Health Report

To Bishop Jeffrey N. Leath, General Officers, Connectional Officers, Host Presiding Elder, Reverend Linda Thomas Martin, Co-Host Presiding Elder, Reverend C. Robert Finch, Pastors, Ordained clergy, Episcopal Supervisor Dr. Susan Leath, Lay Delegates, Missionaries and Youth of this 143rd Session of the West Tennessee Annual Conference in the Thirteenth Episcopal District of the African Methodist Episcopal Church, I present this health report.

Stroke ranks among the top 5 causes of death in the US. African Americans are 50% more likely than Caucasians to experience stroke and twice as likely to die from stroke. Also, African Americans have a greater chance of disability, limiting participation in everyday activities.

Recent research shows that after 4 decades of decline, stroke deaths are declining more slowly, stalled or even reversed among some populations (African Americans, Hispanics, Southern US residents). Between 2013-15, an estimated 32,000 excess stroke deaths might have occurred because of this decreased decline. About 1/3 of these deaths occurred among patients from ages 35-64.

Several reasons exist for the above-mentioned findings, especially among African Americans. African Americans have more risk factors, including (a) high blood pressure (higher blood pressure measurements and earlier age of diagnosis), (b) diabetes, (c) coronary artery disease, (d) obesity (which contributes to the previously-mentioned risk factors as well as stroke), (e) atrial fibrillation, (f) sickle cell disease (especially in children). In addition, lower socioeconomic status limits access to healthier foods and to regular medical care (because of un- or under-insured state and fewer neighborhood clinics).

Strokes are divided into two classes. The vast majority are ischemic, in which a blood vessel to the brain is blocked by a clot, causing damage to that particular part of the brain. Hemorrhagic strokes are much less common; these are caused by a ruptured aneurysm or a leak in a weakened blood vessel.

Symptoms of stroke are often described by the acronym FAST: **F**acial weakness or droop, **A**rm weakness or droop, **S**peech difficulty, **T**ime to call 911. Other symptoms include sudden confusion, sudden severe headache, visual changes, and difficulty with walking, balance or coordination.

We need to recognize these symptoms because time is crucial in treatment of strokes. Quicker activation of Emergency Medical Services and transport to a

Primary Stroke Center determines whether thrombolytics (“clot-busting drugs”) can be given for ischemic strokes. Hemorrhagic strokes are treated with methods which stop bleeding, such as coiling of aneurysms.

Other treatments include medications—oral “blood thinners” (antiplatelet and anticoagulant medications) and cholesterol-lowering medications. Risk factor reduction is of utmost importance, for example, reducing blood pressure and blood sugar, weight reduction and smoking cessation. Therapy is also employed—physical and occupational therapy to improve strength of weakened limbs, and speech therapy to improve speech and swallowing ability.

Side effects might persist even if early treatment is given, and include paralysis of one side of the body, vision or speech difficulty, seizures, memory loss or difficulty swallowing.

Recovery from stroke is slow and unpredictable, and family involvement is essential. Stroke survivors should be allowed to participate in activities to the extent that they are able; however, family members must also be aware of limitations. Caretakers must also recognize effects which may be delayed, such as depression or memory loss. Caretakers also need to recognize that they themselves might become overwhelmed and take advantage of services such as sitters, adult day care, respite care, or even facility placement.

Stroke is expensive, costing hundreds of thousands of dollars per patient. Survivors are often unable to work and, as a consequence, might be unable to afford medications. Those who can work might not be able to obtain health insurance.

Studies have shown that patients are often unaware of how risk factors contribute and might not recognize symptoms of stroke. How can we increase awareness, and therefore improve chances of recovery and survival? Informal settings such as beauty and barber shops, community centers and churches can participate; for example, beauticians in Atlanta and Cincinnati were educated about stroke and were able to pass this information along to customers. We need to continue surveillance of stroke and identification of disparities in specific risk factors, so that targeted interventions can be implemented.