Letter to the Editor

Stroke welcomes Letters to the Editor and will publish them, if suitable, as space permits. Letters must reference a Stroke published-ahead-of-print article or an article printed within the past 3 weeks. The maximum length is 750 words including no more than 5 references and 3 authors. Please submit letters typed double-spaced. Letters may be shortened or edited.


We appreciate the interest of Estol1 in our recently published article.2 Although acknowledging the originality of our approach to primary stroke prevention and soundness of the epidemiological project we plan to perform during the next 10 years, Estol raises 3 main questions: (1) can we afford to add 10 more years of millions of dead stroke patients while experimenting with a new strategy?: (2) should not we focus on already proven, yet underused conventional vascular prevention programs?: and (3) do we need to carry out our research if the information will be soon available using Big Data analytics? Estol also questions the need for regional-specific risk factors and prevention strategies and the enormous effort required to implement our primary prevention strategy.

The answer to the first question is definitely no, we have to act now, and this is exactly what our article called for and what the Stroke Riskometer app is offering. The Stroke Riskometer app should not be seen as an attempt to experiment with a new strategy. This is an educational tool with the potential to educate >5 billion smartphone users about stroke risk factors, their personal risk of stroke, FAST (Face, Arm, Speech, Time) signs, and some strategies to reduce their risk of having a stroke. All the information and recommendations used in the app are based on internationally recognized and accepted guidelines and, as such, do not need to be proved or experimented on.

We would like to emphasize that nobody questions the importance of a wider use of conventional vascular prevention strategies (population-wide prevention strategy and high-risk prevention strategy). However, there are several major issues with these strategies, which the app is able to address as explained in our article.

It should not be forgotten that results of the analysis of any data directly depend on the quality of data being analyzed. The Big Data analytics may provide some useful information but there is no guarantee that the data related to the epidemiology of non-communicable diseases would be of sufficient scientific quality and comparable across regions, a particular concern for epidemiological studies. In this respect, the size of the data does not matter much and is of no guarantee of the validity of the data. There is also a concern that because of technological demands and associated costs to participate in the Big Data analytics, there will still be a lack of epidemiological data from developing countries. Second, the Big Data analytics does not allow the conduct of randomized controlled trials on the prevention and management of various health conditions, which are one of the components of the Stroke Riskometer–based RIBURST (Reducing the International Burden of Stroke Using Mobile Technology) study.

Although we acknowledge that basic approach to primary stroke prevention strategy should be the same across all regions and populations, there is good evidence that the relative significance of various risk factors is different in different regions, populations, and ethnic/racial groups.3–5 Therefore, an understanding of the risk factors for stroke in different ethnic populations is crucial to determining priorities and strategies for targeted stroke prevention in these populations4 and evidence-based resource allocation.

Finally, addressing the last Estol’s question about the enormous effort required to implement our primary prevention strategy, we would like to emphasize that using our Stroke Riskometer preventative strategy on a national and international levels would cost nothing to the societies and virtually nothing to the individuals. Yet, it has the potential to save millions of lives around the world and can be used right now.

Disclosures

Drs Feigin and Krishnamurthi declare that funds resulting from the sale of the professional version of the Stroke Riskometer App will be used for further research and education for stroke prevention. The other author reports no conflicts.

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Response to Letter Regarding Article,"New Strategy to Reduce the Global Burden of Stroke"

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