SPIRIT Chat

09:24:22 From Richa Sharma: Dear audience, please feel free to type questions for the speakers in the chat. We will request the speakers to respond at the end of their talk. Thank you.

09:29:44 From Kevin Sheth: I am curious about the specificity of the potential for the intervention to work on the arm vs the hand/fingers (not that they are mutually exclusive of course). And does that influence the choice of outcome measure.

09:30:08 From Maarten Lansberg: Amazing achievement Warren and Sharron on pulling of such a challenging trial! Fantastic enrollment. At 12 months what is your control group? Do the usual care kids have already had the opportunity to undergo CIMT?

09:33:26 From Karen Furie: Can you project what the child in the video would look like functionally by the time he is school age? Would there be any further spontaneous recovery in later childhood?

09:50:33 From Richa Sharma: Was the trial powered for both cardiovascular event and recovery outcomes?

10:09:33 From Karen Furie: The requirement for consent in English creates a barrier for user-represented non-English speaking groups. How can this be overcome?

10:12:28 From Shadi Yaghi: Thank you, Marteen! You bring up a great point about the consent process of ancillary studies. What is the barrier of having the ARCADIA CSI consent included in the ARCADIA consent?

10:18:44 From Maarten Lansberg: Regarding the consent process, it is my understanding that the ancillary study is seen as a separate study and that therefore a separate consent is required.

10:20:35 From Walter Kernan: Ron: is cognition a possible outcome for trials intended to gather preliminary data for novel therapies for secondary stroke prevention? if so, how many patients are needed to show typical treatment effect.

10:35:49 From Elizabeth Perelstein: Does this scope include the Deaf community?

11:15:12 From Kevin Sheth: Most of our stroke prevention trials in the past have enrolled patients with very mild or no disability (perhaps because of epi and also maybe because of other biases). Based on NIH definition of diversity, should we do more to consider stroke patients with disability?

11:16:21 From Adam de Havenon: This has been an eye opening talk, thank you. The 5% funded rate for R01s in underrepresented groups is very troubling. The NOSI mechanism and the others you described seem like terrific ideas. With these changes and the focus on career development, what do you think/hope the R01 rate will be in 5-10 years?

11:18:18 From Tracy Madsen: Thank you, that was excellent!

11:18:21 From Charles Wira: Thank you Dr. Benson for your outstanding talk!
From Shadi Yaghi: Thank you very much Dr. Benson. Outstanding talk!

From Elizabeth Perelstein: It was answered later in the presentation, thank you though.

From Tracy Madsen: Given ongoing disparities in stroke mortality, how does funding for surveillance studies evaluating ongoing race based disparities fit into the NINDS mission?

From Tracy Madsen: Thank you!

From Shadi Yaghi: Thank you Dr. Broderick for this excellent overview. Do you anticipate that the platform trial design will be used for prevention and recovery trials as well?

From Richard Benson: Richard.Benson@NIH.gov

From Mike Reznik: Thank you for your insights... my research focuses on delirium and acute cognitive issues in patients with stroke, as well as the downstream impact on functional and cognitive outcomes. Thus far I’ve been submitting my proposals to NIA given their interest in delirium, VCID, and other relevant topics. However, is this potentially an area of interest for NINDS as well?

From Mike Reznik: thank you!

From Hooman Kamel: I second that Ope!

From Kevin Sheth: I am listening to this and thinking just one word: persistence. Wow!

From Amre Mohamed Nouh: Thank you, Well done!

From Kevin Sheth: For each of your approaches, is the idea to:

From Kevin Sheth: 1. Identify patients at higher risk?

From Kevin Sheth: 2. Or patients that may be more likely to benefit from mechanical intervention vs medical therapy?