12 y.o.), 55.4% were women. The average cost person/year was 5,962.41 euro ($2,850.27); 73.9% attributable to hospitalisations, 17.5% to drugs, 6.6% to other medical costs. The 32.8% patients died during the follow up period, with a mean age of 84 ± 9 statistically different (p < 0.0001) from survivors (mean age 74 ± 11 y.o.). CONCLUSIONS: Stroke imposes a large social and economic burden on NHS and society because of the large number of hospitalisation and the high rate of mortality. Future investigations will be conducted to assess the relationships between comorbidity, costs, drug therapy and survival.

FACTORS RELATED TO LONGER HOSPITAL STAY AFTER FIRST-EVER ISCHEMIC STROKE

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OBJECTIVES: To assess factors influencing acute hospitalization for patients with first-ever ischemic stroke in Taiwan.

METHODS: Data were prospectively collected from 360 first-ever ischemic stroke patients consecutively admitted to a medical center within 48 hours after symptom onset. Longer stay was defined as length of stay (LOS) >7 days after admission in department of neurology for acute care. The association between demographic characteristics or clinical variables and LOS was examined using multivariate logistic regression analysis. Discrimination of the model was assessed by the area under the curve (receiver operating characteristic curve) of 0.776.

RESULTS: Factors influencing hospital stay longer than 7 days were older age (OR, 1.01; 95% CI, 1.00 to 1.03), sex female (OR, 1.7; 95% CI, 1.1 to 2.5), history of hypertension (OR, 2.06; 95% CI, 1.33 to 3.17), history of diabetes mellitus (OR, 3.1; 95% CI, 1.3 to 7.2), baseline NIHSS score ≥12 (versus 0–6) (OR, 0.35; 95% CI, 0.16 to 0.75), and small vessel occlusive subtype (OR, 0.35; 95% CI, 0.16 to 0.73) were independent predictors of longer stay. Goodness-of-fit test (Hosmer-Lemeshow test) was not significant (P = 0.49), indicating adequate fitness. The model’s discrimination was adequate with an under the curve area (receiver-operating characteristic curve) of 0.776. CONCLUSIONS: The impact of stroke severity need to be understood to manage LOS. Early supported discharge planning would probably reduce the LOS in acute hospitalization of this group of first-ever ischemic stroke patients.

DO PATIENTS WITH ATRIAL FIBRILLATION RECEIVE APPROPRIATE STROKE PREVENTION THERAPY IN PRACTICE?

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OBJECTIVES: Clinical practice guidelines and several clinical trials support the use of warfarin for stroke prevention in most patients with atrial fibrillation (AF). Warfarin should not be used in cases where contraindications exist or the risk of stroke is low. It is not clear what proportion of are there patients at risk of stroke and without contraindications do not receive warfarin in practice. METHODS: A MEDLINE search was conducted (1966–2001) using the MeSH terms anticoagulants, AF, warfarin and cerebrovascular disorder (prevention and control). Practice-based studies reporting the proportion of patients eligible to receive warfarin (i.e., no contraindications to thromboprophylaxis and at moderate or high risk of stroke) who actually received warfarin for stroke prevention in AF were retrieved.

RESULTS: Twenty-one practice-based studies were found, of which 3 were excluded because the patient population or centre-setting significantly varied from the other identified studies. Approximately 47–89% of patients enrolled in the remaining 18 studies were eligible for stroke prevention. Only 15–64% of eligible patients received warfarin and 15–56% did not receive any form of stroke prevention therapy at all (i.e., no warfarin or antiplatelet agent). CONCLUSIONS: Despite the publication of multiple clinical trials and practice guidelines supporting the use of warfarin for stroke prevention in AF, many eligible patients do not receive appropriate preventive therapy, and therefore remain at increased risk of stroke. Reasons for the sub-optimal use of warfarin for stroke prevention in AF require further research.

MANDARIN VERSION OF STROKE IMPACT SCALE: ADAPTATION AND VALIDATION

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OBJECTIVES: To assess the properties of the Mandarin version of Stroke Impact Scale (SIS) versions 3.0, developed by Pamela W. Duncan et al. METHODS: The SIS, a stroke-specific outcome measure, assesses 8 domains: strength (4 items), memory (7 items), emotion (9 items), communication (7 items), activities of daily living/instrumental activities of daily living (ADL/IADL) (10 items), mobility (9 items), hand function (5 items), and participation (8 items). SIS was translated and back-translated