potentially interplay.² Such knowledge is important because it may help identifying subgroups of patients in need of additional specialized care/attention in the early poststroke phase.

Existing studies on lifestyle factors and stroke outcomes have yielded inconsistent results, and most of the studies are small and have focused on selected individual lifestyle factors and on mortality as the only outcome.^{3–10} In addition, most of the existing studies have not been population based and

have often been conducted in specialized units which raise concerns about the generalizability of the findings. There is consequently a need for large-scale studies on unselected patients in order better to comprehend the impact of lifestyle on stroke outcomes, including stroke severity, the risk of important medical complications, and mortality in acute stroke care settings. We therefore examined the individual and the combined associations of different lifestyle factors with clinical outcomes among patients admitted with acute stroke in a nationwide study.

Methods

This population-based follow-up study was based on national Danish registries covering the entire population (=5.6 million). All citizens are assigned a unique 10-digit civil registration number enabling

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STUDY PROTOCOL

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Lifestyle counselling as secondary prevention in patients with minor stroke and transient ischemic attack: study protocol for a randomized controlled pilot study

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Abstract

Background: Most patients with minor stroke or transient ischemic attack (TIA) are discharged with little or no specialised follow-up. Nonetheless, these patients have a high prevalence of cognitive impairments and a considerable risk of recurrent stroke. Smoking cessation, physical activity, and adherence to antihypertensive and antithrombotic medication are highly recommended in patients with minor stroke and TIA. Evidence suggests that simple encouragement to change lifestyle is ineffective. Behavioural interventions might therefore be needed to support patients in managing their own health post-discharge.

Objectives: We aim to test the (1) feasibility of randomisation acceptance and an early initiated, client-centred lifestyle and behavioural intervention in a clinical setting, and (2) potential effect of the intervention on arterial blood pressure in patients with minor stroke or TIA and (3) explore the participants experience of barriers and facilitators for health behaviour after a stroke, including perceived needs and social support.

Methods: We will conduct a randomized controlled pilot trial. Eligible patients with acute minor stroke or TIA ($n = 40$) will be randomly allocated to either early initiated counselling with four weekly post-discharge follow-up sessions for 12 weeks or usual care. The primary outcome will be program feasibility and to discuss the relevance of arterial blood pressure as primary outcome after 12 weeks intervention. Selected participants will be invited to participate in semi-structured interviews, based on purposeful sampling, to evaluate the intervention and explore their experience of life after a stroke. The interviews will be analysed using a five-step thematic analysis approach.

(Continued on next page)

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The obesity paradox in stroke: Lower mortality and lower risk of readmission for recurrent stroke in obese stroke patients

Klaus Kaae Andersen¹ and Tom Skyhøj Olsen^{2*}

Background Although associated with excess mortality and morbidity, obesity is associated with lower mortality after stroke. The association between obesity and risk of recurrent stroke is unclear.

Aims The study aims to investigate the association in stroke patients between body mass index and risk of death and readmission for recurrent stroke.

Methods An administrative Danish quality-control registry designed to collect a predefined dataset on all hospitalized stroke patients in Denmark 2000–2010 includes 45 615 acute first-ever stroke patients with information on body mass index in 29 326. Data include age, gender, civil status, stroke severity, computed tomography, and cardiovascular risk factors. Patients were followed up to 9.8 years (median 2.6 years). We used Cox regression models to compare risk of death and readmission for recurrent stroke in the four body mass index groups: underweight (body mass index < 18.5), normal weight (body mass index 18.5–24.9), overweight (body mass index 25.0–29.9), obese (body mass index ≥ 30.0).

Results Mean age 72.3 years, 48% women. Mean body mass index 23.0. Within follow-up, 7902 (26.9%) patients had died; 2437 (8.3%) were readmitted because of recurrent stroke. Mortality was significantly lower in overweight (hazard ratio 0.72; confidence interval 0.68–0.78) and obese (hazard ratio 0.80; confidence interval 0.73–0.88) patients while significantly higher in underweight patients (hazard ratio 1.66; confidence interval 1.49–1.84) compared with normal weight patients. Risk of readmission for recurrent stroke was significantly lower in obese than in normal weight patients (hazard ratio 0.84; confidence interval 0.72–0.92).

Conclusions Obesity was not only associated with reduced mortality relative to normal weight patients. Compared with normal weight, risk of readmission for recurrent stroke was also lower in obese stroke patients.

Key words: body mass index, mortality, obesity, readmission, recurrent stroke, stroke

Introduction

Obesity is related to a number of diseases such as stroke, heart disease, diabetes, and cancer (1). For primary preventive purposes, there is general agreement to recommend maintaining normal weight, that is, body mass index (BMI), between 18.5 and 25 (2). However, a growing number of studies have shown that in patients with stroke and other cardiovascular diseases, survival is better in overweight and obese patients than normal weight patients (3–7). Thus, it is unclear if recommendations derived

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from primary prevention should be extended to secondary prevention of cardiovascular disease. The more so as studies documenting a beneficial effect of reducing weight on recurrence and life expectancy in cardiovascular disease are yet to be carried out (8–10). One reason to maintain the recommendation would be that obesity, although not increasing risk of death, increases risk of recurrence in cardiovascular disease.

The relation between obesity and risk of stroke recurrence is sparsely investigated. In one study, stroke recurrence rate was similar in lean and obese stroke patients (7). In another recent study, risk of stroke recurrence was not increased in obese stroke patients (BMI > 30) when compared with lean stroke patients (BMI < 25) in a multivariate analysis (11). It is well known, however, that underweight patients (BMI < 18.5) within the lean category may be unhealthy lean due to unintentional weight loss which could lead to an overestimation of the poor prognosis of the lean weight reference group. Thus, the relation between risk of stroke recurrence and BMI is still not clear.

An administrative Danish quality-control registry designed to collect a predefined dataset on all hospitalized stroke patients in Denmark 2000–2010 includes 45 615 acute first-ever stroke patients with information on BMI in 29 326 patients. We studied the independent association between BMI in this cohort and the risk of death or readmission for recurrent stroke within a mean follow-up period of 2.6 years.

Methods

The study is based on data from the Danish National Indicator Project (NIP) described in detail elsewhere (12,13). All Danish hospitals are committed to reporting a predefined set of data into the NIP database on all patients admitted to hospital with acute stroke. Data include age, gender, civil status, stroke severity measured by the Scandinavian Stroke Scale (SSS) (14), stroke subtype, and a predefined cardiovascular profile.

SSS is a validated neurological stroke scale evaluating stroke severity on a score from 0 (worst) to 58 (best) (14). Stroke subtype (haemorrhage/infarct) is determined following computed tomography/magnetic resonance (CT/MR) scan. The cardiovascular profile includes information on: alcohol consumption (≤ 14/21/ > 14/21 drinks per week for women and men, respectively, representing under/over the limit set by the Danish National Board of Health), current daily smoking, diabetes mellitus (DM), atrial fibrillation (AF) (chronic or paroxysmal), arterial hypertension, previous myocardial infarction (MI), previous stroke, and intermittent arterial claudication. Diagnosis of DM, AF, arterial hypertension, previous MI, previous stroke, and intermittent arterial claudication is made following current Danish standards (13) and is either known before onset of stroke or diagnosed during hospitalization. Stroke is defined according to the WHO criteria (15).

Multidomain Lifestyle Interventions for the Prevention of Cognitive Decline After Ischemic Stroke Randomized Trial

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Jaakko Tuomilehto, PhD; Michael Brainin, MD; on behalf of the ASPIS Study Group*

Background and Purpose—Cognitive impairment occurs in $\leq 30\%$ of all stroke survivors. However, effective therapies aimed at preventing poststroke cognitive decline are lacking. We assessed the efficacy of a multidomain intervention on preventing cognitive decline after stroke.

Methods—In this randomized, observer-blind trial patients were recruited within 3 months after an acute stroke in 5 Austrian neurological centers. Patients were assigned to a 24-month lifestyle-based multidomain intervention or standard stroke care. Primary outcomes were the cognitive subscale of the Alzheimer Disease Assessment Scale (ADAS-cog) and occurrence of cognitive decline in the composite scores of at least 2 of 5 cognitive domains at 24 months.

Results—A total of 101 patients were randomized into multi-intervention and 101 into standard care during June 2010 and November 2012. Of them, 76 patients in the intervention group and 83 in the control group were included in the final intention-to-treat analysis. At 24 months, 8 of 76 (10.5%) patients in the intervention group and 10 of 83 (12.0%) patients in the control group showed cognitive decline corresponding to a relative risk reduction of 0.874 (95% confidence interval, 0.364–2.098). The change in ADAS-cog from baseline to 24 months was not different either (median 0 [IQR, –1 to 2] in both groups; $P=0.808$).

Conclusions—This trial found no benefit of 24-month multidomain intervention with focus on improvement in lifestyle and vascular risk factors on the incidence of poststroke cognitive decline in comparison with standard stroke care. Studies with a larger sample size are needed.

Clinical Trial Registration—URL: <http://clinicaltrials.gov>. Unique identifier: NCT01109836. (Stroke. 2015;46:2874–2880. DOI: 10.1161/STROKEAHA.115.009992.)

Key Words: cognition ■ dementia, vascular ■ life style ■ prevention and control ■ stroke

With an estimated total annual cost of €105 billion in Europe in 2010 and an expected increase due to the increasing life expectancy, dementia represents one of the biggest challenges of the century for the economic, social and healthcare system in Europe.¹ There is a strong relationship between stroke and dementia. The prevalence data show that approximately ten percent of patients with stroke already have dementia when stroke occurs, another 10% will develop dementia after a first-ever stroke and additional 30% will develop dementia after a recurrent stroke.² Depending on the criteria used for cognitive impairment—up to 76% of patients with stroke have mild cognitive impairment at three months after an acute stroke.³ Although up to 50% of patients improve cognitively, 30% deteriorate in a delayed fashion between 3

and 15 months poststroke.³ The mechanisms for the delayed onset remain unclear but vascular as well as neurodegenerative mechanisms are involved and stroke seems to accelerate ongoing gradual processes of cognitive decline.

The preservation of cognitive abilities after stroke is increasingly recognized as a crucial target, but no therapeutic strategy has shown convincing clinical evidence of restoring cognitive function or preventing its further decline.^{4–6}

Modifiable risk factors for stroke such as hypertension, dyslipidaemia, diabetes mellitus, smoking, physical inactivity, and poor diet have been associated with an increased risk of cognitive impairment.^{7–10} Thus, it is plausible that effective secondary prevention strategies in combination with lifestyle-oriented interventions adjusted to individual risk factors can

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ORIGINAL ARTICLE

Long-term Efficacy of Occupational Lifestyle Redesign Programme for Strokes



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KEYWORDS
community
integration;
lifestyle redesign;
mental well-being;
stroke recovery

Summary *Objective/Background:* To devise an Occupational Lifestyle Redesign Programme (OLSR), in addition to the existing conventional therapy programme, in a local rehabilitation hospital in order to help stroke outpatients improve their self-efficacy and commitment in self-management after a stroke attack using goal-oriented, challenging, and well-being building activities. The long-term effect on the poststroke quality of life (QOL) and community integration has to be explored.

Methods: This is a retrospective study performed to compare two groups of matched samples of participants (25 each) who have or have not joined the OLSR programme. A telephonic interview was performed to gather the participants' responses. Self-reported outcome measures, including sickness impact [Stroke Adapted Sickness Impact Profile-30 (SA-SIP30)], motivation for general activity [General Activity Motivation Measure (GAMM)], community integration [Community Integration Questionnaire], and subjective well-being [World Health Organization Well-Being Index (WHO-5)] scores were assessed.

Results: Subjective well-being measures had significantly higher scores in the OLSR group ($F = 5.52; p = .023$). The OLSR group also reported a significantly better score in social integration ($F = 4.302; p = .043$). The SA-SIP30 mean score of the OLSR group [mean = 6.64; standard deviation (SD) = 4.35] was much lower, however, with significant difference in Mobility ($F = 4.47; p = .04$) and Household Management ($F = 6; p = .015$) subscores. The mean score of GAMM was also high in the OLSR group (mean = 41.32; SD = 11.98; $p = .06$). Improving "productive activity," "social interaction," "home management," and "emotion" scores (based on factor analysis) are important goals to be achieved in a stroke rehabilitation programme so as to extend its scope from just physical restoration to building a better poststroke life.

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Kualitas Hidup Pasien Stroke dalam Perawatan *Palliative Homecare*

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Abstrak

Stroke merupakan penyakit defisit neurologis multi kompleks yang menyebabkan kecacatan fisik atau mental dapat mempengaruhi semua aspek kehidupan individu termasuk kualitas hidup pasien. Kualitas hidup terkait kesejahteraan hidup pasien dan keluarga dengan pemberian perawatan *Palliative homecare*. Penelitian fenomenologi ini dilakukan untuk mengeksplorasi secara mendalam kualitas hidup pasien dalam perawatan *Palliative homecare*. Partisipan dalam penelitian ini dengan 13 partisipan dengan teknik purposive sampling. Tema yang terkait dengan kualitas hidup adalah domain fisik yang meliputi aktivitas, pola makan, memori dan konsentrasi, mobilitas fisik, bicara, nyeri, tidur dan istirahat. Domain psikologis antara lain gambaran diri, motivasi hidup, perasaan bahagia dan perasaan sedih. Domain sosial antara lain perubahan sosial antara lain perubahan fungsi sosial dan perubahan peran. Pengumpulan data dalam penelitian ini melalui data primer dan data sekunder. Data primer diperoleh dengan indepth interview (wawancara mendalam) kepada partisipan utama dan Fokus Group Discussion (FGD) kepada partisipan pendukung. Data sekunder menggunakan instrumen lain berupa formulir lembar data demografi, rekam medis berupa catatan medis, catatan keperawatan pasien dan catatan lapangan peneliti. Kualitas hidup domain fisik meningkat pada aktivitas, pola makan, mobilisasi fisik dan bicara. Kualitas hidup domain psikologis meningkat pada motivasi hidup, perasaan bahagia. Kualitas hidup domain sosial meningkat pada perubahan fungsi sosial. Penelitian ini berhasil membuktikan bahwa kualitas hidup pasien stroke meningkat dalam perawatan *Palliative homecare*. Perawatan *Palliative homecare* dalam informasi layanan dan kolaborasi dengan tim medis dan sosial worker sangat penting bagi peningkatan kebutuhan pasien dan pencapaian kualitas hidup.

Kata Kunci: stroke, quality of life, palliative homecare

Quality of Life of Stroke Patients In The Care of *Palliative Homecare*

Abstract

Stroke is a neurological deficit multi complex disease that causes physical or mental disability can affect all aspects of an individual's life, including the quality of life of patients. Quality of life related to the welfare of patients and families with the provision of *Palliative homecare*. Phenomenological study was conducted to explore in depth the quality of life of patients in palliative care homecare. Participants in this study with 13 participants using purposive sampling technique. Themes related to the quality of life is domains includes physical activity, diet, memory and concentration, physical mobility, speech, pain, sleep and rest. Psychological domains include self-image, motivation of life, happiness and sadness. Among other social domains of social change include changes in the social function and the role change. Collecting data in this study through primary data and secondary data. The primary data obtained by in-depth interviews (depth interview) to the main participants and Focus Group Discussion (FGD) to support participants. Secondary data using the other instruments in the form of sheet form and demographic data, medical records such as medical records, patient nursing records and field notes the researcher. Quality of life domains increased physical activity, diet, physical mobilization and talk. Quality of life increased in the psychological domain of motivation to live, feeling happy. Quality of life increased in the social domain changes in social function. This study proved that the quality of life of stroke patients in the care of palliative homecare increases. Palliative care in the



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HUBUNGAN ANTARA GAYA HIDUP DENGAN KEJADIAN STROKE USIA DEWASA MUDA DI RSUD DR. MOEWARDI SURAKARTA

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ABSTRAK

Stroke merupakan masalah kesehatan yang utama bagi masyarakat modern saat ini. Stroke dapat menyerang usia muda yang disebabkan oleh pola hidup, terutama pola makan tinggi kolesterol. Penelitian ini bertujuan untuk mengetahui hubungan antara gaya hidup dengan kejadian stroke usia dewasa muda di RSUD Dr. Moewardi. Jenis penelitian ini adalah observasional dengan pendekatan rancangan *case control*. Sampel kasus adalah penderita stroke usia dewasa muda 19-40 tahun, sedangkan sampel kontrol adalah bukan penderita stroke, hipertensi, DM, dan penyakit jantung yang berusia 19-40 tahun, masing-masing sebanyak 57 responden. Teknik pengambilan sampel pada kelompok kasus maupun kontrol dengan metode *purposive sampling*. Pengambilan data melalui teknik wawancara ke rumah responden. Uji statistik yang digunakan untuk analisis data dalam penelitian ini adalah uji *chi square*. Hasil penelitian yang menunjukkan ada hubungan yang bermakna dengan kejadian stroke usia dewasa muda adalah konsumsi makanan tinggi lemak dan kolesterol ($p=0,000$; OR=6,655; 95% CI=2,925 -15,139), aktifitas fisik ($p=0,000$; OR=6,463 ; 95% CI=2,730-15,296), dan aktifitas olahraga ($p=0,000$;OR=15,476 ; 95% CI=5,877-40,754). Sedangkan variabel yang tidak memiliki hubungan yang bermakna dengan kejadian stroke usia dewasa muda adalah konsumsi minuman beralkohol ($p=0,542$; OR=0,687;95% CI=0,204-2,307), penyalahgunaan obat ($p=0,402$; OR=0,482; 95% CI=0,085-2,742), dan perilaku merokok ($p=0,334$; OR=0,688; 95% CI=0,321-1,472).

Kata kunci: Stroke, Usia Dewasa Muda, Gaya Hidup

PENDAHULUAN

Stroke merupakan masalah kesehatan yang utama bagi masyarakat modern saat ini. Dewasa ini, stroke semakin menjadi masalah serius yang dihadapi hampir diseluruh dunia. Hal tersebut dikarenakan serangan stroke yang mendadak dapat mengakibatkan kematian, kecacatan fisik dan mental baik pada usia produktif maupun usia lanjut (Junaidi, 2011).

Menurut WHO (*World Health Organization*) tahun 2012, kematian akibat stroke sebesar 51% di seluruh dunia disebabkan oleh tekanan darah tinggi. Selain itu, diperkirakan sebesar 16%

kematian stroke disebabkan tingginya kadar glukosa darah dalam tubuh. Tingginya kadar gula darah dalam tubuh secara patologis berperan dalam peningkatan konsentrasi glikoprotein, yang merupakan pencetus beberapa penyakit vaskuler. Kadar glukosa darah yang tinggi pada saat stroke akan memperbesar kemungkinan meluasnya area infark karena terbentuknya asam laktat akibat metabolisme glukosa secara anaerobik yang merusak jaringan otak (Rico dkk, 2008).

Berdasarkan hasil Riskesdas tahun 2013, prevalensi penyakit stroke di Indonesia meningkat seiring bertambahnya umur.

Jadwal Kegiatan Penelitian

No	Kegiatan	Bulan																	
		Marat	April	Mei	Juni	Juli	Agustus	September	Oktober	November	Desember	Januari	Februari	Marat	April	Mei	Juni	Juli	
1.	Persiapan (pengajuan penelitian proposal)																		
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3.	Pengumpulan data																		
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7.	Pengolahan data dan analisis data																		
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9.	Seminar ujian hasil																		
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Wassalamualaikum Wr. Wb

Samarinda, 8 Juli 2020

Pembimbing



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Pembimbing : Dr. Hj.Nunung Herlina,S.Kp.,M.Pd

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1.	12 Mei 2020	Konsul Bab 1-3	Tambahkan antara disebelah hubungan. Banyak typing error, perhatikan detail. Tambahkan jurnal luar negeri.	
2.	18 Mei 2020	Konsul Bab 1-5	Perbaiki penulisan. Pembahasannya kurang	
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4.	1 Juni 2020	Konsul Bab 1-5	Perbaiki masih banyak typo. Dapus diurutkan sesuai abjad.	

			Nama orang huruf besar. Perhatikan kata sambung, spasi, dan titik koma.	
5.	1 Juli 2020	Konsul Bab 1-5	Perbaiki masih ada typo ACC maju seminar hasil	
6	2 Juli 2020	Konsul BAB 1- BAB 5	Tambahkan penjelasan RAC Perjelas kriteria eksklusi	
7	3 Juli 2020	Konsul BAB 1- BAB 5	Perluas pembahasan Perbaiki tulisan	
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SKRIPSI: HUBUNGAN ANTARA
GAYA HIDUP DENGAN
KEJADIAN STROKE
BERULANG : LITERATURE
REVIEW

by Cisada Ike Wulandari

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