Intercollegiate Stroke Working Party 2016

National Clinical Guideline on the Management of people with stroke (fifth edition)

Feedback form for comments on draft chapters

This form is for you to make any comments you wish on the draft guideline. It is designed to help us collate all comments.

Comments on the overall structure of the guideline, or on a particular chapter should be titled 'general' but specific marked examples would be helpful.

The guideline is in 7 chapters and has numbered parts (e.g. 6.2, 5.3.2). Please specify the part you are referring to accurately, by number. If necessary add other detail. (e.g. 5.3.1 rec B, 4.2 para 2).

Always please:

- Make your comments or suggestions as specific but as short as possible
- Give any references (and justify anything outrageous!)

Please give your name and email contact.

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Date/version	Peer Review 1 April – 22 April 2016

Part	Comment
Recommendation: 2.2.1 C	Transferring to another hospital might cause vital loss of time if thrombolysis is to be considered.
Recommendation: 2.3.1 E and 3.4.1 D	These are aspirational. CTA may not be readily available in many smaller hospitals (even in 'working hours' – this may depend on the local general radiologists).
Recommendation: 2.7.1. B	This is aspirational – delivery will be difficult.
Recommendations: 2.12.1 and 4.3.1.1	We welcome the attention paid to the psychological aspects of stroke which are not always adequately recognised.
Recommendation: 3.3.1 G	This recommendation could be strengthened. If not embolic source, >4 "TIAs" without a completed stroke would be very unusual and an alternative diagnosis strongly considered.
Recommendation: 3.9	It would be helpful to indicate the duration of anticoagulant therapy for patients with cerebral venous thrombosis (CVT). The recommendations of the American Heart Association (Stroke. 2011;42:1158-1192): • In patients with provoked CVT (associated with a transient risk factor), vitamin K antagonists may be continued for 3 to 6 months, with a target INR of 2.0 to 3.0(Class IIb; Level of Evidence C).

	• In patients with unprovoked CVT, vitamin K antagonists may be continued for 6 to 12 months, with a target INR of 2.0 to 3.0 (Class IIb; Level of Evidence C). • For patients with recurrent CVT, VTE after CVT, or first CVT with severe thrombophilia (ie, homozygous prothrombin G20210A; homozygous factor V Leiden; deficiencies of protein C, protein S, or antithrombin; combined thrombophilia defects; or antiphospholipid syndrome), indefinite anticoagulation may be considered, with a target INR of 2.0 to 3.0 (Class IIb; Level of Evidence C).
Recommendation 4.3:	*"The person with stroke's cognitive status should be taken into account by all members of the multi-disciplinary team when planning and delivering treatment to enable people with cognitive difficulties to participate, and this should be regularly reviewed"* This sentence may be more clearly expressed as: "Cognitive status of stroke patients should be taken into account and regularly reviewed by all members of the multi-disciplinary team when planning and delivering treatment, to enable those with cognitive difficulties to participate."
Recommendation : 4.9.3	*"Health care professionals should recommend vitamin D supplementation in stroke survivors who have symptoms of vitamin D deficiency or are considered to be at high risk e.g. housebound."* Clinical trials have shown that vitamin D supplementation without co-administration of calcium do not prevent osteoporotic fracture. Recent evidence from clinical trials indicates that it is inappropriate to use vitamin D for osteoporosis prevention in community-dwelling adults who do not have specific risk factors for vitamin D deficiency. Calcium supplementation on its own also does not reduce fracture incidence and is no longer recommended for treatment of osteoporosis. (N Engl J Med 2006;354:669-83, Lancet 2011; 377: 1276–87; Lancet 2014; 383: 146–55)
Recommendation: 5.5	The Heart Protection Study (Lancet 2011; 378: 2013–20) provides clear evidence for the efficacy of Simvastatin in stroke prevention (Risk ratio (95% CI) 0·76 (0·68–0·86). However, only Atorvastatin (SPARCL study: adjusted hazard ratio, 0.84; 95 percent confidence interval, 0.71 to 0.99; P = 0.03; unadjusted P = 0.05) is recommended here - should this be reviewed?