

12. CEREBROVASCULAR DISEASE

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12.2	Conditions Considered	
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	Related conditions considered in other chapters:	
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12.3	Introduction:	
	12.3.1 Increased life expectancy has led to a higher proportion of the population in the older age group. This in turn has increased the prevalence of cerebrovascular disease in the community. There are two main manifestations of cerebrovascular disease: stroke and dementia. Dementia is dealt with in Chapter 21. This chapter is concerned with strokes.	
12.4	Stroke, Cerebrovascular Accident (CVA)	
	12.4.1 Clinical Description/Features:	
	(i) A stroke is the popular term used for a cerebrovascular accident (CVA) which is an interruption of the blood supply to, or haemorrhage into, a part of the brain resulting in impaired function of the brain and nervous system. The part of the brain deprived of a blood supply will die and the resulting impairment of body function (ie. neurological deficit; see below) will remain.	
	(ii) The features of a stroke depend upon the site of damage to the brain. The	

most common site of brain damage results in **hemiplegia** (weakness or paralysis of part or all of one side of the body), **hemianaesthesia** (loss of sensation of part or all of one side of the body), and **hemianopia** (loss of vision to one or other side). Strokes affecting the right side of the body are commonly associated with **dysphasia** (difficulty with expressing and understanding language), and strokes affecting the left side are associated with perceptual problems (lack of awareness of the affected part of the body).

- (iii) Stroke affecting a part of the brain called the brain stem may produce **vertigo** (a disturbance of balance with sensations of movement or rotation), difficulty with speech, chewing and swallowing, weakness of the face, difficulty in controlling movements of the eyes, **ataxia** (unsteadiness and incoordination of movement) and nystagmus (fine rapid movements of the eyes).
- (iv) Stroke affecting the cerebellum causes, in the acute phase, incoordination, decreased muscle tone, and some loss of limb power. **Dysarthria** (difficulty with articulating speech), nystagmus, ataxia and disorders of gait, are possible long term effects.
- (v) Unless the stroke is so severe as to cause death within a few days a degree of recovery from the initial level of disability can be expected. One third will eventually make full recovery, one third will remain disabled to some extent, and the remaining third will remain severely disabled and dependent. Most of the recovery takes place within the first six months; no improvement of functional significance can be expected after one year. Recovery and the effectiveness of rehabilitation depend upon many factors including the size and site of the brain damage, the presence or absence of other disabling conditions (dementia, cardiac disease, lung disease, arthritis, mental illness, depression, blindness), motivation and the age of the disabled person.
- (vi) Some affected individuals are prone to series of repeated episodes which resolve within 24 hours (called transient ischaemic episodes) which may cause temporary paralysis, repeated episodes of unconsciousness or altered awareness, and difficulties with speech or other special senses.

12.5 Care Needs

- 12.5.1 Even when the upper limb remains without useful function the use of technical aids such as special cutlery and fastenings on clothes may enable the person to manage alone. If the stroke affects the dominant upper limb, full independence will be more difficult to achieve; however, any need for attention is likely to be restricted to short but necessary significant periods of help in relation to specific tasks such as dressing, washing, or cutting food.
- 12.5.2 Sensory inattention and dysphasia make communication very difficult and if these problems do develop a considerable amount of attention will be

required.

12.6 Mobility Considerations

12.6.1 A majority of younger people with stroke without other complications can be expected to achieve a considerable degree of independence. Most will learn to walk, although some will require the assistance of mechanical aids such as a walking frame, tripod or walking stick. These persons will usually be independently mobile within the house, but their capacity for walking out of doors may remain restricted in terms of distance and speed. Mobility may also be adversely affected by ataxia and gait disturbance in persons who have suffered cerebellar stroke.

12.7 Duration of Needs

12.7.1 Because rehabilitation after a stroke takes time, it may not be possible to make a decision about the long term needs for attention at the outset. In younger people whose condition has not yet stabilized, improvement may well continue for 1 year.

12.7.2 Older people, even when free from complicating conditions, are less likely to achieve independence. Clearly, there can be no sharp cut-off point; each case must be considered individually in the light of the evidence, but the older the person, the less likely will independence be achieved. In addition, older people are more likely to have other complicating conditions such as cardiac disease or dementia which may contribute to their attendance needs.

Where attention needs are present in persons aged over 70, they are likely to persist for life.

12.8 Further Evidence

12.8.1 Should there be any difficulty in assessing a particular case a factual report from an appropriate social worker, occupational therapist, physiotherapist or the GP is likely to help clarify the actual needs.