

# Stroke Care



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Today



Art courtesy: Boehringer Ingelheim Pharmaceuticals Inc.

## Implantable Monitors ID Cause of Stroke, Improve Care

Two factors significantly challenge care of patients who have suffered a stroke: about a quarter of women and more than 40 percent of men will suffer a second stroke in five years, and in at least one in four patients, the cause of the initial stroke is not clear. The latter phenomenon, cryptogenic stroke, is a vast problem that makes preventing re-stroke especially difficult.

But specialists are honing in on one of the culprits, in part on the basis of the SURPRISE (Stroke Prior to Diagnosis of Atrial Fibrillation [AFib] Using Long-term Observation with Implantable Cardiac Monitoring Apparatus Reveal) study presented at the International Stroke Conference (ISC) this year. "The results show that about one out of every five or six cryptogenic stroke patient suffers from paroxysmal Afib," said Rajat Kumar, MD, Medical Director of the Stroke Program at Our Lady of Lourdes Medical Center. "This condition confirms the need for anticoagulation therapy."

### Testing Seeks to Capture Sometimes-Elusive but Tell-Tale ECG

A New Jersey Primary Stroke Center, Lourdes has developed an algorithm for cryptogenic stroke, for patients with strokes initiated by an embolism. The evaluation looks for the source of these blood clots—be they cardiac structural abnormalities, atherosclerotic conditions, hypercoagulation or cardiac arrhythmias. Going beyond the basic work-up means vessel studies that can include MRA of the head and neck and a TEE of heart and valve structures.

*Long-term ECG recording can serve an important role in post-stroke evaluation, and in assessing and modifying risk of re-stroke.*

After stroke, a period of months is typical for return of AFib, the duration of which can sometimes be very short. But insertable subcutaneous monitors function for up to three years. Any AFib detected may be asymptomatic. "Increasingly, paroxysmal AFib is thought to be just as risky as persistent AFib," said Dr. Kumar.

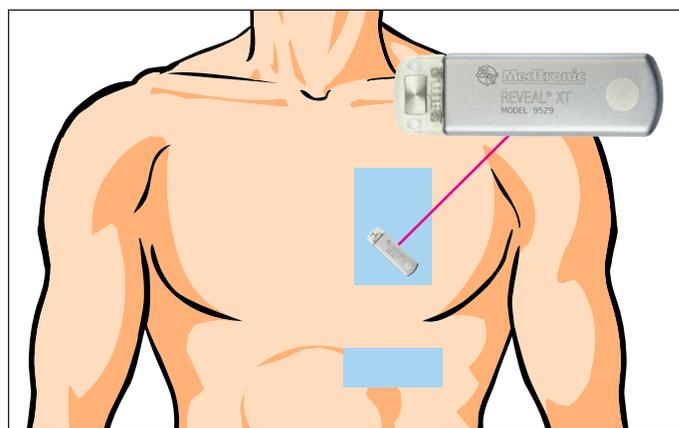
### Bridging Gaps in Stroke Care

"AFib detection is part of an exclusionary testing sequence that applies to anyone, but AFib is particularly prevalent in patients over the age of 60," said Scott Sharets, MD, Director of the Stroke Program at Lourdes Medical Center of Burlington County. Indeed,

the EMBRACE (30-Day Cardiac Event Monitor Belt for Recording Atrial Fibrillation After a Cerebral Ischemic Event) study, which was also reported at the ISC, likewise found that about one in six patients over age 55 years with a cryptogenic stroke or TIA had suffered previously undiagnosed paroxysmal atrial fibrillation.

Lourdes' highly developed stroke program not only includes the availability of stroke consultation with a stroke program neurologist 24/7 and a special inpatient stroke-alert program, but also a stroke prevention clinic to which patients return soon after hospitalization for further individualized stroke-risk evaluation that can include implantable cardiac monitoring. AFib in cryptogenic stroke is systematically underdiagnosed and atrial fibrillation seen increasingly as a progressive condition. With nearly a third of all strokes attributable to re-strokes and guidelines now suggesting treating a TIA as aggressively as a stroke, the time for such care has come.

"The healthcare system focuses a lot on the front end of stroke, but actively managing risk of re-stroke is now starting to get more of the attention that it deserves," said Debra Gillen, MSN, RN, CMSRN, Stroke Program Coordinator at Lourdes. ✝



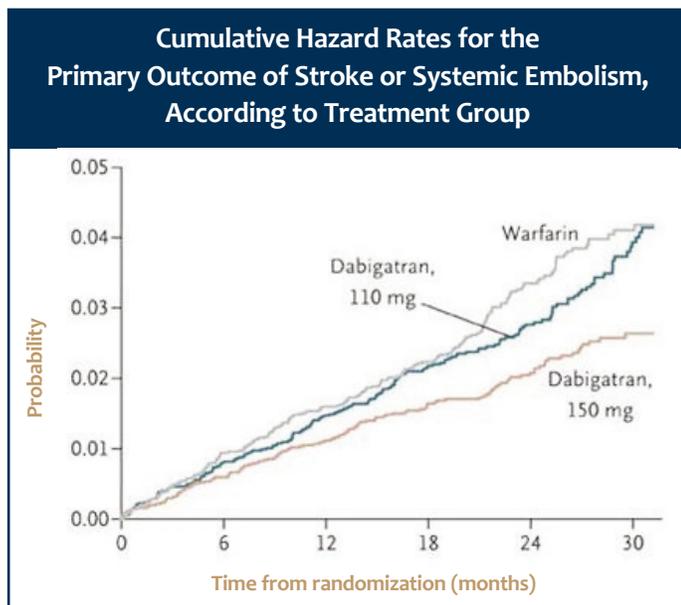
Recommended implant zones are shown (in blue) for cardiac monitor used to detect the basis of cardiac-source embolism in stroke patients. About the size of a thumb drive, at less than 2.5 inches, the unit is easily inserted under the skin. It has no wire leads, transmits data to a receiver held to the chest and does away with compliance issues associated with Holter-style monitoring. If patients feel symptoms, they can tag them in the data with a hand-held device.

For more information, visit [www.lourdesnet.org](http://www.lourdesnet.org) or call 1-888-LOURDES (1-888-568-7337).

## Strides in AC Therapy Bring Options

Physicians have gained expanded choices in anticoagulant therapy for patients at risk of stroke or re-stroke. New drugs allow individualization of this important care step. Patients who have atrial fibrillation (AFib) particularly need preventive treatment.

In his presentation “Advances in Anticoagulant Therapy” at Lourdes Health System’s second annual *Cardiology for the Primary Care Physician* symposium, Lourdes cardiologist Ian Joffe, MD, endorsed CHADS2 as the most validated score of stroke risk in AFib and emphasized assessment of patient bleeding risk through use of the HAS-BLED index. “Placing these two simple scores, the CHADS2 and HAS-BLED, side by side, the physician gets the best sense of whether and how strongly to anticoagulate,” said Dr. Joffe.



Dabigatran is the first drug to show significant additional stroke risk reduction relative to warfarin in patients with AFib. “Dabigatran versus warfarin in patients with atrial fibrillation.” Connolly SJ, Ezekowitz MD, Yusuf S, Eikelboom J, et al, *N Eng J Med*, 2009 Sep 17;361(12):1139-51.

In his presentation “Cardiovascular Care and Medication Management of the Geriatric Patient,” Kevin Overbeck, DO, a geriatrician from the New Jersey Institute for Successful Aging, noted, “In general, we under anticoagulate the elderly. But when we do offer this treatment, we need to regularly monitor their blood clotting through INR testing.”

Simple aspirin anticoagulation may be best for patients with higher bleeding risk. For other patients, clinicians now have alternatives to warfarin. Dabigatran (*Pradaxa*®) is the first drug superior to warfarin in preventing ischemic strokes, explained Dr. Joffe, and one that demonstrates a comparatively lower rate of intracranial bleeding. Rivaroxaban (*Xarelto*®) is another new agent also with a bleeding-risk profile superior to warfarin.

“However, these drugs have more similarities than differences, so as long as clinicians understand the drug they are using—its actions and interactions—they can continue for now to mostly prescribe the one with which they are familiar,” said Dr. Joffe. “Also, if a patient has been stable for years on warfarin, there’s no automatic need to switch to one of the newer agents.”

Dr. Joffe reminded attendees that they should order a metabolic panel on the patient first, because these anticoagulant medications are renal-excreted drugs, and dose should be based on creatinine clearance. The attending physician should discontinue Pradaxa about three to five days before a patient undergoes surgery.

“If a patient is diagnosed with AFib and is stable, the primary physician can start anticoagulant therapy directly out of the office, while the patient is waiting to see a specialist for any additional refinement of the regimen,” said Dr. Joffe. 

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