



Ten things to know about the Clinical Guidelines for Stroke Management 2010

1. The Clinical Guidelines for Stroke Management 2010 are the result of the review, amalgamation and update of the Clinical Guidelines for Stroke Rehabilitation and Recovery 2005 and the Clinical Guidelines for Stroke Management 2007. The new guidelines cover the whole continuum from acute to community care.
2. Stroke unit care significantly reduces death and disability after stroke compared with conventional care for all people with stroke. The organisation of ambulance services, emergency department services and stroke unit specialist care in order to provide stroke unit care to more people with stroke remains the single most important recommendation for improving stroke management (refer Section 1.2.1, p. 35).
3. Early recognition of stroke symptoms, the subsequent response of individuals following a TIA or stroke and the appropriate response of emergency services is paramount to a person with stroke receiving timely, appropriate stroke care (refer Section 2, p. 51).
4. In 2008, only 3% of all ischaemic stroke patients received intravenous r-tPA despite the evidence demonstrating it to be the most effective hyper-acute intervention to reduce the combined end-point of death and disability for ischaemic stroke. New evidence of effectiveness up to 4.5 hours after stroke and implications for the organisation of systems to improve therapy rates are discussed (refer Section 1.1, p. 33; and Section 4.1, p. 59).
5. Annual assessment by a GP or specialist is recommended for stroke survivors at the end of the formal rehabilitation phase of care (refer Section 1.4.2, p. 43). This assessment should identify any ongoing rehabilitation needs; however, current rehabilitation services after the first six months are rarely available although evidence demonstrates further improvements can be made after this time.
6. TIA is a high risk event that requires rapid assessment and treatment ideally by a specialist service, although the risk maybe slightly lower than previously estimated. The guidelines discusses options for organising care for those with TIA and developments in assessment and risk stratification (refer Section 1.5, p. 44; Section 3.1, p. 53).
7. New topics included in the guidelines include the use of hormone replacement therapy and oral contraception in women for secondary prevention (refer Section 5.10, p. 75 and section 5.11, p. 76), cognitive communication deficits (refer Section 6.5.4, p. 92), fatigue (refer Section 7.9, p. 104), and behavioural change (refer Section 7.12, p. 108).
8. Rehabilitation studies have found that most people are able to tolerate an increase in rehabilitation time and commencing rehabilitation within hours or days of stroke is feasible and may assist recovery. These guidelines provide recommendations for the amount of rehabilitation for the first time (refer Section 6.1, p. 79).
9. Since the previous guidelines, important new evidence has emerged that has led to a change in the recommendations. Examples include DVT prevention and contracture management which has led to a change in the recommendations for anti-thrombotic stockings use (refer Section 7.12, p. 108) and routine use of prolonged positioning for muscle stretch (refer Section 7.4, p. 100).
10. Recommendations for returning to drive have also been changed in light of the review and update of the standards for Assessing Fitness to Drive - Commercial and Private Vehicle Drivers 2003 (refer Section 8, p. 113).