Temporal Trends in Public Awareness of Stroke
Warning Signs, Risk Factors, and Treatment

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Background and Purpose—Delay in seeking medical attention after stroke symptom onset is the most important reason for low rates of thrombolytic use for ischemic stroke (IS) in the United States. This may be related to poor recognition of stroke symptoms, or to lack of awareness of time-sensitive stroke treatments. We describe public knowledge of t-PA as a treatment for IS, as well as changes over time in knowledge of stroke warning signs (WS) and risk factors (RF).

Methods—Survey respondents were drawn from our biracial population of 1.3 million using random-digit dialing in 1995, 2000, and 2005 to reflect the age, race, and gender distribution of stroke patients, based on an ongoing stroke incidence study in the same region. They were asked open-ended questions regarding stroke WS, RF, and, in 2005, specific questions regarding t-PA. Comparisons over time were made using \( \chi^2 \) analysis, and were corrected for multiple comparisons.

Results—Over the 10-year study period, 6209 surveys were completed. Knowledge of WS and RF improved between 1995 and 2000. Between 2000 and 2005, knowledge did not improve significantly; however, there was a significant improvement in knowledge of 3 warning signs (12% in 1995 vs 16% in 2005, \( P=0.0004 \)). In 2005, only 3.6% of those surveyed were able to independently name t-PA or “clot buster” when asked: “Suppose you were having a stroke. Do you know of any medication your doctor could give you into the vein to increase your chance of recovering from a stroke?”—although 19% claimed to have heard of t-PA once it was mentioned to them.

Conclusion—Despite numerous national stroke public awareness campaigns, public knowledge of stroke WS and RF has not improved over the last 5 years. In addition, knowledge of t-PA as a treatment for IS is extremely poor. Public awareness messages in the future should focus on the possibility of urgent treatments, in addition to stroke WS and RF, so the public can translate their knowledge into action and present to medical attention more quickly. This may be the highest yield approach to increasing rates of treatment of IS with t-PA. (Stroke. 2009;40:2502-2506.)

Key Words: epidemiology ■ public awareness ■ acute treatment ■ tPA

Stroke is the third leading cause of death in the United States and is a leading cause of major disability.1,2 There have been many improvements in stroke prevention strategies during the last 15 years, including a variety of new medications and surgical procedures for controlling stroke risk factors and preventing stroke.3–8 Despite this, the incidence of stroke during the 1990s in the United States did not decrease,9 and the prevalences of many stroke risk factors have been increasing, especially diabetes.10 A key consideration to improve stroke prevention may be public awareness of stroke risk factors and changes in behavior toward controlling these chronic conditions. Little is known about the change over time in the public’s perception of stroke risk factors.

Once an ischemic stroke occurs, the only US Food and Drug Administration-approved medication available for acute treatment is recombinant tissue plasminogen activator (rtPA).

When given to appropriate patients, rtPA significantly improves functional outcome.11 Unfortunately, rtPA is given to very few patients with ischemic stroke, with US national estimates ranging from 1.6% to 3%.12–14 A previous study found that delay in seeking medical attention after stroke symptom onset is the most frequent reason for low rates of thrombolytic use for acute ischemic stroke.15 Delays may be related to poor recognition of stroke symptoms or to lack of awareness that stroke treatments are time-sensitive. We describe public knowledge of rtPA as a treatment for ischemic stroke as well as changes over time in public knowledge of stroke warning signs and risk factors.

Methods

The Greater Cincinnati/Northern Kentucky region, which includes 2 southern Ohio counties and 3 contiguous Northern Kentucky counties that border the Ohio River, contains an essentially biracial population of 1.3 million. 

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population of 1.3 million. The residents of the study population are reasonably representative of the US population with regard to median age, percentage of blacks, median household income, and percentage of population below the poverty level (Table 1). Only residents of the 5 study counties are considered for participation in the survey. Survey respondents were contacted by telephone in 1995, 2000, and 2005. Only blacks and whites were surveyed, because the population within the sampling frame has a low percentage (<2%) of other ethnic minorities. We used random-digit selection of telephone numbers and random respondent selection within a household.

Details of this method have been previously described.16,17 Because the aim of this survey was to document public knowledge of stroke within those at highest risk for a stroke or transient ischemic attack event, we wanted to ensure that the demographic characteristics of the respondents approximated those of the ischemic stroke population. To achieve this, we created a demographic table that contained the required number of respondents in each of the individual categories defined by age, race, and sex based on a longstanding population-based incidence of stroke study within the same population.9 Once someone in the household was contacted by telephone, questions were asked to determine whether a member of the household matched an unfilled demographic. If not, the call was terminated. To obtain an adequate number of respondents, the total number of calls placed ranged from 25 000 to 41 000 per study period, which includes calls with no answer, nonworking numbers, and businesses (which were excluded). Cell phone numbers were not included in these surveys, because a recent report by the CDC found that cell-phone-only users were still in the vast minority.33 In 1995, 17 634 households were contacted, which yielded 3228 eligibles, of which 2156 (66.8%) agreed to participate, of which 1880 (71.2%) agreed to participate, 397 (15.4%) refused, and 865 (26.2%) were unavailable. In 2000, 25 056 households yielded 3151 eligibles, of which 2173 (69.0%) agreed to participate, 152 (4.8%) refused, and 826 (26.2%) were unavailable. In 2005, 41 836 households yielded 3228 eligibles, of which 2156 (66.8%) agreed to participate, 207 (6.4%) refused, and 865 (26.8%) were unavailable. The decrease in the rate of participation over time was statistically significant (P = 0.0003).

The demographics of the respondents, shown in Table 2, were similar for all 3 study periods with the exception of education, which significantly increased over time: 41% reported education above the high school level in 1995 versus 50% in 2000 (P < 0.001) and 54% in 2005 (P = 0.01) compared with 2000. This is consistent with information from the US Census web site (www.census.org), which shows that the percentage of the overall population of the 5-county study area with a high school diploma increased from 75% in 1990% to 83% in 2000.

The prevalence of disease conferring cerebrovascular risk within the population is presented in Table 2. We found an increasing prevalence of the diagnosis of high cholesterol over time, whereas the prevalence of heart disease, smoking, and prior stroke were stable. The temporal trends in the prevalence of diabetes and hypertension, however, varied over time; history of diabetes significantly increased between 1995 and 2000, but not between 2000 and 2005, whereas the prevalence of hypertension was stable between 1995 and 2000 but significantly increased between 2000 and 2005.

The percentage of the target population who knew at least one risk factor improved from 59% in 1995% to 71% in 2000 (P < 0.0010; Table 3), and knowledge of at least one warning sign improved from 48% to 68% (P < 0.001). However,
between 2000 and 2005, there was little improvement. This lack of improvement was evident in knowledge of at least one risk factor (71% for both study periods), knowledge of at least one warning sign (68% for both study periods), and knowledge of 3 risk factors (4% in 2000, 5% in 2005). However, there was a significant improvement in knowledge of 3 warning signs (5% in 1995 versus 12% in 2000 versus 16% in 2005). However, there was no improvement in the ability of respondents over time and the previous study period’s improvement was still evident. This improvement was still evident after correcting for baseline differences in education between study periods (data not shown).

In 2005, when asked the question, “Suppose you were recovering from a stroke?”, only 3.6% of those surveyed were able to give you into the vein to increase your chance of recovering from a stroke?,” only 3.6% of those surveyed were able to name rtPA (n=79), when compared with those who were not, more likely to have higher education, were more likely to be white (Table 2), and were slightly younger (mean age of those aware 61.0±17.1 years old compared with 62.4±14.1 years old for those unaware, P=0.03). Those aware of rtPA were also more knowledgeable about stroke risk factors and warning signs (P<0.0001 for both). The most common other unaided responses to the acute treatment question were aspirin (5.6%) and warfarin (1.2%).

Logistic regression analysis of demographic factors associated with knowledge of rtPA found that black race was still associated with poorer knowledge of rtPA compared with whites after correcting for education, age, and sex (OR, 0.21; 95% CI, 0.08 to 0.53; Table 4). Education was also independently associated (for those <12th grade education, OR, 0.39; 95% CI, 0.23 to 0.66), but age and sex were not.

If respondents indicated that they had heard of rtPA, we then asked, “How soon does tPA need to be given after a stroke begins for it to be most effective?” in an open-ended manner. “Less than 3 hours” was stated by only 7 (9%) of those familiar with rtPA, although an additional 55 (70%) of responses indicated urgency (including “immediately, within seconds, couple/few hours/within hours, and as soon as possible/the sooner the better”).

**Table 3. Comparison of Knowledge of Stroke Warning Signs and Risk Factors Between Survey Years, Greater Cincinnati/Northern Kentucky Population**

<table>
<thead>
<tr>
<th>No. of correct risk factors known</th>
<th>1995 (N=1880)</th>
<th>2000 (N=2173)</th>
<th>2005 (N=2156)</th>
<th>Trend Over Time P</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>606 (32.2%)</td>
<td>620 (28.5%)</td>
<td>624 (28.9%)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>827 (44.0%)</td>
<td>899 (41.4%)</td>
<td>829 (38.4%)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>398 (21.2%)</td>
<td>571 (26.3%)</td>
<td>600 (27.8%)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>49 (2.6%)</td>
<td>83 (3.8%)</td>
<td>103 (4.8%)</td>
<td></td>
</tr>
</tbody>
</table>

**Table 2. Comparison of Demographics and Stroke Risk Factor Prevalences Between Survey Years, Greater Cincinnati/Northern Kentucky Population**

**Demographics**

<table>
<thead>
<tr>
<th>Demographics</th>
<th>1995 (n=1880)</th>
<th>2000 (n=2173)</th>
<th>2005 (n=2156)</th>
<th>Trend Over Time P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age in years (SD)</td>
<td>63 (16.0)</td>
<td>61 (17.3)</td>
<td>62 (17.4)</td>
<td>0.10</td>
</tr>
<tr>
<td>Women</td>
<td>1121 (60%)</td>
<td>1334 (61%)</td>
<td>1328 (62%)</td>
<td>0.38</td>
</tr>
<tr>
<td>Education &gt;12 years</td>
<td>765 (41%)*</td>
<td>1092 (50%)</td>
<td>1164 (54%)†</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Black</td>
<td>507 (27%)</td>
<td>554 (26%)</td>
<td>529 (25%)</td>
<td>0.21</td>
</tr>
</tbody>
</table>

**Stroke risk factor prevalence**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>818</td>
<td>983</td>
<td>1063</td>
<td>0.0007</td>
</tr>
<tr>
<td>Diabetes</td>
<td>255</td>
<td>353</td>
<td>369</td>
<td>0.006</td>
</tr>
<tr>
<td>Current smoker</td>
<td>402</td>
<td>433</td>
<td>432</td>
<td>0.45</td>
</tr>
<tr>
<td>Heart disease</td>
<td>185</td>
<td>207</td>
<td>192</td>
<td>0.58</td>
</tr>
<tr>
<td>Prior stroke/transient ischemic attack</td>
<td>129</td>
<td>156</td>
<td>178</td>
<td>0.20</td>
</tr>
<tr>
<td>High cholesterol</td>
<td>607</td>
<td>822</td>
<td>936</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

*P<0.05 comparing 1995 with 2000 after correction for multiple comparisons.
†P<0.05 comparing 2000 with 2005 after correction for multiple comparisons.

Discussion

We found that the public knowledge of stroke risk factors did not substantially improve between 2000 and 2005. This finding was the opposite of what would be expected given the mild improvement in educational level among the survey respondents over time and the previous study period’s improvement in knowledge between 1995 and 2000. Knowledge of stroke warning signs did slightly improve; those able to name 3 warning signs improved from 5% in 1995 to 16% in 2005. However, there was no improvement in the ability of the public to name at least one warning sign.

Within this survey, we were also able to track prevalence of stroke risk factors within the general population. We found that the rate of hypertension, diabetes, and hypercholesterol-
Table 4. Logistic Regression Analysis of Predictors of Knowledge Regarding rtPA, 2005 Study Period Only

<table>
<thead>
<tr>
<th>Variable</th>
<th>OR for Knowledge of rtPA* (95% CI)</th>
<th>P</th>
<th>OR for Knowledge of rtPA* (95% CI)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>0.216 (0.086–0.542)</td>
<td>0.001</td>
<td>0.211 (0.085–0.527)</td>
<td>0.0008</td>
</tr>
<tr>
<td>Male</td>
<td>0.653 (0.400–1.066)</td>
<td>0.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education ≤12th grade</td>
<td>0.410 (0.242–0.696)</td>
<td>0.001</td>
<td>0.436 (0.263–0.725)</td>
<td>0.0014</td>
</tr>
<tr>
<td>Increasing age (per decade)</td>
<td>0.991 (0.855–1.155)</td>
<td>0.91</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current smoker</td>
<td>0.520 (0.244–1.06)</td>
<td>0.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior stroke or transient ischemic attack</td>
<td>1.653 (0.911–3.773)</td>
<td>0.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High cholesterol</td>
<td>1.460 (0.911–2.340)</td>
<td>0.12</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Unaided response of “tPA,” an approximation of tPA, or “clot buster” when asked, “Suppose you were having a stroke. Do you know of any medication your doctor could give you into the vein to increase your chance of recovering from a stroke?”

emilia increased during the 10-year period and rates of smoking, heart disease, and prior stroke were stable. This is consistent with other large surveys of disease prevalence. Despite the increased prevalence of stroke risk factors in successive study periods, improvement in knowledge of medical conditions that are risk factors for stroke was not seen in the successive cohort of respondents. A key component of many theories of social learning is the importance of patients’ understanding of their own personal risks. If patients do not understand that these conditions place them at higher risk, they are less likely to pay attention to awareness messages, because they will seem irrelevant.

Understanding that there are potential treatments that might help reverse the problem is also a well-known key determinant of patient behavior. In 2005, we added questions about knowledge of rtPA, and we found that the vast majority of the public were unaware of rtPA as a potential treatment. As expected, educational level was associated with knowledge level, and those knowledgeable about rtPA were also more knowledgeable about stroke warning signs and risk factors. Also, those who were aware of rtPA were likely to be aware that time is of the essence, although most were not able to state a specific time window. Blacks were far less likely to be aware of rtPA even after controlling for education. This is especially tragic, because the risk of stroke is 2 to 4 times higher in blacks than in whites. Public messages regarding stroke should likely be targeted for minority populations.

The lack of improvement in public knowledge of warning signs and risk factors for stroke among our population was especially surprising considering that the multidisciplinary Greater Cincinnati/Northern Kentucky Stroke Team has been actively involved with educating the community about stroke since 1988, including programs for both medical professionals and the lay public. In fact, new messages, efforts, and ad campaigns have increased during the later part of the study periods when knowledge was essentially static. Within a population of 1.3 million, with widespread access to public media and the Internet, it is not possible to track how many stroke educational messages were delivered to which people within the community nor how many other health messages for other disease states competed for their attention within the same timeframe. One potential explanation for the lack of more recent improvement is that there may be a theoretical limit to how much knowledge the public can absorb from such efforts. A more likely explanation is that the national and local campaigns that have been implemented have not been targeted appropriately to the audience nor tested for efficacy before implementation. Clearly, scientific study of the effectiveness of stroke educational efforts at individual and aggregate levels is warranted.

Limitations of our analysis include the study methodology of telephone-based surveys. Random-digit-dialing phone surveys have been criticized recently as being “out of touch” with the ubiquity of cell phones in communities. Recent studies, however, have found that very few households have only cell phones; most homes still have “land lines” in addition to cell phones. This is especially true among the elderly, an important demographic for this survey; a recent study from the National Health Interview Survey estimates 2.3% of the elderly have only cell phone lines. All medical history disease prevalence information was determined by self-report, which is limited by patients’ knowledge of their own medical history. Although this is a standard limitation of telephone surveys, it is a reasonable way to estimate disease prevalence on a large scale among the general public.

Public awareness messages in the future should focus on the availability of urgent treatments in addition to stroke warning signs and risk factors. Some of these messages should be specifically targeted to the black population, who have a higher incidence of stroke and a significant lack of awareness of rtPA compared with the white population. Increased knowledge of acute stroke treatments may motivate the public to translate their knowledge into action and present to medical attention more quickly. This may be the highest yield approach to increasing rates of treatment of ischemic stroke with tPA.

Disclosures

None.

References


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