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TITLE: Augmentation of Acute Stroke Management Via Telemedicine

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ABSTRACT

"Time is Brain"

Stroke is the leading cause of disability and the third leading cause of death in the United States. Urgent stroke management is constrained by a narrow, 3 hour therapeutic window for treatment with intravenous recombinant tissue plasminogen activator (IV rt-PA), the "brain saving" drug. Using IV rt-PA requires rapid diagnosis and an organized approach to acute stroke care.

Emergency room (ER) healthcare providers inexperienced with using IV rt-PA have been reluctant to initiate this treatment, due to known brain bleeding side effects. Misdiagnosing a non-cerebrovascular condition as a stroke is a subsequent concern. Past studies indicated that many ER physicians do not accurately interpret brain computed tomography studies (CTs). Sufficient interpretation of brain CTs is crucial to ruling out brain hemorrhage and cerebral infarctions not amenable to thrombolytic therapy.

Telemedicine technology can provide immediate, remote stroke assessment and treatment by experts. Rural areas in the United States and the US military medical system would benefit from remote expert telemedicine consultants. The ability to better triage patients will not only improve stroke care but will also reduce cost by this drug benefit. The cost of treating stroke in the United States was $40.9 billion in 1997.

A preliminary study demonstrated the use of remote telemedicine examinations to accurately and quickly perform a patient stroke scale assessment necessary for stroke evaluation. Walter Reed Army Medical Center (WRAMC) has a 24-hour on-call stroke team consisting of an interventional radiologist, a neurologist, neurovascular neurosurgeons and an accredited vascular laboratory. Similar resources have proven to decrease mortality rates in a variety of medical conditions at large teaching hospitals. The ability to initialize critical stroke management at remote regions with immediate transfer to the tertiary center would utilize these resources and at the same time improve patient outcomes and quality of life. The proposed study seeks to establish the feasibility of telemedicine consultation in the diagnosis of stroke. Telemedicine evaluation of the neurological examination and brain CTs will be investigated.
Overview

Design:
Prospective clinical trial
Locations:
Phase I: Walter Reed Army Medical Center (WRAMC)
Phase II: WRAMC, (Dr.’s office and ER);
Ft. Bragg, (Dr.’s office); NNMC (Dr.’s office).
Funding:
$ 218,730
Associate Investigators:
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Project Officer:
Ernst Hoffstetter, MS; Telemedicine Directorate
Trials Coordinator:
Gabriele Feolo, RN, MSN; Department of Neurology

Project Description

Background: Acute stroke care has a limited therapeutic window, IV rt-PA =< 3 hours.
- Teledermatology technology can provide a valid diagnostic tool for urgent stroke care.
- Provide stroke expert consultation that may be more effective than telephone advice.
Hypothesis: VTC is a valid clinical tool for urgent stroke care, with no difference in diagnostic accuracy and time efficient patient assessment from “in-person” evaluations.
Objectives

Plan: Test feasibility of telemedicine consultation in the diagnosis of stroke.
- Compare conventional “in-person” vs. “telemedicine” physician evaluations.
- Validate a telemedicine procedure within the critical time frame.
- Explore patients’ and physicians’ satisfaction with examination using VTC.
- Improve patients outcomes and reduce healthcare expenses.

Methodology

Subjects: Simulated patient encounters:
- Normal neurological examination (control subjects).
- Abnormal neurological examination (non-stroke subjects).
- Abnormal neurological examination (stroke subjects).
- Each subject receives two consecutive, neurological evaluations.

Compare: “In-person” vs. “telemedicine” interventions:
- Evaluate accuracy of diagnosis.
- Measure time used for:
  - Patient interview
  - NIHSS examination
  - CT-Scan interpretation

KEY RESEARCH ACCOMPLISHMENTS

Infrastructure

The phase I/pilot study phase was conducted. Six telemedicine consultations were completed. Virtual patient consultations were televised from the WRAMC’s ER (location of the study participant) to the remote neurology consultant (Dr.’s office at WRAMC.)

Deliverables

Decision Support Tools: Developed an MS-ACCESS application executed “on-screen” during the VTC session, (front-end & database).
- Included an IV rt-PA calculator.
- Application ensures uniformity of evaluations.

Modify Phase II study design based on Phase I observations: For data collection and to continue uniformity of evaluations:
- Developed a Website for the remote ER consultant.
- Developed a PDA application for the in-person consultant.
# The WRAMC Tele-Stroke Project
Remote Expert Tele-Medicine Evaluation of Stroke

## Stroke Assessment Questionnaire

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Study case number:</td>
<td>J1234</td>
<td>Patient's initials:</td>
<td>GSF</td>
<td>Symptoms date of onset:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5/28/2002</td>
<td>Symptoms time of onset:</td>
<td>11:35</td>
</tr>
</tbody>
</table>

**What are the patient's symptoms:**

- Headache
- Double vision
- How do you know about patient's symptoms?
- Patient's wife

**Hypertension?**

- Yes

**Hyperlipidemia?**

- No

**Arterial fibrillation?**

- No

**CAD?**

- No

**PVD?**

- No

**DM?**

- No

**Prior stroke?**

- No

**MI in past 1 month?**

- No

**Fever?**

- No

**Chills?**

- No

**Recent dental work?**

- No

**Major head trauma in past 3 months?**

- No

**Major surgery in past 2 weeks?**

- No

**Gastro-intestinal hemorrhage in past 2 weeks?**

- No

**Genito-urinary hemorrhage in past 2 weeks?**

- No

**Antiplaetlets:**

- ASA, Clopidrogel, Ticlopidine, Aggrenox®?

- No

- Anticoagulants/Warfarin?

- No

- Heparin/low molecular heparin?

- No

**LOC questions:**

- One correct = 1

- LOC commands:

  - Both correct = 0

- Gaze:

  - Partial gaze palsy = 1

- Visual fields:

  - Partial hemianopsia = 1

**Left arm:**

- No drift = 0

**Right arm:**

- No drift = 0
VTC Study Intervention / Snap-Shot of a Televised Remote Consultation
REPORTABLE OUTCOMES

Results: "Times Measured"

Assessment Time

CT-Scan Interpretation Time
Results: “Study Diagnosis”

<table>
<thead>
<tr>
<th>Date</th>
<th>Case#</th>
<th>Evaluator Type</th>
<th>NIHSS</th>
<th>DX</th>
<th>DX, If Non Stroke</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/30/2001</td>
<td>1</td>
<td>In Person</td>
<td>0</td>
<td>Non-Stroke</td>
<td>R hand parathesias R/O mononeuropathy</td>
</tr>
<tr>
<td>11/30/2001</td>
<td>1</td>
<td>Telemetry</td>
<td>0</td>
<td>Non-Stroke</td>
<td>appears to be likely carpal tunnel syndrome.</td>
</tr>
<tr>
<td>12/4/2001</td>
<td>2</td>
<td>In Person</td>
<td>0</td>
<td>Non-Stroke</td>
<td>migraine headache, not likely subarachnoid hemorrh</td>
</tr>
<tr>
<td>12/4/2001</td>
<td>2</td>
<td>Telemetry</td>
<td>0</td>
<td>Non-Stroke</td>
<td>Benign headache</td>
</tr>
<tr>
<td>12/6/2001</td>
<td>3</td>
<td>In Person</td>
<td>0</td>
<td>Non-Stroke</td>
<td>r/o myasthenia gravis r/o GBS</td>
</tr>
<tr>
<td>12/6/2001</td>
<td>3</td>
<td>Telemetry</td>
<td>0</td>
<td>Non-Stroke</td>
<td>r/o GBS</td>
</tr>
<tr>
<td>12/18/2001</td>
<td>4</td>
<td>In Person</td>
<td>1</td>
<td>Stroke</td>
<td></td>
</tr>
<tr>
<td>12/18/2001</td>
<td>4</td>
<td>Telemetry</td>
<td>0</td>
<td>Stroke</td>
<td>This is most consistent with a TIA, NIHSS &lt;4.</td>
</tr>
<tr>
<td>1/9/2002</td>
<td>5</td>
<td>Telemetry</td>
<td>1</td>
<td>Stroke</td>
<td></td>
</tr>
<tr>
<td>1/17/2002</td>
<td>5</td>
<td>In Person</td>
<td>0</td>
<td>Non-Stroke</td>
<td>Muscle contraction headache</td>
</tr>
<tr>
<td>3/1/2002</td>
<td>6</td>
<td>In Person</td>
<td>3</td>
<td>Stroke</td>
<td>Could also be psychogenic, did coordinate very well, unlikely complicated migraine HA</td>
</tr>
</tbody>
</table>

**Statistical Analysis**

<table>
<thead>
<tr>
<th>Time in Minutes</th>
<th>Mean</th>
<th>Median</th>
<th>SD</th>
<th>SE</th>
<th>Range</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Time: In-Person</td>
<td>18.17</td>
<td>16.5</td>
<td>4.36</td>
<td>1.78</td>
<td>(16-21)</td>
<td>0.063</td>
</tr>
<tr>
<td>Total Time: Telemedicine</td>
<td>24.62</td>
<td>24.54</td>
<td>4.09</td>
<td>1.67</td>
<td>(20.22-31.45)</td>
<td>(In-Person vs. Telemedicine)</td>
</tr>
<tr>
<td>History Time: In-Person</td>
<td>6.67</td>
<td>6.5</td>
<td>1.37</td>
<td>0.56</td>
<td>(5-9)</td>
<td>0.563</td>
</tr>
<tr>
<td>History Time: Telemedicine</td>
<td>7.44</td>
<td>7</td>
<td>1.87</td>
<td>0.76</td>
<td>(4.5-9.42)</td>
<td>(In-Person vs. Telemedicine)</td>
</tr>
<tr>
<td>NIHSS Time: In-Person</td>
<td>8.5</td>
<td>7.5</td>
<td>2.74</td>
<td>1.12</td>
<td>(7-14)</td>
<td>0.031</td>
</tr>
<tr>
<td>NIHSS Time: Telemedicine</td>
<td>13.95</td>
<td>15.19</td>
<td>2.73</td>
<td>1.12</td>
<td>(10-16.7)</td>
<td>(In-Person vs. Telemedicine)</td>
</tr>
<tr>
<td>Brain CT-Time: In-Person</td>
<td>2.83</td>
<td>3</td>
<td>0.75</td>
<td>0.31</td>
<td>(2-4)</td>
<td>0.125*</td>
</tr>
<tr>
<td>Brain CT-Time: Telemedicine</td>
<td>3.07</td>
<td>2.27</td>
<td>2.11</td>
<td>0.86</td>
<td>(0.88-6.0)</td>
<td>0.313*</td>
</tr>
<tr>
<td>Brain CT-Time: Neuroradiologist</td>
<td>4.67</td>
<td>5</td>
<td>1.5</td>
<td>0.61</td>
<td>(3-6)</td>
<td></td>
</tr>
</tbody>
</table>

(*Neuroradiologist vs. In-Person/Telemedicine)
CONCLUSIONS

Conclusion

- Provide immediate, consistent and efficient stroke consultation (VTC & computerized standardized assessment tool).

- Reduce potential risk of medication errors, (IV rt-PA calculator).

- Tool to learn neurological stroke assessment skills, (residents).

- Protocol is easily transferable to an AMEDD wide urgent stroke care regimen.
- Save healthcare dollars while increasing access and quality of care.
- Benefit for US military medical system and remote areas with expert “telemedicine stroke consultations”.

Next Step
Where Should This Technology Go From Here?

- Plans with sustained funds to continue Phase II with probable remote site for Ft. Bragg, NC and National Naval Medical Center, MD.

- Testing of the Tele-Stroke study protocol in a rural area healthcare setting in the United States (and/or outside the US military medical system).

Infrastructure / Phase II

Total N for all sites = 40 (40 in-person & 40 Tele-consultations.)
N for each remote site = 8 (8 in-person & 8 Tele-consultations.)
N for WRAMC = 24 (24 in-person & 24 Tele-consultations.)
APPENDIX A: PRESENTATIONS, POSTERS, PUBLICATIONS