

## Appendix II: Evidence tables

**EVIDENCE TABLE:** *Treatment of depression*

Author, date, study design	Sample	Interventions	Conclusions
Lipsey et al, 1984 [68] Randomised controlled trial	39 in- or outpatients with stroke and depression	Nortriptyline vs placebo in 6-week trial	8 treated patients withdrawn with complications; reduced level of depression in group tolerating treatment SIGN level of evidence 1+
Andersen et al, 1994 [70] Randomised controlled trial	66 consecutive stroke patients with depression 2-52 weeks after stroke	6 weeks citalopram (10-20 mg/day) vs placebo	Reduced rate of depression in citalopram group SIGN level of evidence 1+
Wiert et al, 2000 [71] Randomised controlled trial	31 depressed patients in rehabilitation unit, within 3 months of stroke	Fluoxetine 20 mg vs placebo for 6 weeks	Greater improvement in depression scored. All measures were similar in both groups SIGN level of evidence 1+
Chemerinski et al, 2001 [152] Randomised controlled trial	23 depressed stroke patients with activities of daily living limitations	Nortriptyline vs placebo	Activities of daily living functioning improved in nortriptyline group SIGN level of evidence 1-
Robinson et al, 2000 [67] Randomised controlled trial	56 depressed/rehabilitation stroke in-patients	Nortriptyline (100 mg/day) vs fluoxetine (40 mg/day) vs placebo for 12 weeks	Nortriptyline had greater response rate than placebo or fluoxetine for depression symptoms SIGN level of evidence 1-
Raffaele et al, 1996 [153] Randomised controlled trial	22 acute stroke patients	Trazodone 300 mg daily or placebo	Barthel activities of daily living index improved with trazodone in patients with abnormal dexamethasone suppression test SIGN level of evidence 1-
Lauritzen et al, 1994 [154] Randomised controlled trial	20 depressed stroke patients	Imipramine and mianserin vs desipramine and mianserin for 6 weeks	Imipramine and mianserin better combination SIGN level of evidence 1-
Fruehwald et al, 2003 [155] Randomised controlled trial with open-label extension	54 consecutive depressed inpatients within 2 weeks of acute stroke	Fluoxetine 20 mg daily vs placebo for 14 weeks, followed by open-label treatment for 18 months	No significant benefit from fluoxetine in randomised controlled trial. Open-label extension showed less depression in fluoxetine group SIGN level of evidence 1- (open-label extension 2-)
Kotila et al, 1998 [72] Cohort controlled trial	594 patients with first-ever stroke	2 districts with active rehabilitation programme after discharge, and social group activities compared with 2 districts without either of the above	Prevalence of depression at 3 and 6 months lower in districts with active rehabilitation programme. Content of programmes not detailed SIGN level of evidence 2-

**EVIDENCE TABLE: Prevention of depression by prophylactic antidepressants**

Author, date, study design	Sample	Interventions	Conclusions
Palomaki et al, 1999 [76] Randomised controlled trial	100 consecutive acute stroke patients aged < 71 years	Mianserin 60 mg daily, or placebo; to prevent depression. Duration 12 months, seen at 2, 6, 12, 18 months	No difference in depression, or activities of daily living independence; low rate of depression (6–16%). Routine mianserin not included SIGN level of evidence 1+
Dam et al, 1996 [69] Randomised controlled trial	52 patients 1–6 months post stroke; unable to walk	Fluoxetine, maprotiline or placebo for 3 months	Fluoxetine associated with better functional outcome. Depression symptoms in 6 on maprotiline and fluoxetine groups SIGN level of evidence 1–
Reding et al, 1986 [77] Randomised controlled trial	27 inpatients in stroke rehabilitation unit	Trazodone vs placebo; variable treatment duration, average 32 days	Non-significant trend for Barthel activities of daily living scores to improve more on trazodone. Depression outcomes not reported SIGN level of evidence 1–
Robinson et al, 2000 [67] Randomised controlled trial	48 non-depressed stroke rehabilitation inpatients	Nortriptyline (100 mg) vs fluoxetine (40 mg) vs placebo for 12 weeks	Neither active drug improved mood or level of recovery and functioning SIGN level of evidence 1–
Narushima et al, 2002 [75] Randomised controlled trial	48 stroke patients	Nortriptyline vs fluoxetine vs placebo for 12 weeks	Both active groups had lower incidence of depression while on treatment SIGN level of evidence 1–
Grade et al, 1998 [156] Randomised controlled trial	21 consecutive stroke rehabilitation patients	Methylphenidate vs placebo for 3 weeks	Treated group had less depression symptoms and better activities of daily living scores but there were differences in baseline mood and activities of daily living scores SIGN level of evidence 1–

**EVIDENCE TABLE: Information giving and education for people with stroke and caregivers**

Author, date, study design	Sample	Interventions	Conclusions
Forster & Young 1996 [107] Randomised controlled trial	240 patients at home after stroke	Specialist nurse visits (6+ over 6 months) or normal services alone	No beneficial effect on patients' disability, social activities, or mood; or caregiver stress SIGN level of evidence 1+
Dennis et al, 1997 [108] Randomised controlled trial	417 patients 30 days post stroke	Family care worker or standard care	Family care worker group more satisfied, but possible increase in patient helplessness; no other differences detected SIGN level of evidence 1+
Evans et al, 1988 [100] Randomised controlled trial	206 rehabilitation stroke patients and their caregivers	Nothing, education, or education and counselling sessions for caregivers soon after stroke	Education and counselling resulted in better knowledge, more effective problem solving and adjustment at 12 months SIGN level of evidence 1-
Friedland & McColl, 1992 [157] Randomised controlled trial	88 stroke patients at home after rehabilitation	Special social support intervention, or nil (normal service)	No difference in the type (and extent of use) of supports or in psychosocial function (general health questionnaire, sickness impact profile) SIGN level of evidence 1-
Lomer & McLellan 1987 [93] Randomised controlled trial	48 patients and 44 relatives after admission for stroke	Information leaflet on stroke	Showed increased knowledge about stroke illness, treatment and prognosis. No effect on knowledge of services. Poor recall of receiving information in 33% SIGN level of evidence 1-
Pain & McLellan 1990 [158] Randomised controlled trial	36 recently discharged stroke patients	Personalised information booklet	No difference in social activities or physical functioning SIGN level of evidence 1-
Mant et al, 1998 [101] Randomised controlled trial	71 acute stroke patients and their caregivers	Information pack for patients and caregivers after stroke	Showed better knowledge; no differences in satisfaction with or use of services; no differences in mood or quality of life SIGN level of evidence 1-
Rogers et al, 1999 [99] Randomised controlled trial	204 stroke patients and 176 caregivers	Interactive stroke education programme (6 x 1hr sessions)	No difference in patient or caregiver quality of life (Shortform 36 questionnaire) but patients more satisfied with information received SIGN level of evidence 1-
Mant, 2000 [109] Randomised controlled trial	323 patients and 267 caregivers	Family support worker or standard care (mean of 5 contacts in 6 months)	Family support increased social activities (Frenchay Activity Index) and quality of life for caregivers, but had no benefit for patients SIGN level of evidence 1-
Goldberg et al, 1997 [116] Randomised controlled trial	55 recently discharged stroke patients	Case management focusing on information, psychosocial needs and assistance with problem solving	No significant improvement in psychosocial or quality-of-life outcomes SIGN level of evidence 1-
O'Mahoney et al, 1997 [89] Observational study	76 community stroke patients	Assessment of satisfaction with information and advice given	More advice and/or better means of giving advice and information needed, particularly for psychological and relationship issues SIGN level of evidence 2+

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*Information giving and education for people with stroke and caregivers (cont.)*

Author, date, study design	Sample	Interventions	Conclusions
Van der Smagt-Duijnsteet al, 2001 [84] Observational study	106 relatives of hospitalised stroke patients	Assess the needs of relatives	Relatives' needs are in 3 main areas: information, counselling, and accessibility of staff SIGN level of evidence 2-
Dowswell et al, 2000 [95] Qualitative	101 recently discharged stroke patients	Qualitative assessment of specialist nurse visits	Education needs of patients are complex, diverse and change over time SIGN level of evidence 3+
Hanger & Mulley, 1993 [90] Observational study	1397 people who telephoned stroke advice centres	Assess information needs	Information needs diverse, including basic information about strokes, communication difficulties, rehabilitation and community supports SIGN level of evidence 3
Hanger et al, 1998 [96] Observational study	215 stroke patients and their caregivers	Assess information needs over time	Information needs change over time, with psychological issues more prominent at 6 and 24 months SIGN level of evidence 3
Wellwood et al, 1994 [86] Observational study	164 acute stroke patients	Assess level of knowledge of stroke	Most patients and caregivers want more information/discussion during hospital stay. Needs of patients and caregivers may differ SIGN level of evidence 3
Evans & Held, 1984 [104] Own historical control	43 stroke rehabilitation patients	Stroke education classes (1 hr/wk) with interaction	Patients reported less anxiety and better knowledge immediately after intervention SIGN level of evidence 3
Clark & Smith, 1998 [159] Observational study	60 stroke patients in rehabilitation unit	Multivariate analysis of factors relating to satisfaction with progress	More satisfaction with service associated with more information about stroke and services SIGN level of evidence 3

**EVIDENCE TABLE: Leisure/recreation after stroke**

Author, date, study design	Sample	Interventions	Conclusions
Forster & Young, 1996 [107] Randomised controlled trial	240 patients at home after stroke	Specialist nurse visits (6+ over 6 months) or normal services alone	No beneficial effect on patients' disability, social activities, or mood; or caregiver stress SIGN level of evidence 1+
Dennis et al, 1997 [108] Randomised controlled trial	417 patients 30 days post stroke	Family care worker or standard care	Family care worker group more satisfied; but possible increase in patient helplessness; no other differences detected SIGN level of evidence 1+
Parker et al, 2001 [120] Multicentre randomised controlled trial	466 recently discharged stroke patients	Occupational therapy for leisure or conventional occupational therapy	No benefit of leisure-based therapy found SIGN level of evidence 1+
Walker et al, 1999, 2001 [118, 160] Randomised controlled trial	185 acute stroke patients not admitted to hospital	Occupational therapy at home to improve personal and extended activities of daily living	Beneficial effect on extended activities of daily living at 6 and 12 months SIGN levels of evidence 1- [118], 1+ [160]
Mant et al, 2000 [109] Randomised controlled trial	323 patients and 267 caregivers	Family support worker or standard care (mean of 5 contacts in 6 months)	Family support increased social activities (Frenchay Activity Index) and quality of life for caregivers, but had no benefit for patients SIGN level of evidence 1-
Goldberg et al, 1997 [116] Randomised controlled trial	55 stroke patients recently discharged	Case management focusing on information, psychosocial needs and assistance with problem solving	No significant improvement in psychosocial or quality-of-life outcomes SIGN level of evidence 1-
Drummond & Walker, 1995 [119] Randomised controlled trial	65 recently discharged stroke patients	Occupational therapy for leisure or conventional occupational therapy vs no additional input	Frequency of leisure participation increased in occupational therapy leisure group SIGN level of evidence 1-
Logan et al, 1997 [122] Randomised controlled trial	111 recently discharged stroke patients	Enhanced occupational therapy vs conventional occupational therapy	Early benefit in extended activities of daily living which did not persist SIGN level of evidence 1-
Jongbloed & Morgan, 1991 [123] Randomised controlled trial	40 recently discharged stroke patients	Leisure-focused occupational therapy vs environmental occupational therapy	No benefit of leisure therapy SIGN level of evidence 1-
Gilbertson et al, 2000 [124] Randomised controlled trial	138 recently discharged stroke patients	Occupational therapy (10 visits) focusing on activities of daily living and leisure vs conventional care (no occupational therapy follow-up)	Improved extended activities of daily living at 8 weeks but did not persist at 6 months SIGN level of evidence 1-
Corr & Bayer, 1995 [117] Randomised controlled trial	110 recently discharged stroke patients	Occupational therapy for 6 months (4 visits) vs no occupational therapy	No significant benefit in leisure or extended activities of daily living found SIGN level of evidence 1-

(cont.)

*Leisure/recreation after stroke (cont.)*

Author, date, study design	Sample	Interventions	Conclusions
Hackett et al, 2000 [115] Case control	639 stroke survivors at 6 years	Assess long-term impact of stroke on quality of life	Social functioning of survivors was lower than in age/gender-matched population controls, but no different to case controls, despite increased dependency SIGN level of evidence 2++
Anderson et al, 1995 [112] Observational study	241 caregivers of community stroke patients	Assess impact of stroke on leisure, social activities and emotional health	Leisure and social activities severely restricted for caregivers one year after stroke SIGN level of evidence 2+
Feibel & Springer, 1982 [114] Observational study	91 hospitalised stroke patients	Assess relationship of depression to leisure/social activities	Depressed patients had significantly more restricted leisure activities than non-depressed patients SIGN level of evidence 2-
Dijkerman et al, 1996 [111] Own historical controls	57 recently discharged stroke patients	Compare leisure/social activities before and after stroke	Frequency of leisure reduced after stroke. Outdoor activities more severely affected than indoor activities SIGN level of evidence 2-
Greveson & James, 1991 [94] Observational study	62 stroke survivors at 3 years	Assess impact of stroke on leisure and social activities	Leisure and social activities severely restricted. Only 16% had any leisure activities or hobbies SIGN level of evidence 2-

**EVIDENCE TABLE: Predictors of safe driving after stroke**

Author, date, study design, sample	Interventions	Outcomes	Conclusions
Mazer et al, 2003 [161] Randomised controlled trial 97 people referred for driving evaluation following stroke	Visual attention retraining programme using 'useful field of view' versus traditional visuoperceptual training programme	No difference overall People with right-hemisphere brain lesions had more success with on-road driving test after ?novel intervention	Possible that specific targeting of right-hemisphere lesions could improve on-road results SIGN level of evidence 1-
Akinwuntan et al, 2002 [144] Retrospective study of a 2-year predriving evaluation 104 participants	Predriving assessments: Neurological examination Visual tests Neuropsychological tests Road test Team decision and performance of on-road test	41 (39.4%) found suitable to drive 45 (43.5%) not immediately suitable 18 (17.3%) not suitable  Neuropsychological tests (scanning mean reaction time, figure of Rey and visual neglect) most important indicators of road test  Road test most important determinant of group decision	Predictive accuracy of team decision limited, road test even lower  More real-road-related tests necessary SIGN level of evidence 2+
Klavora et al, 2000 [145] Comparison of two off-road assessment batteries with on-road outcome 56 people aged 44-82 years, 6 months or more after stroke	Dynavision Performance Assessment Battery (DPAD) Cognitive Behavioural Driver's Inventory (CBDI) On-road testing	A 4-minute endurance subtest from the DPAD superior to the CBDI in predicting success/failure of on-road test  Those that passed both the endurance test and the CBDI also passed the road test	Age not a predictor These off-road tests provided reasonable prediction for the outcome of the on-road test SIGN level of evidence 2-
Mazer et al, 1998 [146] Evaluation of ability of perceptual tests to predict on-road driving outcome after stroke 84 people approximately 4.5 months post stroke	Battery of perceptual tests (8 in all) then on-road test (occupational therapist plus driving assessor)	The Motor Free Visual Perception Test (MVPT) [162] was the best single predictor, and combination with the Trail Making B test [163] proved the best overall predictor	Off-road screening for perceptual deficit is useful in predicting those not ready for on-road testing after stroke SIGN level of evidence 2-