

STROKE RISK FACTORS: WHAT PATIENTS AND FAMILIES SHOULD KNOW

Evaluating the risk for stroke is based on heredity, natural process and lifestyle. Many risk factors for stroke can be changed or managed, while others that relate to hereditary or natural processes cannot be changed.

RISK FACTORS THAT YOU AND YOUR HEALTH CARE PROVIDER CAN CHANGE, TREAT OR CONTROL:

High blood pressure – The most important controllable risk factor for stroke is controlling high blood pressure. In an adult, high blood pressure is defined as a systolic pressure of 140mm Hg or higher and /or a diastolic pressure of 90 mm Hg or higher for an extended time.

Diabetes mellitus – Diabetes is treatable, but having it increases the risk for stroke.

On ASA website, TIAs are under non-modifiable risk factors w/prior stroke/mi (can't change the past)

Carotid and other artery disease – The carotid arteries in the neck supply blood to the brain. When the carotid arteries are narrowed by atherosclerosis (plaque in artery walls), they may become blocked by a blood clot. People with peripheral artery disease (narrowed blood vessels in legs/arms) have a higher risk of carotid artery disease, which raises their risk of strokes.

Atrial fibrillation – This heart rhythm disorder raises the risk for stroke because the heart's upper chambers quiver instead of beating effectively. This lets the blood pool and clot.

If a clot breaks off, enters the blood stream and lodges in an artery leading to the brain, a stroke results.

Other heart disease – People with coronary heart disease or heart failure have a higher risk of stroke as those with hearts that work normally. Dilated cardiomyopathy (an enlarged heart), heart valve disease and some types of congenital heart defects may also increase the chance of stroke.

Cigarette smoking – Smoking is the number one preventable risk factor for stroke. The nicotine and carbon monoxide in tobacco smoke reduce the amount of oxygen in your blood. They also damage the walls of blood vessels, making clots more likely to form. Using some kinds of birth control pills combined with smoking cigarettes greatly increases stroke risk.

Certain blood disorders – A moderate increase in the number of red blood cells thickens the blood and makes clots more likely, thus increasing the risk of stroke. Sickle cell anemia increases risk of stroke because the “sickled” cells tend to stick to vessel walls, which can block arteries to the brain, causing a stroke.

High blood cholesterol and lipids – High blood cholesterol and lipids increase the risk for stroke. Diet: diets high in salt can increase blood pressure. Excess calories lead to obesity. Fruits and veggies can decrease risk of stroke. A poor diet has lots of saturated fats and/or trans fats.

Physical inactivity and obesity – Being inactive and/or obese can increase your risk of high blood pressure, high blood cholesterol, diabetes, heart disease and stroke.

Excessive alcohol use – More than two drinks per day in men, or more than 1 drink/day in women is considered excessive. This can raise blood pressure, and binge drinking can lead to stroke.

Illegal drug abuse – Intravenous drug abuse carries a high risk of stroke. Cocaine, amphetamine, and heroin use have been linked to strokes and heart attacks. Some have been fatal even in first-time users.

IT IS VERY IMPORTANT THAT YOU FOLLOW UP WITH YOUR PRIMARY CARE PHYSICIAN SOON AFTER YOUR DISCHARGE FROM THE HOSPITAL TO CONTINUE ADDRESSING YOUR CONTROLABLE RISK FACTORS FOR STROKE.

RISK FACTORS FOR STROKE THAT CANNOT BE CHANGED:

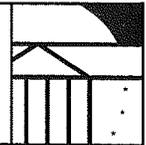
Age – Stroke happens to people of all ages, including children. But the older you are, the greater your risk for stroke.

Sex (gender) – Stroke is more common in men than women. However, more women than men die of strokes. Use of birth control pills and pregnancy pose special risks for women.

Heredity (family history) and race – The chance of stroke is greater for someone whose parent, grandparent, sister or brother has had a stroke. African Americans have a much higher risk of death and disability from a stroke than Caucasians do, in part because the African American population has a greater incidence of high blood pressure.

Prior stroke, TIA, or MI increases risk of another stroke. A TIA is a “warning stroke” that does not cause long-term damage but is a strong predictor of future stroke. Recognizing and treating TIAs can reduce the risk of a major stroke. It is very important to recognize the warning signs of a TIA or stroke. Call 9-1-1 to get medical help immediately if they occur! Do not take these lightly!

Virginians live in part of the “stroke belt”; strokes are more common in the Southeastern United States than in any other part of the country.



WHAT YOU NEED TO KNOW ABOUT POST-STROKE DEPRESSION (PSD)

KNOW THE FACTS:

Of the 600,000 American men and women who experience a first or recurrent stroke each year, an estimated 10 to 27 percent experience major depression. An additional 15 to 40 percent experience some symptoms of depression within two months following a stroke. Depression is one of the major contributors to delaying and/or preventing recovery from a stroke.

DO ALL PEOPLE WHO HAVE A STROKE SUFFER FROM DEPRESSION?

- Approximately 50% of people who suffer a stroke will develop depression within the first 2 years.
- Prevalence varies over time, but peaks 3 to 6 months after stroke.
- At one year post-stroke, there seems to be approximately a 50% decline in signs and symptoms of depression.
- Aphasia (difficulty with speech and/or communication) and dysarthria (difficulty talking) contribute to the development of post-stroke depression. PSD also increases over time for aphasic patients.

WHAT TYPE OF REHAB IS AVAILABLE THAT CAN HELP WITH PSD?

- Antidepressant medications are commonly used along with psychological counseling. Physical therapy, occupational therapy and speech therapy do not specifically treat depression, but can be useful in helping survivors develop strategies to deal with functional losses.

IS DEPRESSION AFTER STROKE CAUSED BY PHYSICAL DAMAGE TO THE BRAIN, OR DO THESE PATIENTS HAVE A PREVIOUS HISTORY OF DEPRESSION?

- Approximately 20% of stroke patients have a prior history of depression.
- Depression can be due to the damage to the brain from the stroke, but can also be a response to the physical, cognitive, and social impairments that have resulted from the stroke.
- Injury to specific areas of the brain has been noted to have an increase risk of developing PSD. These areas include the frontal and temporal lobes of the brain.
- The size of the stroke and pre-stroke social functioning also appear to affect the likelihood and severity of depression after stroke.

IS AN OLDER PERSON WHO SUFFERS A STROKE MORE LIKELY TO BECOME DEPRESSED?

- After a stroke, younger people are more likely to develop depression than older people.

IS IT SAFE TO TAKE ANTI-DEPRESSANT MEDICATIONS TOGETHER WITH STROKE MEDICATIONS?

- The patient should always check with their physician and notify them of any new combinations of drugs.
- Stroke patients may be put on a medication for anticoagulation (preventing blood from clotting quickly). One commonly used medication is warfarin (Coumadin). Some antidepressants may interact with warfarin, so bleeding times through lab work should be monitored closely and checked soon after starting an antidepressant.

HOW DO MOST PEOPLE GET TREATED FOR DEPRESSION?

- With early detection and treatment, individuals suffering from PSD can make significant improvements.
- It is important to get treatment as soon as the symptoms of PSD are recognized, because PSD is associated with excess suffering, handicap, suicidal ideation and mortality and it hampers rehabilitation.
- It is important to maintain social contacts after stroke. Social isolation can significantly increase mortality and morbidity in patients who suffer from PSD.
- Although there are no systematic studies of psychotherapy in PSD, it is often recommended for both the patient and caregivers/family members in an effort to help adjust to loss of function and compromised self- image and self- esteem.
- Anti-depressant medications are often recommended.
- Continued psychological counseling for both family and patient can be helpful.
- Rehabilitation activities/ facilities and prevention of isolation can help decrease depression.

HOW DO I KNOW IF PSD IS AFFECTING ME OR MY FAMILY MEMBER?

The following signs and symptoms may occur:

- Sad, anxious, or "empty" mood
- Feelings of hopelessness, pessimism
- Feelings of guilt, worthlessness, helplessness
- Loss of interest or pleasure in hobbies and activities that were once enjoyed, including sex
- Decreased energy, fatigue, being "slowed down"
- Difficulty concentrating, remembering, making decisions
- Insomnia, early-morning awakening, or oversleeping
- Appetite and/or weight changes
- Thoughts of death or suicide or suicide attempts
- Restlessness, irritability

**If five or more of these symptoms are present every day for at least two weeks and interfere with routine daily activities such as work, self-care, and childcare or social life, seek an evaluation for depression.

HOW DO I GET HELP FOR ME AND MY FAMILY MEMBER?

Resources:

American Stroke Foundation
9707 East Easter Lane
Englewood, CO 80112-3747
info@stroke.org
http://www.stroke.org
Tel: 303-649-9299 800-STROKES (787-6537)
Fax: 303-649-1328

actioncenter@asha.org
http://www.ninds.nih.gov
naricinfo@heitechservices.com

www.CDC.gov/stroke

strokeclubs@earthlink.net
http://www.strokeassociation.org
naa@aphasia.org
www.strokecenter.org

These guidelines are general and cannot take into account all of the circumstances of a particular patient. Judgment regarding the propriety of using any specific procedure or guideline with a particular patient remains with that patient's physician, nurse or other health care professional, taking into account the individual circumstances presented by the patient.