All About Strokes

All About Strokes - Pre-Conference Workshop (Repeated)

Thursday, 20 June 2013	Start 8:30am	Duration: 120mins	Skellerup
	Start 11:00am	Duration: 120mins	Skellerup

All About Strokes

Overview of stroke services in NZ ..... John Fink
Primary prevention ..... Chris Ellis
New oral anticoagulants ..... Gordon Royle
Acute stroke treatment ..... Alan Barber
Secondary stroke prevention ..... Peter Wright
Rehabilitation ..... Ajay Kumar

Q and A panel

Stroke Services In New Zealand

Dr John N Fink
Christchurch Hospital

Introduction / Disclosures

Canterbury District Health Board
Te Poari Hauora ō Waitaha

STROKE FOUNDATION OF NEW ZEALAND INC

MINISTRY OF HEALTH
MANATŪ HAUORA

Outline

- History:
  - Development of Stroke Services in NZ
- Level of Expectation of DHB Stroke Services
- Interface of General Practice with Secondary Care Stroke Services
  - TIA management

Why Stroke?

- #3 cause of death in NZ after all cancer and heart disease
- #1 cause of long-term adult disability
- 9000 New Zealanders have a stroke each year
  - 24/day
  - 2500 stroke deaths/year
- ¼ strokes in NZ (>2000/y) occur <65y age
- 5% of hospital admissions, 12% hospital beds

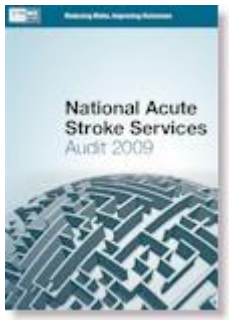
History

- 2001
  - Stroke Rehab Unit Christchurch
  - Stroke Ward MMH
  - Stroke thrombolysis becoming available at Auckland and Christchurch only
  - NZ Stroke GL 1996 – ignored


life
stroke

3


NEW ZEALAND GUIDELINE
STROKE


National Acute
Stroke Services
Audit 2009


New Zealand
Clinical Guidelines for
Stroke Management
2010

21

Stroke Service Opens @ Lakes

LAKES DISTRICT HEALTH BOARD

JUNE 2013

Inside this issue:

New Stroke Unit Follows Move into Redeveloped OPRS

Patients and staff moved into the new Older Persons and Rehabilitation Service (OPRS) redeveloped facility in the Elderly Services Building on the morning of Wednesday 29 May.

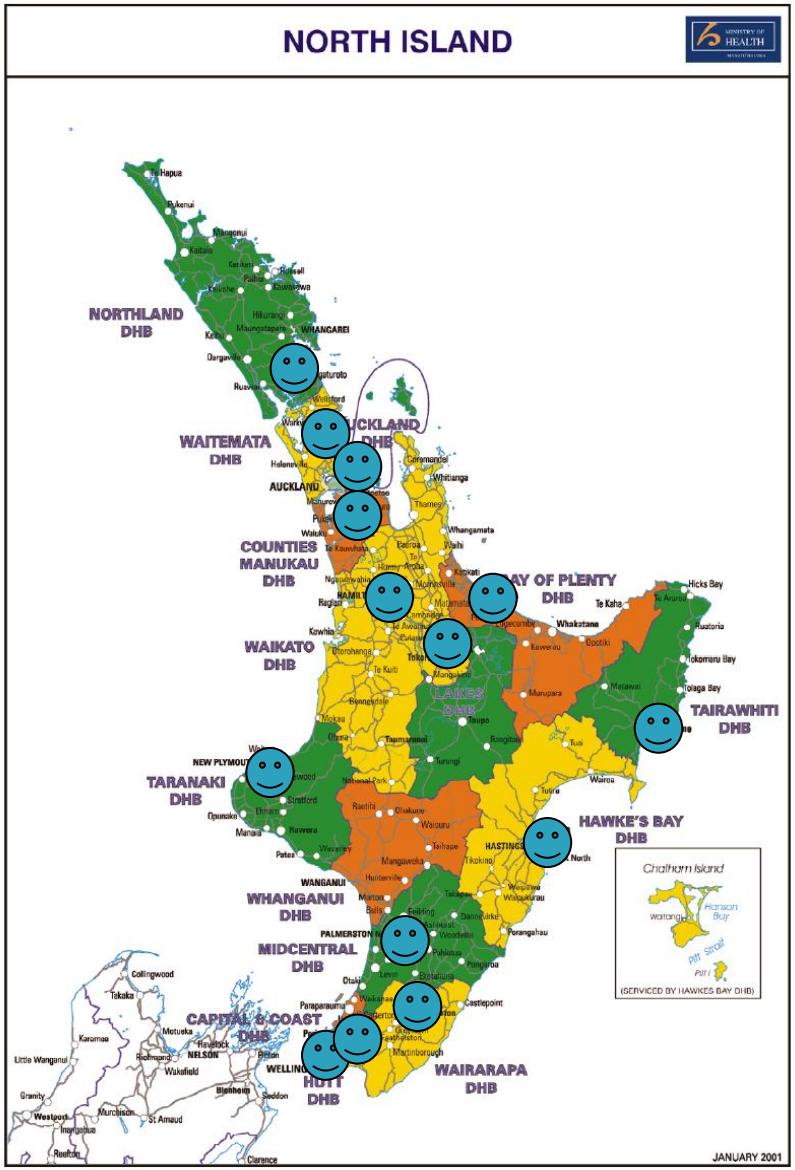
The building has been redeveloped, with new roofing and cladding, and was officially opened mid-May by Lakes DHB Chair Deryck Shaw and Ngati Whakaue kaumatua Pihopa Kingi. The temporary relocation of OPRS stretched out to 14 months, due to the reroofing and re-cladding required to fix leaky building issues.

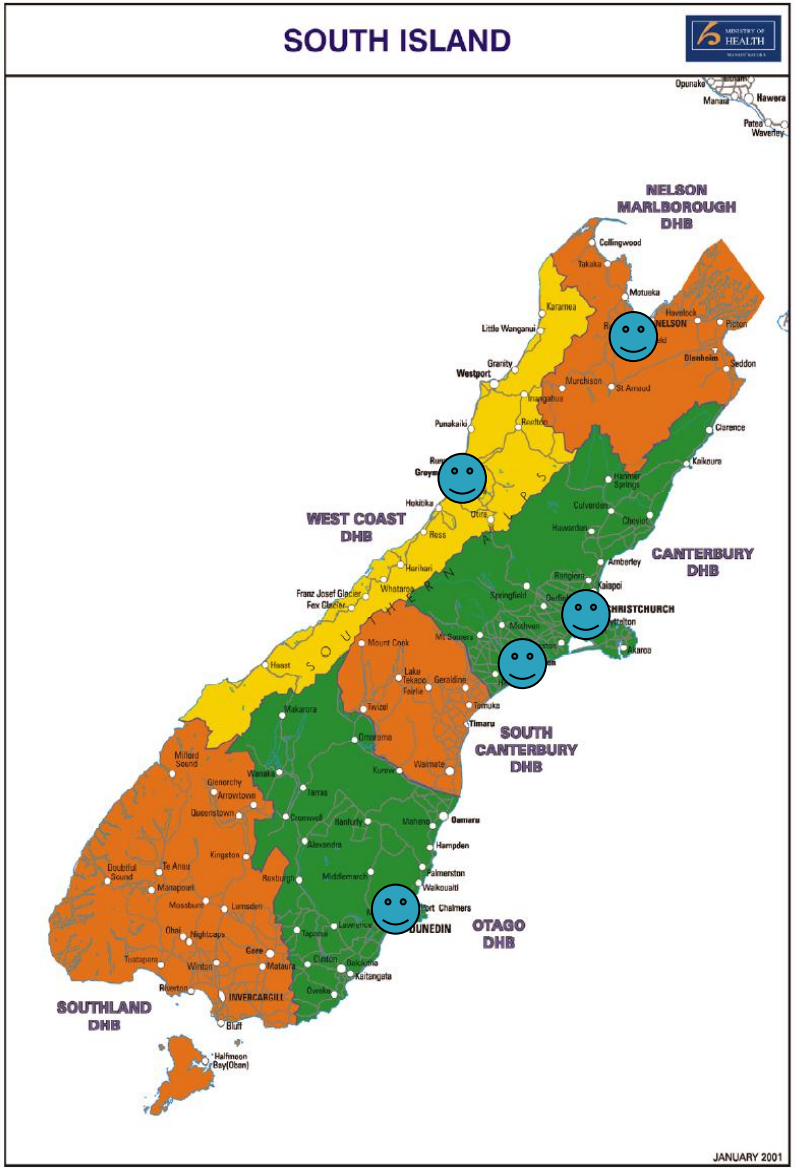
The redeveloped facility has outpatient clinic areas, a new reception area and a new lift to the basement which will take equipment used in the community to a cleaning, resource and storage area. Features of OPRS include:

- An increase in beds from 16 to 21 with the potential to increase to another four beds in the future.
- A special room with a bariatric hoist and hoists have been added to an additional five bed spaces.
- Ensuites added to three three-bedded rooms and six one-bedded rooms
- An assessment flat upgrade.

A fortnight after OPRS moved into its new premises, the stroke unit that has been an integral part of planning for the redeveloped OPRS will open, on Monday 10 June.

Stroke Project team: Rosemary Viskovic (back left), CNM Johanna Spaans (back right), Dr David Silverman and Chinta Charteris.


NORTH ISLAND
NORTHLAND DHB
WAITEMATA DHB
AUCKLAND DHB
COUNTIES MANUKAU DHB
WAIKATO DHB
BAY OF PLENTY DHB
LAKES DHB
TAIRAWHITI DHB
TARANAKI DHB
HAWKE'S BAY DHB
WHANGANUI DHB
MIDCENTRAL DHB
CAPITAL & COAST DHB
HUTT DHB
WAIRARAPA DHB
Chatham Island
(SERVICED BY HAWKES BAY DHB)
JANUARY 2001


SOUTH ISLAND
NELSON MARLBOROUGH DHB
WEST COAST DHB
CANTERBURY DHB
SOUTH CANTERBURY DHB
OTAGO DHB
SOUTHLAND DHB
JANUARY 2001

Stroke Networks

- Stroke Network National Leadership Group
  - Workstreams:
    - TIA project
    - Stroke Thrombolysis
    - Rehabilitation
    - Best practice resource project
- Regional Stroke Networks
  - Northern
  - Midland
  - Central
  - South Island

Expectations of DHB Stroke Services

- All DHBs should provide organised stroke services

Box 1: Definition of organised stroke services

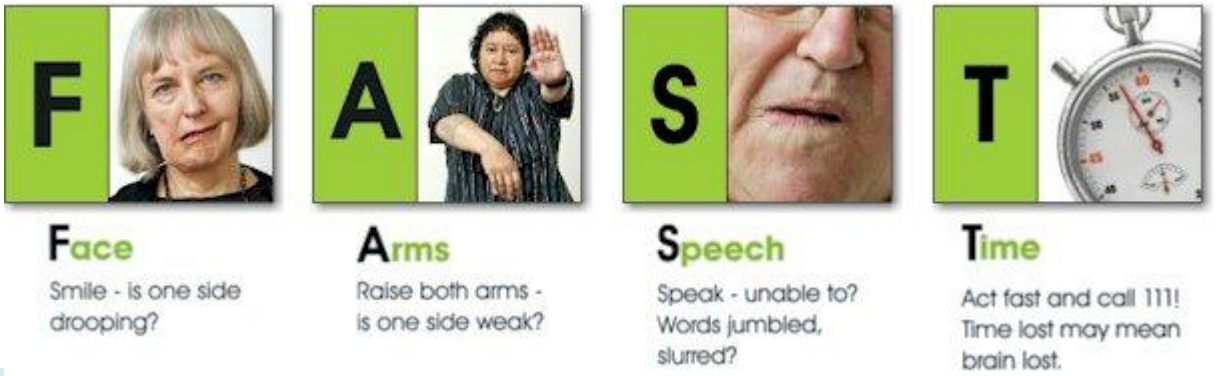
- All people with acute stroke are the responsibility of, and are managed by, services specialising in stroke and rehabilitation.
- The organisation has a 'lead clinician' for stroke services.
- Care is provided and coordinated by an interdisciplinary team skilled in stroke and rehabilitation.
- All people with stroke or transient ischaemic attack (TIA) have a comprehensive assessment and appropriate secondary prevention measures are provided.
- Systems exist to identify people with stroke and TIA not admitted to hospital and to ensure that they receive all necessary services, particularly prompt assessment, treatment and secondary prevention.

Expectations of DHB Stroke Services

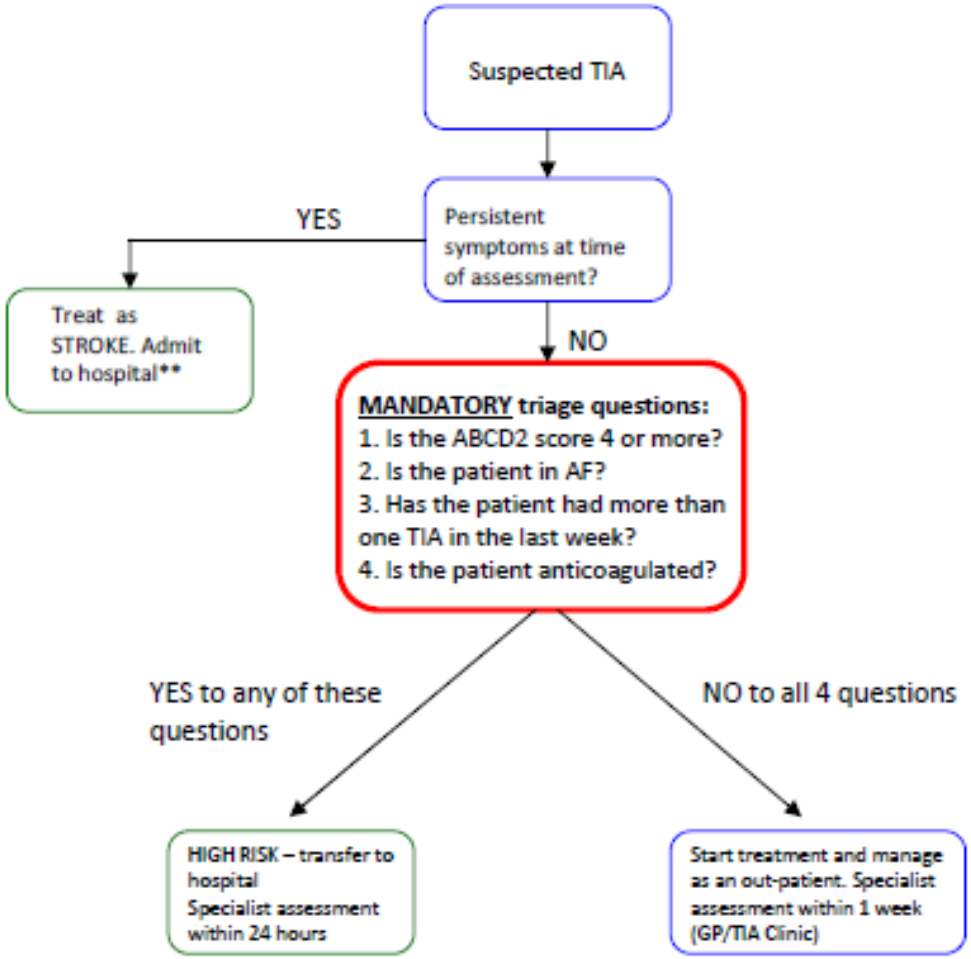
- Acute Stroke
  - “All” patients with acute stroke should be admitted to hospital for immediate investigation and management
  - Target = 80% of stroke patients will be admitted to a stroke unit.

Expectations of DHB Stroke Services – Thrombolysis

- All large and medium DHB's should provide a stroke thrombolysis service
  - Target = 6% ischaemic strokes
  - How to achieve?
    - 1: Hospital Services / Stroke Teams
    - 2: Ambulance Services
    - 3: Public Awareness

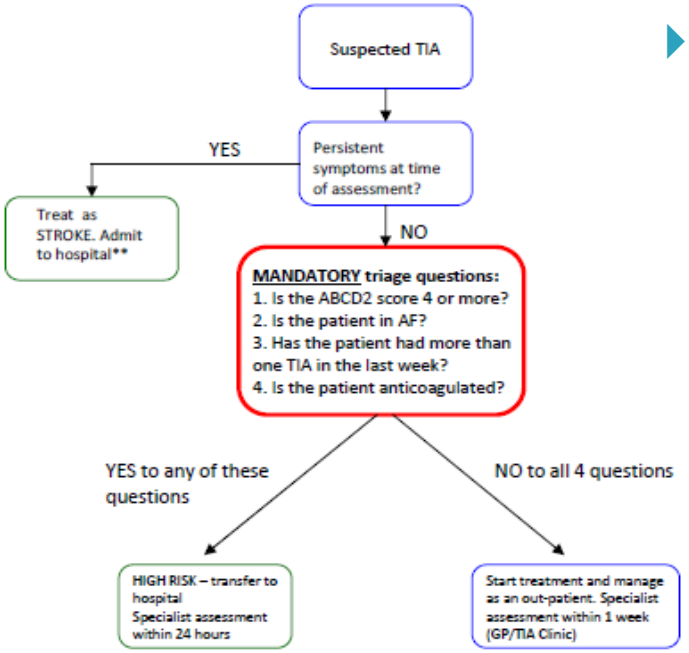


Expectations of DHB Stroke Services – TIA



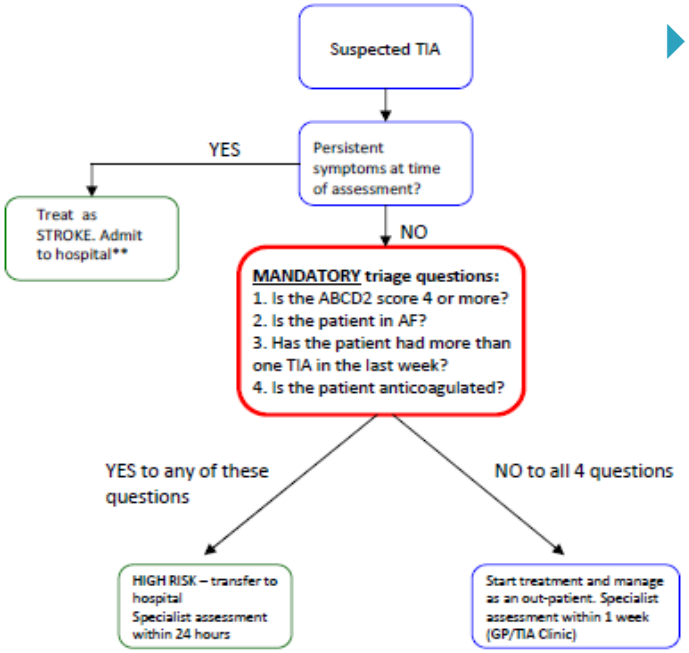
- >7d from onset = 'lower risk'
- Immediate treatment for **all** patients

Interface of General Practice with Secondary Stroke Services – TIA



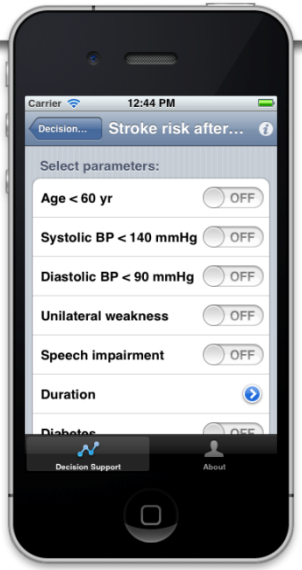
- Questions:
  - How do we achieve this?
    - 1. Accurate diagnosis and triage
    - 2. Correct immediate Rx
    - 3. Access to specialist services
    - 4. Access to investigations
  - Regional networks are focusing on implementation of DHB-appropriate pathways

Interface of General Practice with Secondary Stroke Services – TIA

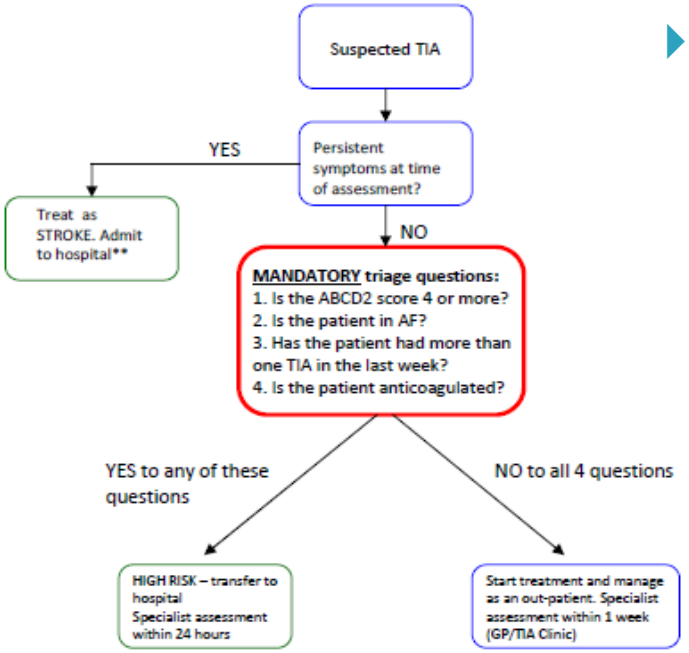


- Questions:
  - What is the ABCD2 score?

ABCD^2	Risk Factor	Criteria	Score
A	Age	>60 years	1
B	Blood Pressure	SBP>140, DBP>90	1
C	Clinical features	Unilateral weakness Speech disturbance only	2 1
D	Duration	>60min 10-59min	2 1
D2	Diabetes	Present	1

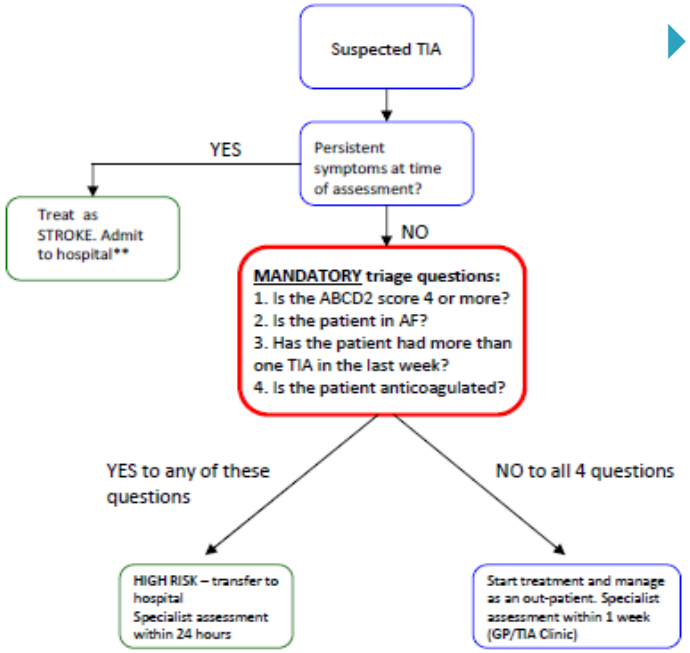


Interface of General Practice with Secondary Stroke Services – TIA



- Questions:
  - What is the ABCD2 score?
  - Does your DHB have a clear referral pathway for
    - High risk TIA?
    - Lower risk TIA?
      - Specialist assessment
      - Imaging – eg Carotid U/S

Interface of General Practice with Secondary Stroke Services – TIA



- Questions:
  - What is the ABCD2 score?
  - Does your DHB have a clear pathway for
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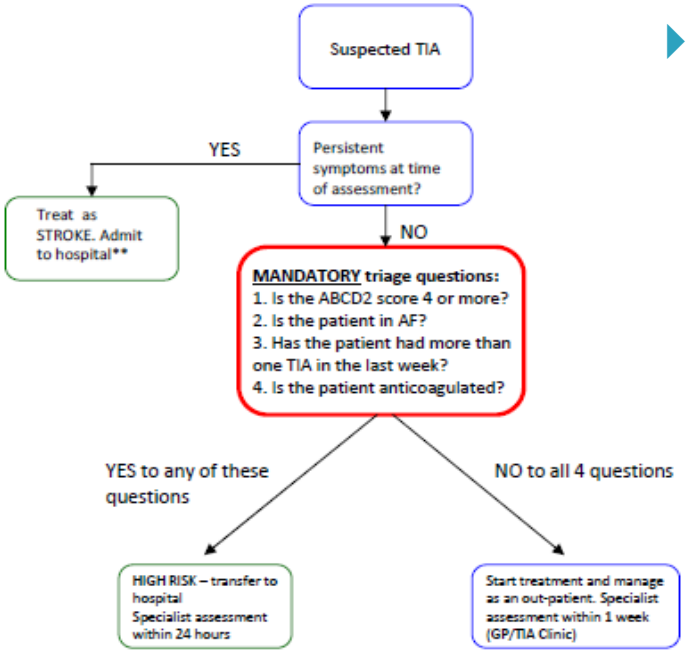
    - Lower risk TIA?
  - What is the best immediate treatment?

Interface of General Practice with Secondary Stroke Services – TIA



- Questions:
  - What is the ABCD2 score?
  - Does your DHB have a clear pathway for
    - High risk TIA?
    - Lower risk TIA?
  - What is the best immediate treatment?
    - antiplatelet: aspirin or clopidogrel
    - BP lowering: eg ACEi
    - Statin: eg atorvastatin 80mg

TIA Electronic Decision Support (EDS) Software for GPs

- Dr Anna Ranta, Neurologist
  Palmerston North

TIA Electronic Decision Support (EDS) Software for GPs

- Helps to make an accurate diagnosis
- Stratifies patients into high and low risk
- Prompts immediate medication initiation
- Grants access to rapid CT/U/S if indicated
- Links to patient information leaflets
- Links to appropriate Rx in GP PMS
- Generates referrals (ED/TIA/lab/radiology)
- Gives feedback/help w/ test interpretation


File Edit Patient Module Report Tools Utilities Setup ManageMyHealth ConnectedCare CAT Window Help
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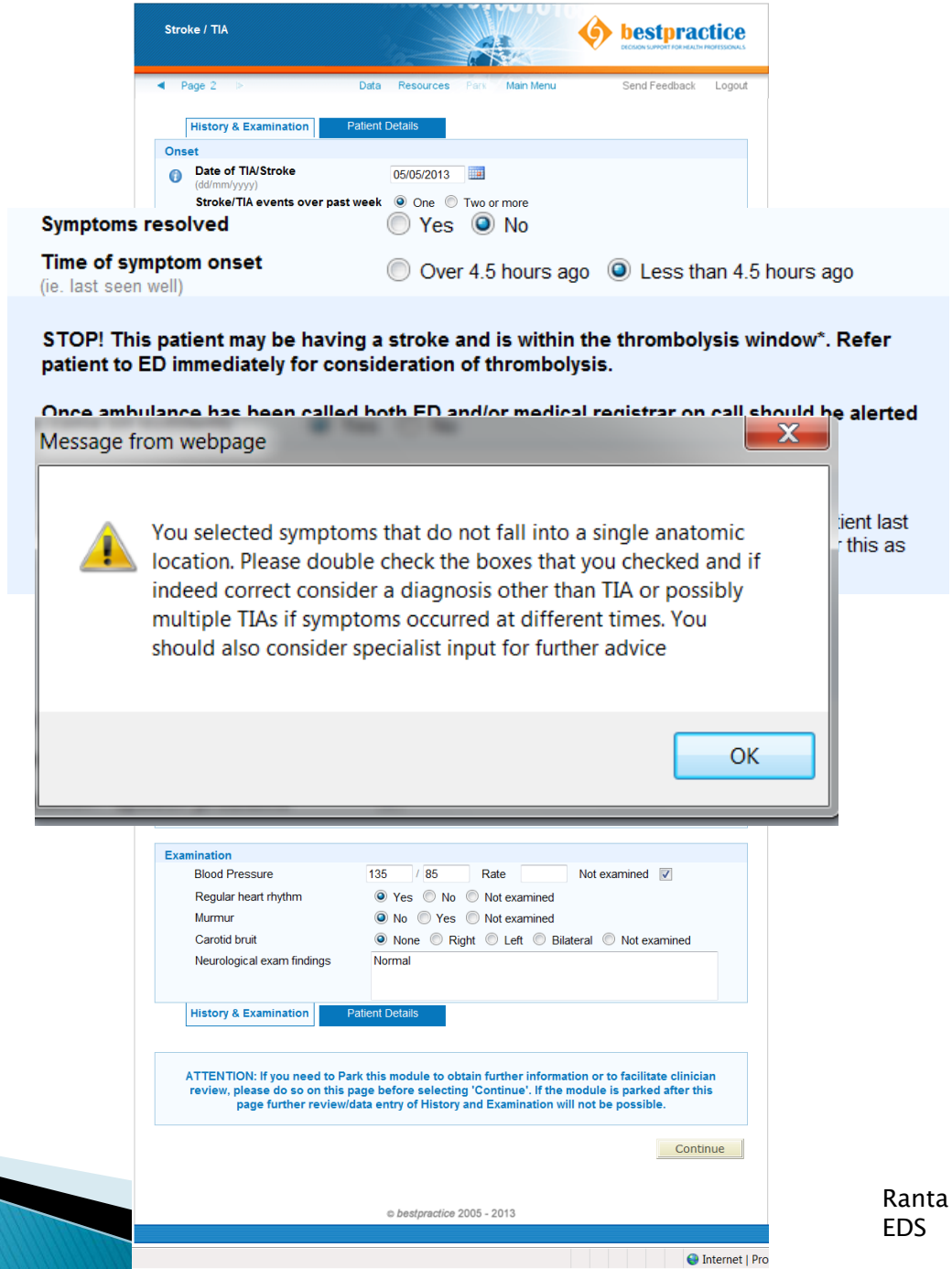
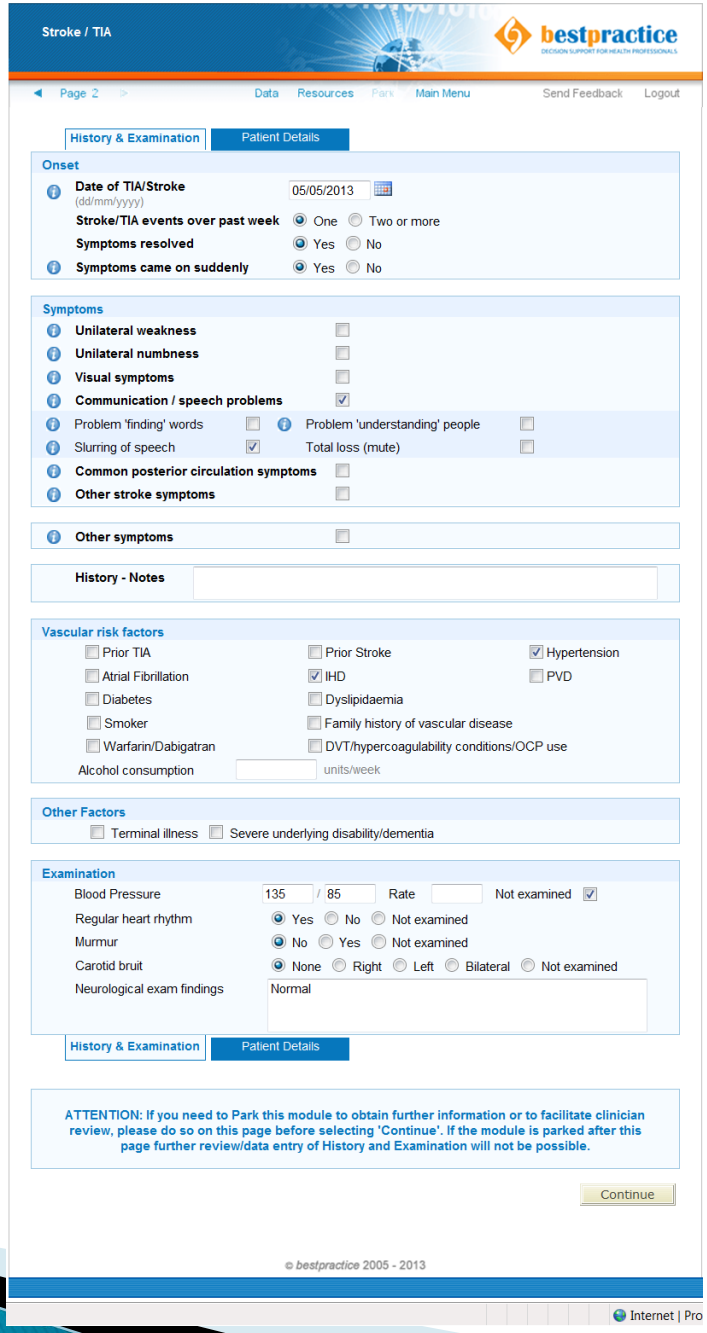


Ranta ANZAN 2013 TIA EDS



Ranta ANZAN 2013 TIA EDS


Stroke / TIA
bestpractice
DECISION SUPPORT FOR HEALTH PROFESSIONALS
Page 3
Data
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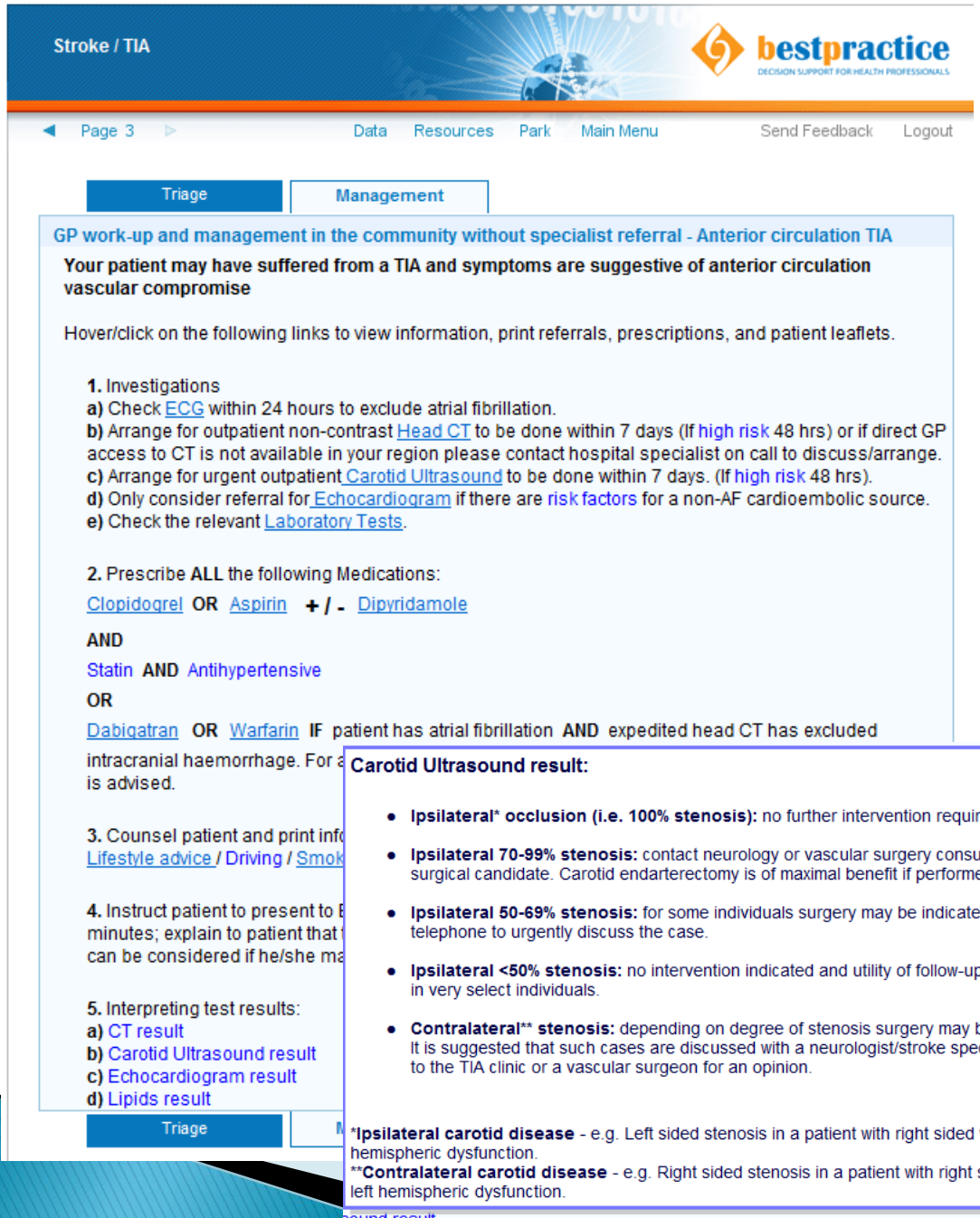
Triage
Management
Your patient may have suffered from a TIA and the estimated seven day stroke risk is Low
You have two management options:
a) Refer to TIA Clinic AND (before patient leaves surgery):
Initiate/continue ALL of the following Medications:
Clopidogrel OR Aspirin + / - Dipyridamole (UNLESS patient is on Warfarin or D
AND
Statin AND Antihypertensive
AND
Counsel patient on Smoking Cessation AND No Driving for minimum of 1 month.
Print TIA Information Leaflet
OR
b) Arrange comprehensive TIA/stroke work-up in t
Triage
Management
ATTENTION: Please ensure that all referrals an
handing them to the patient - this software is intended as a tool to support, but not replace practitioner
clinical judgement.
Continue
TIA Risk Calculation (ABCD2)
Age: 1 pts (age >= 60)
Blood Pressure: 0 pts (bp < 140/90)
Clinical Features: 1 pts (Speech affected without weakness)
Diabetes on medication / Insulin: 0 pts (does not apply)
Symptom Duration: 0 pts (Duration of TIA < 10 min)
Your patient's ABCD2 score is: 2
TIA Risk Assessment
High Risk
ABCD2 score ≥4
≥2 events over 7 days
Atrial Fibrillation
Anticoagulation
Low Risk
ABCD2 score <3
≥7 days since last event
Based on ABCD2 score alone (excluding other high risk indicators) see table below for estimated stroke risk in %:
ABCD2 score 0-3 4-5 6-7
Land Transport Recommendations:
1. Private license (Class 1 and 2)
Single TIA: no driving for minimum of 1 month.
Multiple TIAs: no driving for minimum of 3 months provided the condition has been adequately investigated and treated.
2. Vocational license (Classes 2-5 and/or a P,V,I or O license endorsement)
Single TIA: no driving for a minimum of 6 months and then only if cause has been identified and satisfactorily treated, including a specialist assessment. Note that these individuals may resume private driving after a minimum of 1 month.
Multiple TIAs: people should not return to vocational driving. However the Director of Land Transport may consider granting a license 12 months after the last attack if an appropriate specialist report supports such an application.


Stroke / TIA
bestpractice
DECISION SUPPORT FOR HEALTH PROFESSIONALS
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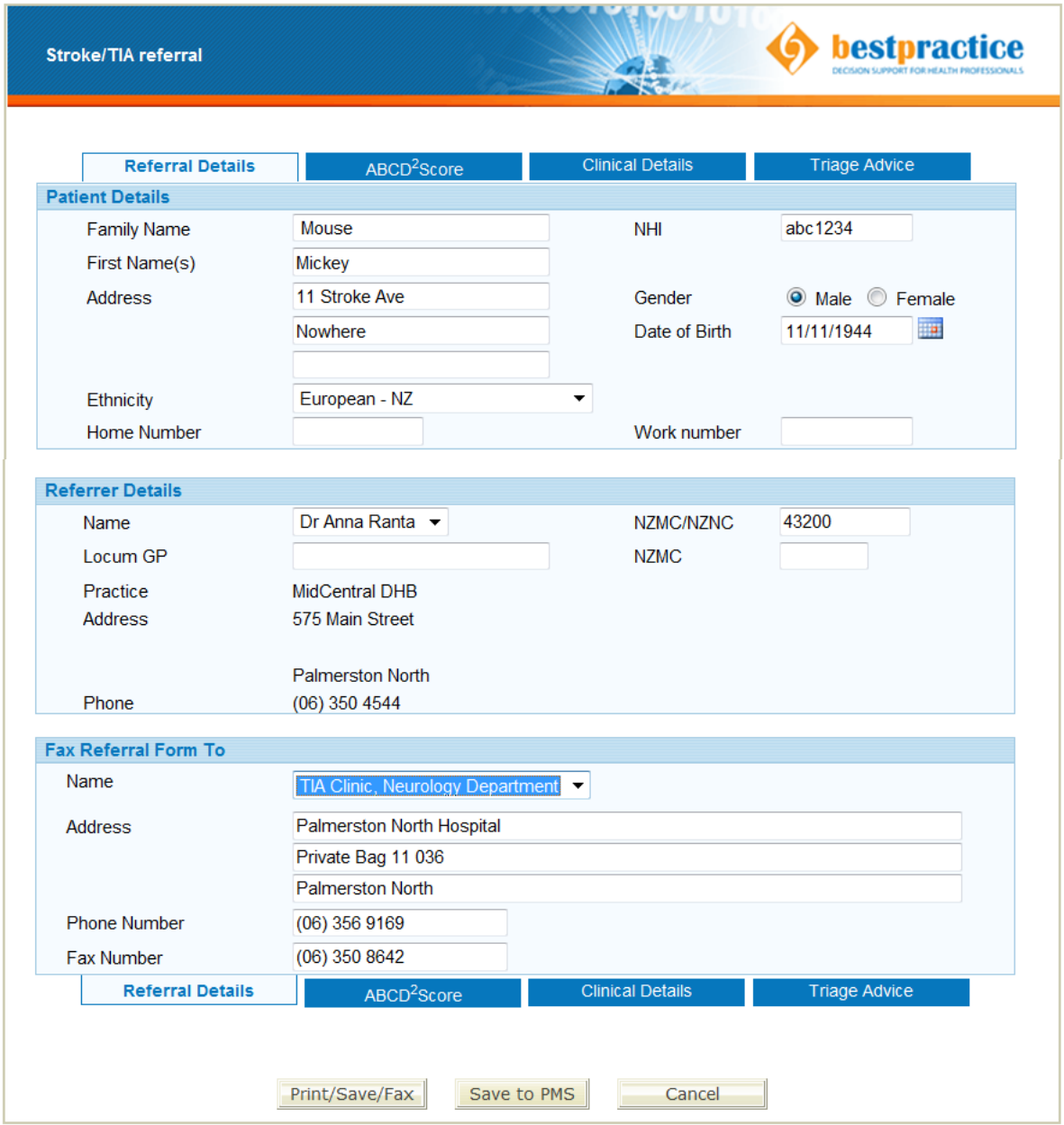
GP work-up and management in the community without specialist referral - Anterior circulation TIA
Your patient may have suffered from a TIA and symptoms are suggestive of anterior circulation vascular compromise
Hover/click on the following links to view information, print referrals, prescriptions, and patient leaflets.
1. Investigations
a) Check ECG within 24 hours to exclude atrial fibrillation.
b) Arrange for outpatient non-contrast Head CT to be done within 7 days (If high risk 48 hrs) or if direct GP access to CT is not available in your region please contact hospital specialist on call to discuss/arrange.
c) Arrange for urgent outpatient Carotid Ultrasound to be done within 7 days. (If high risk 48 hrs).
d) Only consider referral for Echocardiogram if there are risk factors for a non-AF cardioembolic source.
e) Check the relevant Laboratory Tests.
2. Prescribe ALL the following Medications:
Clopidogrel OR Aspirin + / - Dipyridamole
AND
Statin AND Antihypertensive
OR
Dabigatran OR Warfarin IF patient has atrial fibrillation AND expedited head CT has excluded
intracranial haemorrhage. For a
is advised.
3. Counsel patient and print info
Lifestyle advice / Driving / Smok
4. Instruct patient to present to E
minutes; explain to patient that t
can be considered if he/she ma
5. Interpreting test results:
a) CT result
b) Carotid Ultrasound result
c) Echocardiogram result
d) Lipids result
Triage
M
Carotid Ultrasound result:
Ipsilateral* occlusion (i.e. 100% stenosis): no further intervention required.
Ipsilateral 70-99% stenosis: contact neurology or vascular surgery consultant immediately via telephone if patient deemed good surgical candidate. Carotid endarterectomy is of maximal benefit if performed within 2 weeks of TIA.
Ipsilateral 50-69% stenosis: for some individuals surgery may be indicated. Contact neurologist/stroke specialist via telephone to urgently discuss the case.
Ipsilateral <50% stenosis: no intervention indicated and utility of follow-up ultrasound highly questionable except in very select individuals.
Contralateral** stenosis: depending on degree of stenosis surgery may be considered, but intervention is not urgent. It is suggested that such cases are discussed with a neurologist/stroke specialist. Alternatively the patient could be referred to the TIA clinic or a vascular surgeon for an opinion.
*Ipsilateral carotid disease - e.g. Left sided stenosis in a patient with right sided weakness and dysphasia and thus left hemispheric dysfunction.
**Contralateral carotid disease - e.g. Right sided stenosis in a patient with right sided weakness and dysphasia and thus left hemispheric dysfunction.



Ranta ANZAN 2013 TIA EDS

Stroke Services in NZ

- Are becoming more “organised”
- Expectations include:
  - Designated lead stroke physician
  - Thrombolysis service in most centres
  - Clear referral pathway for TIA
- Help facilitate improvements!
  - Engagement is needed between PHO’s and Secondary Care stroke services