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Original research article

The quality of life of patients after an acute stroke

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ABSTRACT

The way in which the quality of life of patients is limited after an acute stroke can manifest in several areas. Patients often experience disorders of the motor system, speech, cognitive skills, self-maintenance and others. The objective of the study was to determine how respondents assess the impact of an acute stroke on the quality of their lives and how they rate their recovery afterwards. A total of 100 respondents with an average age of 55.4 years were included. The study was conducted using a standardized “Stroke Impact Scale Version 3.0” questionnaire. Descriptive statistics, Mann–Whitney *U* test and Spearman's correlation coefficient, were used to analyze the data obtained. Based on statistical tests, we found a relationship between the age of respondents and the assessment of the following domains: Communication, ADL, Mobility, Hand and Participation. Dependence between the assessment of individual domains and sex was not proven. The rate of recovery of patients after an acute stroke is not associated with age ($p = -0.20$). It is significantly related to the assessment of individual domains. The quality of life, as well as the overall recovery rate of acute stroke patients, is reduced. It is not influenced by the age or sex of the patients. Age is related only to the assessment of selected areas of patient life.

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Introduction

Acute stroke occupies a leading position in many national health statistics, both in prevalence and incidence, but also as a cause of mortality. According to Brozman et al. [1], acute stroke is an acute focal or global disorder of brain function with a presumed vascular cause.

The basic clinical entities are: focal cerebral ischaemia – cerebral infarction, spontaneous intracerebral haemorrhage, spontaneous subarachnoid haemorrhage.

The early differentiation of clinical entities is critical due to different treatment strategies for each type of acute stroke [2].

In developed countries, the prevalence is estimated to range from 200 to 600 cases per 100,000 persons, with their prevalence increasing over time [2]. In Slovakia, approximately

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400 new cases per 100,000 inhabitants occur annually, or approximately 20,000 diseases per year [3]. After myocardial infarction and malignant tumours, strokes are the third most common cause of death [4].

In the Czech Republic and old member states of the European Union, 90–160 diseases occur per 100,000 inhabitants. After a stroke, a third of patients die within 1 month, and about half remain disabled [3].

Vascular diseases of the brain are given worldwide attention for their serious economic and social impact on the patient, his/her family and society [5]. 70% of stroke survivors suffer permanent consequences and more than 30% have a severe permanent disability. Strokes are the most common cause of disability, especially in the older population. In Europe, the proportion of the older population is rising. An increase in the proportion of the elderly population over the age of 65, which is the age of the most frequent stroke risk, is projected [6].

Cerebrovascular diseases are also the second most common cause of dementia in the elderly population. Most stroke survivors suffer from depression, other psychological problems or incontinence. In summary, strokes are a disease with one of the greatest health and economic impacts on society. In the US, \$34.3 billion per year is spent on the treatment of stroke patients [6].

The proven risk factors for strokes are hypertension, heart disease, diabetes mellitus, fat metabolism disorder, TIA, and smoking. Other (ambiguously proven) risk factors include alcohol, addictive substances, lifestyle – especially obesity, physical inactivity, inappropriate diet and emotional stress [7–9]. The quality of life of stroke survivors depends on many factors, especially on timely and properly initiated treatment, nursing care, and subsequent rehabilitation. To restore all patient functions and return patients to day-to-day activities, cooperation should be sought not only with the patient, but also with his or her family and those close to him or her. In the treatment and recovery process, patients need to feel the support of those closest to them. The changes also relate to the further functioning of the family, which has to cope with the sudden illness of a person close to them and the new situation. In the care process, the family can use ADOS services, or homes of nursing care [10].

After an acute stroke, the fate of the patient is very individual. It depends on the age, the overall wear and tear of the organism and, last but not least, the time during which the disease may have arisen. According to Brozman et al. [1], significant advances have been made over the last 10 years, particularly in the treatment of cerebral infarctions. The aim of stroke treatment is to achieve the fastest recanalization of the closed cerebral artery that has caused cerebral ischaemia. The latest findings have demonstrated the efficacy and safety of intravenous thrombolysis up to 4.5 h after the onset of difficulties. Hence, a higher percentage of affected patients than previously have a hope of cure [2].

Apart from long-term pharmacological treatment, rehabilitation is very important. Patients begin to practice this on the hospital bed, then go to rehab departments. Another option is spa treatment. Rehabilitation is mainly focused on walking, self-sufficiency and self-care of the patient. Motivation and encouragement for further life are important [11].

The study

The main objective of the study was to determine (a) how respondents assess the impact of an acute stroke on the quality of their lives; (b) how they rate their recovery after an acute stroke.

Materials and methods

A total of 100 patients, irrespective of age, sex, and social status, were included in the study. The only condition for inclusion was that the patient had survived at least one month post stroke. The upper limit of the post-stroke time was not established. The objective was not to compare how each patient recovered after an acute stroke, and therefore we did not consider other criteria for including respondents in the study, such as degree of severity of the disease, extent of physical, sensory and psychological impairment, rehabilitation methods, etc.

Respondents were approached in neurological outpatient clinics and doctor's offices in the districts of Zvolen, Banská Bystrica, and Žiar nad Hronom. Participation in the study was anonymous. It was carried out in 2016–2017.

In the study, the Stroke Impact Scale Version 3.0 [12] was used.

The rating scale is commonly used in professional publications, and its use is not subject to the prior consent of the authors. The purpose of the questionnaire was to assess the impact of acute stroke on the health and quality of life of patients who were previously integrated and self-sufficient.

The questionnaire was divided into the following domains:

1. Strength;
2. Memory;
3. Emotion;
4. Communication;
5. Activities of daily living (ADL);
6. Mobility;
7. Hand;
8. Participation;
9. Stroke recovery.

The conclusion was question No. 9 – the patient's perception of how well he or she has recovered from stroke.

Scoring: All items were rated on a 5-point Likert scale (1 = not a problem at all, 5 = could not do at all). The domain of Strength and 3 items of the Emotion domain were rated on a scale, where 1 = a lot of strength, 5 = no strength at all. These exceptions were respected in the evaluation. The aggregate results have been generated for each domain. The rating for each domain ranges from 0 to 100. The resulting rating is therefore also possible in percent. The last item evaluates the overall perception of the recovery by respondents. It is presented in the form of a visual analogue scale from 0 to 100 (0 = no recovery and 100 = full recovery).

The standardized Cronbach's coefficient alpha was used to verify reliability of the questionnaire domains. All domains of the questionnaire have a high validity (Table 1).

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