Preventing stroke should be one of the most important priorities of any healthcare system. It is a devastating outcome for patients and their families, second only to cancer in terms of what patients most want to avoid.

Managing stroke and its sequelae has huge cost implications for health and social care systems. In this issue of the BJGP, three articles deal with the subject of stroke and its better prevention. One important theme is the earlier triage of stroke in patients presenting with symptoms, with the article by Mellor and colleagues showing that UK GP receptionists appear to have good theoretical knowledge of predictive symptoms, but performed a little less well when role players simulating patients with symptoms possibly due to stroke, telephoned practices. However, 69% were advised to call emergency services immediately, with lower urgent dealings for the scenarios that were pre-rated as ‘difficult’.

In terms of stroke prevention, alongside detection and management of hypertension and other vascular risks, the most important strategy is the diagnosis and stroke risk stratification and management of atrial fibrillation [AF]. Atrial fibrillation is the commonest cardiac arrhythmia, with about 1–2% of the general population estimated to be affected. It is a particularly common disorder in older people, with over 5% aged ≥65 years experiencing AF, and around 10% of people aged ≥75 years, with the prevalence predicted to rise. However it is the associated stroke risk that makes atrial fibrillation important, not its arrhythmia effects.

Patients with AF are at an almost fivefold higher risk of stroke compared to age-matched individuals with normal sinus rhythm, as well as at a twice as high risk of all-cause mortality and heart failure. About 20% of all ischaemic strokes are attributable to embolism as a result of AF. Not only do patients with AF have more strokes, they also develop more recurrent strokes and more severe strokes, regardless of age. Following a stroke, patients with AF are more likely to be left with long-term disability and require long-term care.

Fortunately, there are very effective treatment options to significantly attenuate this AF stroke risk, with recent guideline updates in the US, Europe, and the UK converging over the evidence guiding their recommendations. However, repeated audits in these same countries show much under-diagnosis of AF and under-management of stroke risk, despite the huge evidence base. Most variation occurs in general practice, where there is often less understanding of the evidence base, or differing perceptions on the generalisability of the evidence base compared to specialists, or greater concerns over risks of treatments than of benefits.

The European Primary Care Cardiovascular Society (EPCCS) considered that the largely specialist developed guidelines would benefit from contextual changes or clarifications of the evidence to aid the uptake of guidance in European primary care. An EPCCS Consensus Group made its recommendations based on ‘the trade-off between the benefits and harms of any intervention, taking into account the quality of the underpinning evidence’ as cited by the National Institute for Health and Care Excellence (NICE) in their grading of evidence. The wording used in the EPCCS recommendations, recently published in the European Journal of Preventive Cardiology, denotes the certainty with which the statements are made. They also stress the importance of discussion with the patient about the risks and benefits of the interventions, and critically their values and preferences.

There are two research articles in this issue of the BJGP that deal with this under-researched area of practice in relation to anticoagulant monitoring, and should guide future guideline iterations. Both articles by Ward and colleagues deal with self-monitoring of international normalised ratio (INR) based on follow-up of all the patients purchasing point-of-care INR machines in the UK over a 12-month period. There are a few surprises: the number is low (only 299 people) and a tiny proportion of those are on a vitamin K antagonist requiring monitoring, but then the machine reader is expensive. Around half were self-managing as well as self-monitoring, and yet only 46% had received personal training (relying instead on the machine information leaflets), and training was less likely (15%) if the patient was new to self-monitoring. However, INR control was high (mean time in therapeutic range >75% and persistence high >90%) at 12 months. Testing intervals were rather frequent (mean 11 days) and quality assurance done rather infrequently, which further suggests the need for more training and formal dosing decision support (rarely provided). Further, less testing may justifify the NHS paying for INR readers.

Returning to the EPCCS Stroke Prevention on Atrial Fibrillation practical guidance article, this covers six areas including:

- how to identify patients with atrial fibrillation;

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New evidence, reliable synthesis of the data, and practical implications of subsequent guidance all need a focus on stroke given its importance to health funders and the general public.

• how to determine their stroke risk and whether to recommend modification of this risk, and
• what management options are available, with practical recommendations on maximising benefit and minimising risk if anticoagulation is recommended and the reasons why antplatelet therapy is no longer recommended.

The summary evidence is presented for each area and simple summary recommendations are highlighted, with areas of remaining uncertainty listed. A 20-page coloured monograph of the full guidance is available on the EPCCS website [http://www.epccs.eu/d/442/epccs-consensus-guidance-on-stroke-prevention-in-atrial-fibrillation-spaif-primary-care; login required]. It highlights the summary recommendations and indicates where the position taken is clearly evidence-based (green), and where it is more inferred and consensus-based (blue). It is also specified when studies were carried out in primary care settings, and therefore where the evidence is most relevant for GPs.

There are a few areas where the guidance departs somewhat from specialist guidance, especially in relation to screening for AF and the relative benefits and risks of treating people with moderate AF stroke risk (CHA2DS2-VASc score of 1), but mainly the guidance helps to ‘translate’ how to implement the evidence in routine practice.

Importantly, the competing interests of the EPCCS and the contributors are fully stated. However, in these times when any commercial association is deemed by some to entirely negate any expressed opinion, the EPCCS was careful to ensure that many of the contributors had no competing interests at all. This ensured rigorous debate on the limitations and implications of many studies and their relative weight in the final recommendations: the nihilist view was expressed as strongly as the interventionist view.

Atrial fibrillation-related stroke is a very major public health priority for most health systems. This practical guidance can assist generalist community physicians to translate and implement the large evidence base for this major cause of preventable stroke. The research gaps continue to be filled, as the three articles in this issue illustrate. New evidence, reliable synthesis of the data, and practical implications of subsequent guidance all need a focus on stroke given its importance to health funders and the general public.

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