Functional Outcome After Common Poststroke Complications Occurring in the First 90 Days

Gitta Rohweder, MD; Hanne Ellekjær, MD, PhD; Øyvind Salvesen, PhD; Eirik Naalsund, RN; Bent Indredavik, MD, PhD

Background and Purpose—The aim of this study was to explore the associations of common medical complications with functional outcome at 90 days post stroke.

Methods—Patients with unselected acute stroke were included and observed for 16 predefined complications during the first week. Fifty percent (244 patients) were allocated to follow-up of 13 complications until 90 days and then assessed with the modified Rankin Scale 90. Common complications were defined as complications with frequencies of ≥5%. Ordinal logistic regression (worsened outcome), as well as binary logistic regression for severe dependency and death (modified Rankin Scale score>3) was performed.

Results—Seven of the 13 complications occurred at a frequency ≥5%. Recurrent stroke and chest infection were found to have an odds ratio for worsened outcome of 7.45 (95% confidence interval, 2.83–20.96; P<0.0001) and 3.28 (95% confidence interval, 1.16–9.29; P=0.025), respectively. Infections other than chest infections and urinary tract infections had an odds ratio for worsened outcome of 1.59 (95% confidence interval, 1.12–2.24; P=0.009) and falls an odds ratio of 1.43 (95% confidence interval, 1.06 to 1.93; P=0.021). Myocardial infarction, urinary tract infections, and pain were not associated with a worsened outcome in terms of modified Rankin Scale 90.

Conclusions—Recurrent stroke and chest infections were strongly associated with a worsened outcome. Other infections and falls were associated with less worsening. For myocardial infarction, urinary tract infections, and pain no association with functional outcome was found. Active strategies for prevention and early treatment of the first 2 complications seem advisable; patient monitoring as part of comprehensive stroke unit care should ensure timely identification and treatment of all complications. (Stroke. 2015;46:65-70. DOI: 10.1161/STROKEAHA.114.006667.)

Key Words: complications ■ patient outcome assessment ■ stroke ■ stroke unit
Subjects and Methods

The SU, Department of Medicine at the University Hospital of Trondheim, serves as the primary hospital for 200000 inhabitants of South Trondelag and as the tertiary hospital for Central Norway. All patients, admitted consecutively between January 1, 2002, and May 15, 2003, and presenting with symptoms consistent with acute stroke (n=664), were included in the study if the following criteria were fulfilled: (1) a diagnosis of acute stroke according to the World Health Organization’s definition, (2) computerized tomographic scan exclusion of alternative pathologies (eg, tumor, trauma, infection, and vasculitis; n=110), and (3) admission to the SU within 24 hours of stroke onset (n=54). Screening for inclusion was halted after completed inclusion of 500 patients. Of the 500 patients thus eligible for inclusion, 11 did not wish to participate during follow-up. A total of 489 patients were included in the analysis of complications during the first week.10

Fifty percent of these patients were randomly allocated to 90-day follow-up, and these 244 patients are the contributors to this study (Figure 1).

All patients received initial diagnostic evaluation and treatment in accordance with our SU protocol.13,14 It stresses physiological homeostasis, a strategy for early mobilization and integration of medical and nursing care, and rehabilitation via a multidisciplinary team. There was a strong focus on prevention of complications, including routine swallowing evaluation before any oral intake, frequent ultrasound assessment for urinary retention and the use of intermittent urinary catheterization as necessary.

After discharge from the SU, the patients were followed up by an early supported discharge service, previously described.11 As part of this service, all patients received an outpatient follow-up medical evaluation 4 weeks after discharge. At 90 days, a home-visit and functional assessment using modified Rankin Scale (mRS) scores15 were performed by a staff-member unfamiliar with the patient.

Assessment of Complications

During the first week after admission, patients were screened daily for 16 prespecified complications by specially trained physicians, nurses, and physical therapists.10 Two-hundred forty four patients were allocated to weekly follow-up via telephone to the patient or the primary caregiver for 3 months and with assessment of the following complications: stroke recurrence, seizure, chest infection, UTI, other infections, falls (serious and nonserious), pressure sores, pulmonary embolism, deep vein thrombosis, myocardial infarction, and pain (shoulder and other). All complications were based on a clinical diagnosis, and their definitions were similar to the definitions used in previous studies.6,8 The definitions and the frequencies of these complications have been published previously.10

Data Analysis

Complications occurring in 5% of patients or more over the entire 3-month period were defined as common complications and were analyzed for their association with functional outcome at 90 days. Ordinal logistic regression was performed to calculate an odds ratio (OR) for worsened outcome and binary logistic regression with a cutoff between mRS 3 and 4 was performed to calculate an OR for bad outcome. Both were adjusted for the potential confounders: age, sex, prestroke mRS and Scandinavian stroke scale (SSS) day 1; the latter represents stroke severity. Ordinal logistic regression analysis is judged to provide a more sensitive estimate than analysis of a dichotomized-outcome and it was, therefore, chosen as a primary end point.6,17 A cutoff between mRS 3 and 4 was used, when the conditions of the parallel line-test for proportionality were not met. The calculations were performed in SPSS and Stata.

Ethics

This study was part of a larger investigation on recovery after stroke and was approved by the regional ethics committee.

Results

The patients baseline characteristics are shown in Table 1. A total of 56% of patients were women and the mean age was 76.5 years (SD±9.8). Ninety percent had an ischemic stroke and 10% had a hemorrhagic stroke. Mean SSS day 1 was 40.3 (SD±16.6). Mean estimated prestroke mRS was 1.6 (SD±1.1) and mean mRS day 1 was 3.47 (SD±1.3).

As presented in Table 2, the following 7 complications occurred in ≥5% of patients: recurrent stroke 5%, myocardial infarction (MI) 7%, chest infection 17%, UTI 28%, other infections 13%, falls (combined-serious and nonserious) 29%, and pain (combined-shoulder and diffuse pain) 57%. The following complications seizures, pressure sores

| Table 1. Baseline Characteristics of the Patients (n=244) |
| Characteristics | n  | %  |
| Women           | 137 | 56 |
| Age, y, mean±SD | 76.5±9.8 |

<table>
<thead>
<tr>
<th>Risk factors</th>
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<tbody>
<tr>
<td>Hypertension</td>
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<tr>
<td>Previous stroke</td>
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<tr>
<td>Atrial fibrillation</td>
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<tr>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>Previous myocardial infarction</td>
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<tr>
<td>Smoking</td>
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<td>TIA</td>
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<table>
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<tr>
<th>Diagnosis</th>
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<tbody>
<tr>
<td>Ischemic stroke</td>
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<td>Hemorrhagic stroke</td>
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</table>

TIA indicates transient ischemic attack.
pulmonary embolism, and deep vein thrombosis occurred at a frequency of 2.5, 2.9, 1.2, and 2.5%, respectively and were not analyzed further. mRS at day 90 (mRS90) varied greatly between the complications. In unadjusted analysis, recurrent stroke, MI, and chest infection were associated with a worsening of survival and function (mRS ≥ 3) at 90 days; pain and falls were to a lesser degree (Figure 2).

Table 3 shows the results of the outcome analysis adjusted for age, sex, prestroke mRS and SSS day 1. According to both the shift and the dichotomized analyses recurrent stroke and chest infection had an OR for worsened outcome of 7.45 (95% confidence interval [CI], 2.83–20.96; P < 0.0001) and 3.28 (95% CI, 1.16–9.29; P = 0.025), respectively, and an OR for bad outcome (mRS > 3) of 10.45 (95% CI, 1.03–38.93; P < 0.0001) and 2.52 (95% CI, 1.14–5.3; R = 0.022). Infections other than chest and UTI, as well as falls, had ORs for worsened outcome of 1.59 (95% CI, 1.12–2.24; R = 0.009) and 1.43 (95% CI, 1.06–1.83; P = 0.019), respectively. The ORs for bad outcome (mRS > 3) were 2.09 (95% CI, 1.15–3.80; P = 0.015) and 1.41 (95% CI, 1.06–1.88; P = 0.019). Myocardial infarction, as well as UTI and pain, was not associated with a reduction in functional outcome.

**Discussion**

Functional outcome after a stroke is in large part determined by the nature of the incident stroke. Other established factors associated with reduced functional outcome are advanced age and a reduced level of premorbid function. In this study, we were able to show that recurrent stroke and chest infection were strongly associated with reduced functional outcome at 90 days. Falls and other infections had a much weaker association with reduced functional outcome. No other complication assessed was associated with a reduction in function.

Five percent of our patients were found to have a recurrent stroke. Other studies reported a frequency of 2% to 18%. In our study, this complication had an OR of 7.5 for a worsened outcome and an OR of 10.5 for major disability or death. Early work-up for transient ischemic attack or minor stroke reduced the 90-day recurrent stroke rate from 10.3% to 2.1% in the Oxford Vascular Study. Analogously, recurrent stroke can be considered a likely failure of prevention, justifying a repeated work-up with an aim to improve prophylaxis. Large artery disease, previous MI, and atrial fibrillation seem to be the factors predisposing toward early recurrence and should be actively sought after.

A total of 17% of our patients had a chest infection, with an adjusted OR of 3.3 and 2.5 for worsened outcome and for dependency and death, respectively. This complication is reported at a frequency of 10% to 22% in other studies and known to be associated with high-mortality. In a study of 14,293 US Medicare patients admitted for stroke, pneumonia was identified in 6.9% of patients and conferred a 3-fold increase in 30-day mortality.

![Figure 2. Distribution of modified Rankin Scale (mRS) scores at 90 days.](image-url)
The stroke-related causes are judged to be multifactorial: reduced swallowing ability, reduced mobility and thereby lung-mechanics, and central nervous system injury-induced immune depression.24–27 Performing a swallowing evaluation before any oral-intake has been shown to decrease the incidence of aspiration pneumonia 3-fold.28 Preventive use of antibiotics is under investigation as a possible strategy in high-risk patients.29 Early initiation of antibiotic therapy is generally recommended and seems to be one of the interventions that make SU care so effective.3 Greater emphasis on patient-mobilization is likely another important preventive aspect of SU care. Although it is established that mobilization within 7 days reduces the number of serious complications, and too much time spent in bed is detrimental, the optimal timing (within 24, 48, or 72 hours from onset of a stroke) and quantity of mobilization are not clear yet.30–32 Incentive spirometry, commonly used in the postoperative management of patients, could be an accessory measure in those patients, which cannot be mobilized to a standing position. Its use seems most promising in the context of a multifactorial care program, including oral care and mobilization, which has been shown to reduce postoperative pneumonia by 38%.33

Infections other than chest infection and UTI occurred in 13% of patients and represent various causes, mostly skin and intravenous line infections, and also sepsis and cholecystitis. This group of infections was shown to be associated with worsened outcome with an OR of 1.59, and severe disability and death with an OR of 2.09. Scant reports describe a frequency of MI or cardiac failure of 2% to 4% in patients poststroke.5,7,9 In our study, despite being associated with a high-rate of disability and mortality in the unadjusted analysis, this serious event, which occurred mainly in older patients, was not independently associated with a reduction in functional outcome.

UTI occurred in 28% of patients. The reported frequency varies between 7% and 27%.6–9,34–38 This infection was not independently associated with a reduction in 90-day function in our study. A similar result was obtained in a study of 412 patients by Stott et al.34 Pain, including shoulder-pain and diffuse pain, occurred in 57% of patients. No association with functional outcome at 90 days could be found.

The reported frequency varies widely for most of the complications, and our results are usually at the higher end of this range. Variations in definition of complications, timing and duration of follow-up, and case-mix are probably contributing factors to the variation in complication rates. Although our results could in part imply a failure of prevention, they might, alternatively, reflect thorough screening procedures. We do think that a foremost strength of our study is the fact that it was performed in an SU combined with an organized follow-up service (early supported discharge), which has shown good outcomes previously for patients with stroke, and whose members were actively searching for complications. With this approach, one would expect to best approximate a complete reporting of events. Another strength of the study is the choice of end point, because the functional outcome at 3 months is a predictor for long-term survival.39

A potential weakness of our study is the lack of assessment for neuropsychiatric complications: delirium, depression and poststroke fatigue. These could be assessed concomitantly with the assessment of softer end points and patient reported outcomes.

Ten years have passed between the conduction of the study and this analysis. During this time, stroke care may have improved, and this may have lead to a reduction in the frequency of complications. However, the relative associations with outcome should not have been affected by this process. To our knowledge, an equally comprehensive outcome

<table>
<thead>
<tr>
<th>Complication</th>
<th>OR (95% CI) for Worsened Outcome</th>
<th>P Value</th>
<th>OR (95% CI) for mRS&gt;3</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent stroke</td>
<td>7.45 (2.83–20.96)</td>
<td>&lt;0.0001</td>
<td>10.45 (1.03–38.93)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>MI</td>
<td>1.83 (0.62–5.36)</td>
<td>0.272</td>
<td>1.89 (0.42–8.53)</td>
<td>0.408</td>
</tr>
<tr>
<td>Chest infection</td>
<td>3.28 (1.16–9.29)</td>
<td>0.025</td>
<td>2.52 (1.14–5.54)</td>
<td>0.022</td>
</tr>
<tr>
<td>UTI</td>
<td>1.19 (0.63–1.74)</td>
<td>0.323</td>
<td>1.33 (0.91–1.93)</td>
<td>0.137</td>
</tr>
<tr>
<td>Other infection</td>
<td>1.59 (1.12–2.24)</td>
<td>0.009</td>
<td>2.09 (1.15–3.80)</td>
<td>0.015</td>
</tr>
<tr>
<td>Falls</td>
<td>1.43 (1.06–1.93)</td>
<td>0.021</td>
<td>1.41 (1.06–1.88)</td>
<td>0.019</td>
</tr>
<tr>
<td>Pain</td>
<td>1.00 (0.92–1.09)</td>
<td>0.961</td>
<td>0.94 (0.80–1.10)</td>
<td>0.439</td>
</tr>
</tbody>
</table>

Ordinal logistic regression was performed, correcting for age, sex, prestroke mRS, and SSS day 1 (worsened outcome). Binary logistic regression for severe dependency or death (mRS>3) was performed correcting for the same confounders (bad outcome). CI indicates confidence interval; MI, myocardial infarction; mRS, modified Rankin Scale; OR, odds ratio; SSS, Scandinavian stroke scale; and UTI, urinary tract infection.
analysis with regards to complications has not become available in the literature in the intervening years.

Looking to the future, it would be interesting to explore, which of these complications are associated with an increase in morbidity and mortality in the longer term. Especially important is a follow-up in regards to falls, which according to the geriatric literature conveys a serious prognosis and is important in patient safety campaigns. Preventive antibiotics for aspiration pneumonia in high-risk patients and a multifactorial approach to mobilization and chest physical therapy in the context of an SU deserve further study.

Conclusions

In our study, 2 complications, recurrent stroke and chest infections, were strongly associated with a worsening of outcome at 90 days post stroke. Other infections and falls were associated with worsening of a lesser magnitude. Pain, although common, seemed not to be associated with a reduction of functional outcome. Cardiovascular assessment and secondary stroke prevention, as well as the prevention and treatment of aspiration pneumonia, seem important in stroke care. Patient monitoring as part of comprehensive SU care should ensure timely identification and treatment of all complications and is applicable in all healthcare settings.

Acknowledgments

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Disclosures

None.

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脳卒中発症後 90 日間によくみられる合併症発現後の機能的転帰

Functional Outcome After Common Poststroke Complications Occurring in the First 90 Days

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脳卒中発症後 90 日間において頻度の高い医療上の合併症と機能的転帰の関連性を検討することを目的とした。

方法：急性脳卒中患者を非選択的に登録し、最初の 1 週間、事前に決めた16の合併症について観察した。50%（244例）を13の合併症の総合観察群に割付け、90日間観察し、改変Rankinスケールを用いて90日後に評価した。頻度の高い合併症は発症率が5%以上の合併症を定義した。重度の障害および死亡（改変Rankinスケールスコア＞3）について、順位ロジスティック回帰分析（転帰の悪化）および二項ロジスティック回帰分析を行った。

結果：13の合併症中7つが5%以上の頻度で発生した。転帰の悪化についてのオッズ比は、脳卒中再発が7.45（95%信頼区間[CI]：2.83 ～ 20.96, p < 0.0001）、胸部感染症が3.28（95%CI：1.66 ～ 9.29, p = 0.025）であった。胸部感染症および尿路感染症以外の感染症における転帰の悪化についてのオッズ比は1.59（95%CI：1.12 ～ 2.24, p = 0.009）で、転倒のオッズ比は1.43（95%CI：1.06 ～ 1.93, p = 0.021）であった。改変Rankinスケールの評価において、胸部感染症、尿路感染症、および疼痛は転帰の悪化と関連していないかった。

結論：脳卒中再発と転帰の悪化は転帰の悪化と強く関連していた。その他の合併症と転倒は転帰の悪化とそれほど強く関連していないかった。心疾患、尿路感染症、および疼痛と機能的転帰との関連性はみられなかった。頻度の高い2つの合併症に対する積極的な予防戦略および早期の治療を行うことが望ましいと考える。包括的な脳卒中ユニットにおいて患者のモニタリングを行うことにより、適宜得た合併症の特定および治療が確保されるべきである。

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表3 転帰の悪化（順位ロジスティック回帰分析）および転帰不良（90日時点のmRS > 3）についてのOR

<table>
<thead>
<tr>
<th>合併症</th>
<th>転帰の悪化についてのOR (95%CI)</th>
<th>p 値</th>
<th>mRS &gt; 3についてのOR (95%CI)</th>
<th>p 値</th>
</tr>
</thead>
<tbody>
<tr>
<td>脳卒中再発</td>
<td>7.45 (2.83 ～ 20.96)</td>
<td>&lt;0.0001</td>
<td>10.45 (1.03 ～ 38.93)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>MI</td>
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<td>1.33 (0.91 ～ 1.93)</td>
<td>0.137</td>
</tr>
<tr>
<td>その他の感染症</td>
<td>1.59 (1.12 ～ 2.24)</td>
<td>0.009</td>
<td>2.09 (1.15 ～ 3.80)</td>
<td>0.015</td>
</tr>
<tr>
<td>転倒</td>
<td>1.43 (1.06 ～ 1.93)</td>
<td>0.021</td>
<td>1.41 (1.06 ～ 1.88)</td>
<td>0.019</td>
</tr>
<tr>
<td>疼痛</td>
<td>1.00 (0.92 ～ 1.09)</td>
<td>0.961</td>
<td>0.94 (0.80 ～ 1.10)</td>
<td>0.439</td>
</tr>
</tbody>
</table>

年齢、性別、脳卒中前のmRS、および1日目のSSSで補正して順位ロジスティック回帰分析を行った（転帰の悪化）。同じ交絡因子で補正して重度の障害または死亡（mRS > 3）についての一過ロジスティック回帰分析を行った（転帰不良）。CI：信頼区間、MI：心疾患、mRS：改変Rankinスケール、OR：オッズ比、SSS：スカンジナビア脳卒中スケール、UTI：尿路感染症。