Training and Consistency in Stroke Assessments
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See related article, pages 2507–2511 and 2557–2559.

Stroke is a global disease. It needs global tools for description and outcome assessment, common definitions for risk factors, common definitions for complications such as symptomatic hemorrhage, and common investigation protocols.

Research into treatments for stroke depends on enrollment of large numbers of patients, possible only through international cooperation. Wide variation in initial stroke severity requires us to describe the population that we enroll. The National Institutes of Health Stroke Scale is now the most widely used scale for measuring stroke severity in clinical trials and lies second only to the modified Rankin Scale for choice as a primary end point. This trend to homogeneity is important; consistency in language is required within trials and to interpret their results. For example, use of common scales allowed pooling of data from the National Institute of Neurological Diseases and Stroke, Alteplase Thrombolysis for Acute Noninterventional Therapy in Ischemic Stroke, and European Cooperative Acute Stroke Study trials to examine the influence of onset to treatment time with alteplase. It lets us understand trends in clinical practice, facilitating comparisons over time and across regions. With clinical trial data from 10s of thousands of patients archived by groups such as the Virtual International Stroke Trials Archive, it is now possible to examine trends in natural history, to plan selection criteria for future trials, and perhaps to crossvalidate trial results using data that were collected in a consistent manner using common tools.

These benefits that accrue from use of common scales depend on consistency of application across raters and over time. There will be a temptation to modify the scale to improve reliability, by adding or omitting items, and by adjusting the weighting given to components. This should be resisted. An imperfect scale applied consistently will be more useful than modifications intended to improve validity or reliability. The articles by Lyden and colleagues in this issue provide reassurance in this respect. By demonstrating that even among general (nonexpert) users, the National Institutes of Health Stroke Scale can achieve good interrater reliability, Lyden and colleagues contribute to the variation in severity ratings, to outcome assessments, and perhaps even to the trial conclusion. This must be a topic for continued effort because description of patients’ baseline characteristics and outcomes plays such a crucial role in determining whom we should treat and how effective are our interventions.

We should congratulate Dr Lyden and colleagues for taking an imperfect tool and guiding its use in a way that has made it an invaluable part of every modern stroke trial and a mandatory skill for professionals in at least one country.

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None.

References

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