Stroke FOUNDATION

Clinical Guidelines for Stroke Management 2017

Evidence Gaps

Gaps in evidence

The following list is not exhaustive but identifies areas discussed in the Clinical Guidelines where further research is needed, or where an intervention should be considered within the framework of conducting research.

Aboriginal and Torres Strait Islander populations

There is very little evidence for this population and further research is required.

Chapter 2: Early assessment and diagnosis

Further evidence is required regarding:

Imaging – the use of CT perfusion or MRI perfusion-diffusion imaging to identify patients who could benefit from reperfusion therapies beyond standard time windows.

Chapter 3: Acute medical and surgical management

Further evidence is required regarding:

ICH – surgery/surgical options:

- The use of surgical evacuation for supratentorial intracerebral haemorrhage (lobar, basal ganglia and/or thalamic locations).
- The use of intraventricular thrombolysis via external ventricular drain catheter in patients with intraventricular haemorrhage.

Neuroprotection – putative neuroprotective agents, including hypothermic cooling.

Dysphagia –

- Non-invasive brain stimulation.
- Surface neuromuscular electrical stimulation.
- Swallowing training (exercises).

Chapter 5: Rehabilitation

Further evidence is required regarding:

Upper limb – brain stimulation (transcranial direct stimulation or repetitive transcranial magnetic stimulation).

Gaps in evidence

ADL –

- Brain stimulation (transcranial direct stimulation or repetitive transcranial magnetic stimulation).
- Use of amphetamines.

Aphasia – brain stimulation (transcranial direct current stimulation or repetitive transcranial magnetic stimulation).

Cognitive communication disorder in right hemisphere stroke – there is some preliminary data that suggests that some people with cognitive communication disorders following stroke will benefit from treatment to improve their cognitive communication skills (including prosody and interpretation of metaphors) in the acute and chronic stages. However further research is required.

Cognitive rehabilitation

Attention and concentration

Perception – interventions to improve perception.

Executive function

Neglect –

- Cognitive rehabilitation (defined broadly and could include interventions such as visual scanning training or computerised training methods).
- Non-invasive brain stimulation.

Weakness – electrical stimulation:

- Optimal treatment parameters (frequency and pulse width).
- Timing and duration of the intervention for specific patient subgroups (i.e. weak vs very weak).

Memory – interventions for memory.

Chapter 6: Managing complications

Further evidence is required regarding:

Spasticity – acupuncture.

Fatigue

Gaps in evidence

Chapter 8: Community participation and long-term care

Further evidence is required regarding:

Self-management

Peer support – further research on peer visits is needed to determine the preferred format and timing, and the characteristics of stroke survivors most likely to benefit.

Carer support – further research is needed on the ideal timing of carer support/information provision and the most efficient and convenient delivery format for consumers.