

Public consultation feedback and response Stroke Living Guidelines Updates

November 8 – December 20, 2021

Author	Organisation	Topic	Feedback	Actions taken
Pieta McCarthy on behalf of ACT Health, Chief Medical Officer 1.12.21	ACT Health	Aphasia Pressure injury	The ACT jurisdiction has no feedback on the current updates to Aphasia (Chapter 5) or Pressure Injury (Chapter 6) of the National Clinical 'Living' Stroke Guidelines.	Noted. No change required.
Marian Brady M.Brady@gcu.ac.uk 3.12.21	Glasgow Caledonian University and the University of Queensland	Aphasia	<p>Many thanks for the opportunity to feedback on the planned update to the aphasia recommendations. I support the recent update in aphasia recommendations shared.</p> <p>I am emailing as I would like to draw your attention to a second linked paper (open access link below) that formed part of the same RELEASE project. This paper reports IPD network meta-analysis approach using data from 25 RCTs and IPD on >900 people after stroke and considers dosage, intensity and frequency of SLT and associations with gains in language (overall language, functional communication and auditory comprehension).</p>	Incorporated into the evidence summary and background text. Aligns with current recommendation. We have added as underlying evidence reference.
Jennifer Lethlean 10.12.21	Individual	Aphasia	The original recommendation was all inclusive of language areas including auditory comprehension. It seems with the new recommendation, auditory comprehension has now been omitted. I'm assuming this is based on the results from the Cochrane review. I note in the evidence to decision there is mention of auditory comprehension benefits in the RELEASE study so could we still include it in the updated recommendation? Auditory comprehension goals are very commonly identified by PWA and worked on clinically so I would strongly suggest that this is included.	Originally it is correct that the omission was due to the Brady Cochrane review which noted "No evidence of benefit or harm was found for naming or auditory comprehension." This is based on 9 trials (n=399) for immediate effects (low quality of evidence) and 2 trials (n=111) for 6 month follow up (very low quality of evidence). However, it is correct the more recent RELEASE study which involved an individual patient data meta-analysis did find a clear benefit and therefore we have updated the recommendation to include it.

<p>Leisa Byrnes (on behalf of allied health group in NSW)</p> <p>20.12.21</p>	<p>Allied Health</p>	<p>Aphasia Pressure injury</p>	<p>Speech Pathology Feedback: Senior Neuro reviewed the draft and agrees with the acute aphasia recommendations in chapter 5.</p> <p>One query was raised regarding the recommendation for language therapy sessions in the acute phase, with the understanding that this should be offered more intensively than 2-3 times per week for best outcomes.</p> <p>Physiotherapy feedback: I have no specific concerns re the pressure injury new practice point although it seems overly broad. On the face of it, while all staff involved with the care of the patient should be involved with identifying pressure areas, their role in providing care and treating the pressure injury is determined by the scope of that profession. For example, all staff may assist with positioning of limbs. However, a nurse may do dressings but an Allied health Assistant would not. May benefit from an addition: Staff and carers of patients with stroke at risk of pressure injuries (in hospital, in residential care and home settings) should be trained to assess skin, provide appropriate pressure area care, and treat pressure injuries consistent with existing guidelines within the scope of their profession.</p> <p>Occupational Therapy feedback: The Pressure Injury addition is relevant to OT however we are already meeting this guideline as we comply with National Standard 5 (Comprehensive Care) and assess PI care for all patients we see. As we are blanket referred all stroke patients we will already be achieving this. If there are patients that don't come through to OT (we miss them on a weekend for instance) then the nursing staff conduct a PRIMP to ensure the PI risk is managed. This seems like a general statement to make sure the stroke guidelines reference PI care but we already have other overarching things in place to manage this.</p>	<p>Regarding acute language therapy: the largest and more recent study (VERSE) found more intense therapy did not provide additional benefits. Higher intensity studies have also reported higher drop-outs. Hence while the Brady Cochrane review reported potentially better effects with high-intensity this was based on only 2 smaller studies (n=84) and graded as low quality of evidence (for functional communication which was the preferred outcome rather than impairment based outcomes which had higher quality of evidence).</p> <p>Regarding pressure injury: While we recognise not all staff will provide care for pressure injuries the use of the phrase '...within the scope of their profession.' would relate to almost all guideline recommendations and the working group decided to leave the wording as is.</p>
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March 22 – May 5, 2022

Author	Organisation	Topic (and Recommendation if relevant)	Feedback	Actions taken
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Timothy Kleinig (individual) 28.03.22	Royal Adelaide Hospital & University of Adelaide Acute medical	Pre-hospital care Treatment for depression and/or anxiety	It would be helpful to have some guidance in the MSU section as to what would be considered a 'large metropolitan area'. This would be a difficult question to answer definitively but some guidance may (in practical terms) help drive establishment of MSUs in those cities smaller than Melbourne or Sydney. Population cut-offs for 'likely', 'possible' and 'probably not' cost-effective might be useful if these are at all available. For the anxiety recommendation I would suggest deleting 'listening to relaxing music' from the recommendation. Firstly, there is no evidence at all cited, and secondly it is a truism that listening to relaxing music is relaxing....	Further information has been provided in the rationale and practical information. However, it is beyond the scope of the guidelines to make specific recommendations and local factors will need to be calculated when considering a MSU. 'Listening to music' has been removed from the recommendation.
Renee Martin (on behalf of Jenny Campbell) (group) 27.04.22	Department of Health WA Multidisciplinary	Pre-hospital care (Chapter 1) "Mobile stroke units are only appropriate in large metropolitan areas with agreed criteria for use (e.g. clinical and time-based criteria to ensure specificity of treatment)". "General practitioners are encouraged to educate reception staff in the FAST stroke recognition message and to redirect any calls about suspected acute stroke to 000."	The WA Stroke Clinical Advisory Group (SCAG) agrees with the evidence presented around reduction in thrombolysis delivery times via a stroke ambulance. It suggests more detail is required regarding the population density appropriate for consideration of a stroke ambulance (in Melbourne via personal communications this has been 1 million population living within a 20-kilometre radius of the ambulance base). Additionally, WA suggest further detail is required around the proposition that stroke ambulance triage is superior to a large vessel occlusion (LVO) stroke severity score (such as Rapid Arterial Occlusion Evaluation, RACE) in optimal transfer time of this subset of acute ischaemic stroke patients. Comment from Liaison GP & Clinical lead for Primary Care Integration, Health Networks, Department of Health. Agreed that this would be good in principal but noted issues with logistics including; <ul style="list-style-type: none"> • How would education of reception staff be supported as patients may not relay medical issues to reception staff. • How will these be addressed if patients book appointments online as reception staff do not have any interaction with patients. • Noted that it would be important to change recorded messages playing while patients are on hold or messages to be displayed when booking online to alert patients who may require urgent review. • Public education to recognise signs of stroke and call an ambulance rather than call/book online an appointment with a General Practitioner. 	Further information has been provided in the rationale and practical information. However, it is beyond the scope of the guidelines to make specific recommendations and local factors will need to be calculated when considering a MSU. Additional reference to the ability for MSU to more appropriately transport patients to the best hospital setting (comprehensive vs primary centre) based on one study we know. This information is included in the practical info section. Noted. There are still a number of patients who attend primary care rather than go to hospital. We agree ongoing public education is important but reception staff are an important first step and the simple FAST message used for the general population should also be clearly understand by reception staff as well.
Pieta McCarthy (on behalf of Dr Dinesh K Arya) (group) 28.04.22	ACT Health Multidisciplinary	Pre-hospital care (Chapter 1) For patients in major cities with suspected stroke who are potentially eligible for reperfusion therapies, pre-hospital treatment in a mobile stroke unit is recommended.	<ul style="list-style-type: none"> • This new recommendation is being proposed as a 'strong' recommendation. The guideline itself suggests that the quality of evidence of the five papers quoted varies from 'very low' to 'moderate'. • Not all major cities have mobile stroke units. Whether mobile stroke unit are appropriate for all major cities may require further 	* While we agree not all outcomes had moderate certainty of evidence GRADE methods use a number of considerations. In this case we felt a strong recommendation was reasonable based on the moderate

		<p>Prevention of depression (Chapter 6) For stroke survivors, antidepressant medication may be used to prevent depression.</p> <p>Treatment for anxiety (Chapter 6) a. Behavioural changes after stroke can impact on a person's ability to engage in meaningful activities and also their quality of life. Therefore, the impact of any behavioural changes on relationships, employment and leisure should be assessed and addressed across the lifespan. b. Stroke survivors and their families/carers should be given access to individually tailored interventions for personality and behavioural changes. This may include positive behaviour support programs, anger-management therapy and rehabilitation training and support in management of complex and challenging behaviour.</p>	<p>consideration. There are many factors which affect a decision to proceed with mobile units at a given location.</p> <p>This is being put forward on the basis of 'weak' evidence. The certainty of the quoted evidence is 'very low'.</p> <p>This is a consensus-based recommendation, but there is no evidence provided.</p>	<p>certainty outcomes and the overall impact of reperfusion. * Further information has been provided in the rationale and practical information. However, it is beyond the scope of the guidelines to make specific recommendations and local factors will need to be calculated when considering a MSU.</p> <p>Regarding prevention of depression -the overall quality of evidence was rated as very low but there was an overall benefit found. Hence why we have only made a weak recommendation. Additional information has been added to this section.</p> <p>Regarding anxiety -the evidence summary (as seen in the Research evidence section) provides the summary of the evidence. Additional information has been added around SSRI drugs. The rationale has also been updated.</p>
<p>John Pierce (individual) 23.03.22</p>	<p>Unknown Speech pathology</p>	<p>Dysarthria (chapter 5) recommendation</p>	<p>While the rationale makes a recommendation against non-speech oromotor exercises, I think it is important to also state this recommendation against using them in the recommendation itself as this treatment is still fairly prevalent.</p>	<p>The recommendation notes interventions should "target connected speech". Non-speech exercises do not target connected speech which implies they are not recommended (and this is detailed more in practice info section). We have changed the wording of the recommendation slightly to be more explicit. We also are conscious that the previous recommendation (against) was based on one small study (n=20) and on review we didn't think this provided high certainty of evidence for or against. Hence we have focused on recommending interventions that are likely to be effective.</p>

				Obviously we will continue to review this topic given the low overall certainty of the evidence.
Caroline Baker (on behalf of the aphasia CRE) (group) 05.05.22	Aphasia CRE Multidisciplinary	Mood assessment (PP): Stroke survivors with suspected altered mood (e.g., depression, anxiety, emotionalism) should be assessed by trained personnel using a standardised and validated scale for use in people with stroke.” In the practical information section it states: “For people with communication and cognitive impairments, an observational tool may be more appropriate. Ideally this tool should capture anxiety and depressive symptoms.” Prevention of Depression (Chapter 6) “For stroke survivors, antidepressant medication may be used to prevent depression. (Allida et al 2020)”	Rephrase to clarify that routine mood screening should occur for all stroke survivors due to ‘high risk’ of mental health problems. Also, people with aphasia need assessments developed for their communication needs (Kneebone et al., 2016; Kneebone et al., 2016). The only reason ‘routine screening’ was discontinued as a recommendation and replaced with to be done for ‘suspected cases’ is that it does not necessarily lead to treatment. It is a relatively cheap procedure, and many cases will be missed if it is not routine practice. Treatment will continue to be neglected if screening is limited. Further we consider if it is not done routinely it may be neglected altogether. Suggested rewording (recommendation): “Stroke survivors should be screened for altered mood (e.g., depression, anxiety, emotionalism) routinely by a trained health professional using a psychometrically sound scale developed for people with stroke (Kneebone et al., 2016). People with aphasia need assessments developed for their communication needs. Following mood screening, those with possible depression or anxiety require further assessment using a clinical interview by those with appropriate mental health training and competence to communicate with people with aphasia.” For practical info section add evidence to support this e.g., (Eccles et al 2017; Van Dijk et al., 2016). “For people with communication and cognitive impairments, an observational tool (e.g., The Stroke Aphasic Depression Questionnaire; The Behavioural Outcomes of Anxiety) may be more appropriate. Ideally this tool should capture anxiety and depressive symptoms. Supported communication techniques may also be used to discuss symptoms with the person and self-report using appropriate tools (e.g., Depression Intensity Scale Circles) ” We disagree that the recommendation be changed from Weak AGAINST to Weak FOR when adverse event data are limited and insufficient to determine possible harms in persons with stroke (Allida et al., 2020) and it is established older adults (who make up the majority of those with stroke) are more vulnerable to side effects (e.g., note NICE 2009; Taylor, 2018) Suggest: remain Weak AGAINST	Mood assessment was not changed and does not formally form part of this public consultation. However, we have reviewed this section and have added further details into the practical info section. There is a lack of evidence to demonstrate screening improves patient outcomes and as such have kept the practice point unchanged. We realise in applying this recommendation some services where resources allow may choose to routinely screen all patients. Practical information updated as suggested. We have amended content related to this recommendation. Both the Allida 2020 and Legg 2021 Cochrane reviews report reduced incidence of depression. We have added more detail about harms and the importance to consider both benefits and harms. However, there is no data in the two stroke reviews to show an increase in harm with

		<p>For "For stroke survivors, psychological therapies (e.g. problem solving, motivational interviewing) may be used to prevent depression" In Rationale: "Psychological therapies such as problem solving and motivational interviewing may be effective in preventing depression but may only be suitable for stroke patient without cognitive and communication impairment."</p>	<p>Add evidence to Benefits and Harms section as follows: Side effects are higher in older people (who make up the majority of those with stroke) on balance anti-depressant for prevention of depression cannot be justified (FOCUS 2019; Taylor, 2018).</p> <p>In the Evidence to decision framework (resource implications) section or elsewhere could add evidence for cognitive behavioural therapy (Wang et al., 2018). For Rationale: Motivational interviewing has been modified for people with aphasia and is feasible (Holland et al 2018). There is a range of psychological therapies that are suitable for survivors of stroke with cognitive and communication disabilities (e.g., aphasia). Suggested rewording: "Psychological therapies such as problem solving, solution-focused brief therapy, peer befriending and motivational interviewing may be effective in preventing depression or enhancing mental and psychological well-being. Communication partner training and goal setting can also enhance mood and wellbeing. These therapies and approaches can be modified and are feasible to deliver for people with cognitive and communication disabilities such as aphasia (Baker et al., 2018; Hilari et al., Holland et al 2018; Northcott et al., 2021)."</p>	<p>age. Overall we don't feel the harms outweigh the benefits but have added further information in the rationale about identifying stroke survivors with higher risks for depression.</p> <p>Wang et al was a review of treatments for depression after stroke and the authors conclusion was that evidence for CBT is still inconclusive. We feel it does not add anything to the prevention section.</p> <p>We have added details about the feasibility of adapting approaches for people with aphasia in the practical info section.</p>
		<p>Treatment for depression (chapter 6) Updated draft recommendation "For stroke survivors with depression, antidepressants, which include SSRIs should be considered..."</p>	<p>Suggest adding information regarding the below where appropriate e.g. under Resources and other considerations: Individual factors (such as medical condition; age) and potential adverse events; withdrawal and side effects of medications must be considered in clinical decision-making with the stroke survivor (FOCUS 2019; Taylor, 2018).</p> <p>For current information in practical info suggest rephrase and add evidence: "Adaptations to therapy ensure its suitability for people with cognitive and communication disabilities such as aphasia are required (e.g., additional structure, reminders, communication supports, communication partner training for health professionals facilitating therapy) (Baker et al., 2018; Kneebone 2016; Thomas et al., 2013)."</p>	<p>Added as suggested.</p> <p>We have added details about the feasibility of adapting approaches for people with aphasia in the practical info section.</p>
		<p>For updated rec regarding structured exercise programs...</p>	<p>Add evidence for people with aphasia: People with aphasia should be offered communicatively accessible psychological therapies. They may benefit from a range of psychological therapies with communication supports (e.g., behavioural therapy) (Baker et al, 2018; Thomas et al., 2013).</p>	<p>Added as suggested.</p>

		<p>For values and preferences (exercise rec)</p> <p>Consider adding new recommendation for PREVENTION of anxiety</p> <p>Treatment of anxiety</p> <p>Suggested consensus-based recommendations to add</p>	<p>Add evidence for people with aphasia: People with aphasia and families highly value and want access to psychological therapy and support (Baker et al 2019; Iwasaki et al 2021).</p> <p>Add evidence for people with aphasia: People with aphasia should be offered communicatively accessible therapies. Some non-drug interventions may enhance well-being and/or reduce anxiety levels (Ryan et al., 2021).</p> <ul style="list-style-type: none"> • People with aphasia and their families should be offered psychological care that is communicatively accessible and appropriate to their needs (e.g., supports, therapy, triage to mental health specialists). • Health professionals working with people with aphasia should have the competencies specifically needed to work with people with aphasia, including supported communication training. • People with aphasia should be routinely screened for mood problems after stroke using clinically feasible and valid tools designed for and accessible to people with aphasia (e.g., Behavioural Outcome of Anxiety; Stroke Aphasic Depression Questionnaire). • People with aphasia with possible depression or anxiety should have further assessment of mood through a clinical interview by specialist health professionals (medical practitioner and/or psychologist) who are competent in communicating with people with aphasia, and health professionals should liaise or work with speech pathologists, if needed. Communication supports and strategies should be used in the clinical interview (e.g., effective communication partner; pictorial supports; input from speech pathologist as needed). 	<p>Added as suggested.</p> <p>We will consider this as part of our annual review process later in the year.</p> <p>We have added comments to practical info. However we note that Ryan concluded: "The quality of the RCT trials was at least adequate but none demonstrated a benefit to anxiety outcomes. Those studies that reported benefit were of lower-level evidence with respect to National Health and Medical Research Classifications." We therefore don't think this is useful reference.</p> <p>We have incorporated these suggestions throughout this section.</p> <p>* We have widened this suggestion but included specific mention of people with aphasia</p> <p>* Reference to this point included in the introductory text</p> <p>* This information has been added to the practical info section</p> <p>* This information has been added to the practical info section</p>
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