Strengthening the Link
The Critical Role of Children in the Stroke Chain of Recovery
Stephen M. Davis, MPA, MSW

See related article, pages 2809–2816.

Stroke remains a devastating disease killing someone every 3 to 4 minutes and leaving up to 30% permanently disabled according to the most recently available statistics.1 The estimated cost of this disease from 2005 to 2050 will exceed $2 trillion with most of this cost related to disabled survivors’ loss of earnings.1 Sadly, studies have revealed that most strokes cannot be treated due to delayed presentation to an emergency department well outside of thrombolytic treatment windows.2,3 Currently, only 2% to 6% of eligible patients receive lifesaving thrombolytic therapy.4

In the quest to find a solution to this problem, researchers have studied factors that are associated with earlier emergency department arrival. This research has revealed that the majority of delayed presentation occurs during the first 2 steps in the stroke chain of recovery: identification and dispatch.5 Specifically, recognition of stroke signs and symptoms (identification) and activation of the emergency medical services system by calling 911 (dispatch) are both associated with less delay and concomitant earlier emergency department arrival for treatment.6–9 Most importantly, the presence of a bystander or other witness is also associated with earlier arrival7,10 perhaps, in part, because it is usually someone other than the stroke victim who initially calls 911 for help.11

Recent demographic trends suggest that young children may increasingly be the family member or bystander present during the onset of stroke. There has been a steady increase in the number of children living with their grandparents (30% since 1990) with an estimated 5.7 million grandparents living with their grandchildren in 2000.12 Additionally, many individuals are delaying their births beyond age 30,13 resulting in more children experienced a stroke. Of note is the fact that one classroom in the study, whereas the FAST program14 had students interact with a stroke survivor during the 50-minute class program. Furthermore, the Brain Child Project15 used a local TV personality to describe his experience with stroke as well as live performances by actors well known to the children acting out stroke symptoms. Although the KIDS Project16 did not directly use a live person, it did use a video of a local teacher who had experienced a stroke. Of note is the fact that one classroom in the study by Williams and Noble only viewed a video of the live performance by the hip-hop artist but appear to have had similar positive knowledge gains. Therefore, a video of a person to which the children can relate may be just as efficacious as having the person physically present in these programs.

The evidence also suggests that recurring exposure to an educational intervention may increase long-term stroke knowledge gains in children. Both the Brain Child Project15 and the FAST program14 involved somewhat brief, 1-day education sessions with the children, and both showed some knowledge loss, although very minimal, between the immediate posttest and long-term follow-up (−0.22% in the Brain Child Project and average point losses of 0.4 [warning signs] and 0.9 [risk factors] in the FAST program). The “Hip-Hop” Stroke Program involved 1-hour lessons over 3 days, but also found some slight diminishment in stroke knowledge at 3 months from the immediate posttest (stroke localization −7%, urgent action −2%, symptom recognition −0.1 point). In contrast, the KIDS Project involved 50-minute sessions given 4 times per year throughout grades sixth through eighth

The opinions in this editorial are not necessarily those of the editors or of the American Heart Association.

From the Department of Emergency Medicine, West Virginia University, Morgantown, WV.

Correspondence to Stephen M. Davis, MPA, MSW, Department of Emergency Medicine, West Virginia University, PO Box 9149, Morgantown, WV 26506. E-mail sdavis@hsc.wvu.edu

(Stroke. 2008;39:2695-2696.)

© 2008 American Heart Association, Inc.

Stroke is available at http://stroke.ahajournals.org

DOI: 10.1161/STROKEAHA.108.519496
and demonstrated an increase in stroke knowledge in each knowledge domain at the end of eighth grade.

Given the positive impact on stroke knowledge demonstrated by the previously discussed child stroke education programs, assessing the impact that these programs have on actual behavior such as calling 911 and early presentation for treatment is the logical next step in the research continuum for these activities. Adult stroke education programs have previously demonstrated an increase in both frequency of visits and time to presentation for stroke as well as rates of thrombolytic treatment. In addition to these future research efforts, there are a few other program areas that still need to be addressed in the quest to find the most effective and lasting stroke educational program with children.

None of these child stroke education programs have yet been able to successfully demonstrate actively involving parents in the process, which has been identified as an element necessary for the successful education of children. In particular, the KIDS Project, which was the only program that included parents (although indirectly) in the curriculum, had a parental participation rate of 18% in the intervention group and 16% in the control group. Therefore, it is currently unknown whether these programs affect parental knowledge of stroke as well. The KIDS Project results suggest that actively including parents in the process, as opposed to having children take home material to teach the parents, may be a more effective approach.

The impact of these programs on knowledge of stroke risk factors has also been somewhat disappointing. There was better retention of stroke warning signs versus risk factors in the FAST program and better test performance on symptom recognition items as opposed to stroke prevention measure items in the current “Hip-Hop” Stroke Program. Miller and colleagues suggest that this situation may be due to the fact that stroke risk factors are more abstract than signs and symptoms and thus harder for children to remember. They further suggest that the FAST mnemonic (Face, Arm, Speech, Time to call 911) facilitates the retention of stroke symptoms and response knowledge. This supposition is supported by Williams and Noble’s results in which symptoms specifically contained within the FAST mnemonic were better retained at the long-term follow-up than other symptoms. More research could seek to develop a comparable mnemonic for stroke risk factors and test this theory.

Research should also be conducted on stroke education programs for the very young, because half of all grandchildren who live with their grandparents are younger than age 6. Specifically, data from the Brain Child Project showed that the biggest intervention effect was observed in the fifth grade, whereas the smallest was found among second graders. Williams and Noble’s “Hip-Hop” Stroke Program found success in grades fourth through sixth, and the FAST program’s average participant age was 13.25. Therefore, there is still a need for efficacious stroke recognition programs for very young children in kindergarten through third grade.

Finally, research is needed in rural and remote areas where the cultural elements that may lead to successful stroke educational programs for children may differ from the ones used in the reported studies. Regardless of their geographical location, however, changing societal demographics coupled with the importance of a bystander to stroke recognition and activation of the emergency medical services system highlight the critical link that children represent in the stroke chain of recovery. The successful results of the “Hip-Hop” Stroke Program coupled with the previous efforts of the FAST program, KIDS Project, and the Brain Child Project have truly demonstrated that this critical link can be strengthened.

Disclosures
None.

References

Key Word: educational campaigns
Strengthening the Link: The Critical Role of Children in the Stroke Chain of Recovery

Stephen M. Davis

Stroke. 2008;39:2695-2696; originally published online July 17, 2008;
doi: 10.1161/STROKEAHA.108.519496

Stroke is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2008 American Heart Association, Inc. All rights reserved.
Print ISSN: 0039-2499. Online ISSN: 1524-4628

The online version of this article, along with updated information and services, is located on the
World Wide Web at:
http://stroke.ahajournals.org/content/39/10/2695

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Stroke can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Stroke is online at:
http://stroke.ahajournals.org//subscriptions/