Neurodegeneration

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Review

Prevalence of dementia in ischaemic or mixed stroke populations: systematic review and meta-analysis

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ABSTRACT

An understanding of the epidemiology of poststroke dementia (PSD) is necessary to inform research, practice and policy. With increasing primary studies, a contemporary review of PSD could allow for analyses of incidence and prevalence trends. Databases were searched using a prespecified search strategy. Eligible studies described an ischaemic or mixed stroke cohort with prospective clinical assessment for dementia. Pooling prevalence of dementia was calculated using random-effects models at any time after stroke (primary outcome) and at 1 year (range: 6–18 months), stratified for inclusion of prestroke dementia. Meta-regression explored the effect of year of study. Sensitivity analyses removed low-quality or outlier studies. Of 12,505 titles assessed, 44 studies were included in the quantitative analyses. At any time point after stroke, the prevalence of PSD was 16.5% (95% CI 10.4% to 25.1%) excluding prestroke dementia and 22.3% (95% CI 18.8% to 26.2%) including prestroke dementia. At 1 year, the prevalence of PSD was 18.4% (95% CI 7.4% to 38.7%) and 20.4% (95% CI 14.2% to 28.2%) with prestroke dementia included. In studies including prestroke dementia there was a negative association between dementia prevalence and year of study (slope coefficient =−0.05 (SD: 0.01), p<0.0001). Estimates were robust to sensitivity analyses. Dementia is common following stroke. At any point following stroke, more than one in five people will have dementia, although a proportion of this dementia predates the stroke. Declining prevalence of prestroke dementia may explain apparent reduction in PSD over time. Risk of dementia following stroke remains substantial and front-loaded, with high prevalence at 1 year post event.

INTRODUCTION

Improving our knowledge of the neuropsychological effects of stroke is of increasing international interest. The 2011 James Lind Alliance, a UK priority setting workshop, identified managing cognitive issues as the most important topic for stroke research.1 There is agreement that cognitive problems after stroke are substantial; however, the rates reported vary widely between studies. Previous research has suggested that a history of stroke almost doubles the risk of dementia in the population aged over 65 years.3 The comparison and interpretation of these studies are challenging due to differences in study design, that is, duration of follow-up timeframes and the casemix of patients included, for example, combining studies with an intracerebral haemorrhage focus with ischaemic stroke.

A key meta-analysis conducted in 2009 reported that around 10% of patients had dementia prior to stroke, 10% developed stroke soon after the first stroke and over 30% developed dementia after recurrent stroke.3 These review data have since been used to inform policy4 5 and have informed sample size calculations for studies using poststroke dementia (PSD) as the outcome.6 Many studies included in this review are now decades old. In the context of temporal change in dementia prevalence, a new analysis that includes contemporary data seems warranted. The last decade has seen increasing recognition of the importance of PSD with various primary studies on the topic. A contemporary review may offer an estimate of PSD prevalence with greater precision than previous reviews7 8 and would allow for incorporation of risk of bias assessment and framing the certainty of summary results using the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) system.

A consensus approach to PSD diagnosis has been proposed, with recent descriptions from various expert groups describing incident dementia with a temporal relationship to stroke.4 9 PSD is part of the spectrum of poststroke cognitive impairment. While PSD has an operationalised definition, variation in definitions and classifications is an issue for other syndromes included in the poststroke cognitive impairment rubric. Limiting a review to PSD allows for a more defined population. Arguably a review that tries to pool data on PSD and milder forms of cognitive impairment risks such heterogeneity that any estimates of prevalence become unhelpful.

An increasingly ageing population coupled with a decline in mortality after stroke10 means that PSD may become more prevalent particularly since the risk of stroke and dementia rises exponentially with age.10 11 Although there are indications of declining incidence of stroke and dementia in developed countries, this may not be the case for developing countries.12 Information on PSD prevalence would be useful to provide estimates to design appropriate services to manage the burden of PSD.13 As the population prevalence of PSD may show temporal variation, an analysis would allow for exploration of temporal trends.

Therefore, the primary aim of this study was to collate the available evidence to provide a pooled
prevalence of dementia after ischaemic or mixed stroke. Our secondary aims were to explore subgroups of interest, to assess the effects of study quality and to explore potential heterogeneity in terms of time since stroke, presence of prestroke dementia, recurrent stroke, setting and year of study.

METHODS
This review was conducted in adherence with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines
(online supplemental files 2 and 3). We used a validated search strategy from an existing review for our primary search. We adapted the search strategy to the focus of our review, limiting to studies of PSD only. We included primary studies published in peer-reviewed journals that included people who had ischaemic stroke, transient ischaemic attack or undifferentiated stroke cohorts and reported quantitative data on the occurrence of PSD at any time point after the stroke event. We accepted any clinical diagnostic assessment, provided it was based on a recognised classification, for example, the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD). No restrictions were placed on country, written language or year of publication.

We excluded studies where the primary population of interest was exclusively intracerebral haemorrhage, subarachnoid haemorrhage or traumatic brain injury as all these groups have distinct cognitive recovery profiles. The following types of studies were also excluded: case studies with too few patients to gain reliable conclusions (less than 20 patients); case–control studies and randomised control trials, as they would not give representative population data; and studies that did not use a recognised clinical classification criterion, for example, the use of a single screening tool such as the Mini Mental State Examination or the Montreal Cognitive Assessment without an accompanying clinical diagnostic assessment. Abstracts, letters, editorial comments and commentaries were also excluded.

Search methods for identification of studies
Our search syntax used a combination of exploded medical subject headings ‘dementia’ or ‘vascular dementia’ or ‘multi-infarct dementia’ and ‘stroke’. We searched MEDLINE (OVID) and EMBASE (OVID) electronic databases from 2008 (to capture any in press papers that may have been missed in the 2009 search) to July 2019 and conducted forward and backward citation searching of included studies. To identify earlier studies, we assessed the inclusion and exclusion criteria of the previous review. We reassessed all studies against our revised inclusion and exclusion criteria. We also hand-searched the following journals for relevant articles published between January 2009 and July 2019: Stroke (American Heart Association), International Journal of Stroke (World Stroke Organization) and European Stroke Journal (European Stroke Organisation). If relevant abstracts were identified but the papers were not available, we contacted the author regarding publication status. Similarly, where relevant data were not available in the published manuscript, we contacted the study authors. As a validation exercise, we cross-checked our selected titles with other reviews that have a stroke cognition focus and no new titles were found.

Selection process and data extraction
All aspects of the selection process were completed by two reviewers (ZLH, TZY). Reviewers were blind to each other’s data extraction; data were compared and discrepancies resolved with access to a third arbitrator (TJQ) as required. We extracted data from eligible papers using a prespecified and piloted proforma, based on the Cochrane data extraction tool and designed to be harmonised with the original study. We collected data on prevalence of dementia (proportion, with corresponding measure of uncertainty), details of the cohort and the methods used to ascertain stroke and dementia status. Where the time point of assessing PSD was not reported, an assumption was derived using the reported dates of cohort inception and the date of paper publication (online supplemental S1,S2).

Data analysis
The primary outcome for the analysis was prevalence of PSD at any time post stroke, stratified by inclusion or exclusion prestroke dementia. The secondary outcomes were prevalence of PSD at 1 year (allowing for studies with relevant data within a 6–18 months range), stratified by inclusion and/or exclusion of prestroke dementia, and prevalence of prestroke dementia, noting whether prestroke dementia was measured at the time of stroke or only in those patients who survived to follow-up assessment. We calculated point estimates with 95% CI for all these analyses. Study heterogeneity was expected so we used random-effect models throughout.

Subgroup analysis
We explored heterogeneity across a series of predefined subgroups of interest: stroke type, which included three levels: first-ever stroke (FES), recurring stroke (RS) or mixed population (cohorts which consisted of both FES and RS populations, yet prevalence data were not reported separately for each population); setting (hospital-based or community-based study); contemporary (published within the previous 10 years) or historical (published more than 10 years ago); and the country’s level of income using the WHO classification (high-income or middle-income or low-income country). These subgroup analyses were conducted for the primary outcome and limited to stroke type for the secondary outcome. Data on PSD were pooled at the following time points: baseline to 3 months, 6 months, 12–18 months, 2–5 years and ≥ 6 years. Due to availability of data, the denominators used for the subgroup analyses were those reported for the inception cohort and therefore may vary from the denominators used in the main analysis which were subject to attrition (online supplemental S3–S5).

Sensitivity analysis
We removed studies considered to be outliers from the meta-analysis to examine the effect on the pooled prevalence. Outliers were identified if the study’s CI did not overlap with the CI of the pooled effect. If the analysis is robust then there should be minimal change in the pooled estimate. We further performed sensitivity analysis restricting to those studies judged as low or moderate quality.

Meta-regression analysis
To explore any temporal change in PSD prevalence, we performed a meta-regression of dementia prevalence at any timeframe against the year of study recruitment. Where a cohort was recruited over a longer time period than 1 year, we used the study midpoint. We used Spearman’s correlation to test the association between study quality (ordinal sum of risk of bias assessment) and the year of study recruitment. All quantitative analyses were performed using Comprehensive Meta-Analysis V2.2 (USA) and Statistical Package for the Social Sciences (SPSS) V26.
Quality of assessment

We appraised the methodological quality and level of bias using the Newcastle-Ottawa Scale (NOS) for observational studies. We assessed individual studies including those in the original study using seven relevant items, classified into three categories: the selection of the study groups, the comparability of the groups and the ascertainment of outcome of interest for cohort studies (online supplemental file 3). Points were awarded for each quality item, and the highest quality studies were awarded up to 8 points. No formal cut-offs exist to define low or high risk of bias with the NOS. Therefore, we used cut-offs previously described to form the basis of our scoring system and to pair the score with traffic light coding. Studies with 0–2, 3–5 and 6–8 points represented low, moderate and high quality, respectively. Findings from quality assessment informed a sensitivity analysis limited to studies of high quality.

Publication bias

Publication bias was assessed by visual inspection of the funnel plots and complemented with statistical testing using Egger’s weighted regression and Begg’s rank correlation test. P<0.05 was considered to be suggestive of statistically significant publication bias.

Strength of evidence

An assessment of overall strength of evidence based on the GRADE framework, modified to be suitable for an observational epidemiology question, was performed. Risk of bias, consistency of results (heterogeneity), directness (applicability of included studies to research question), precision (based on CIs of summary estimate) and publication bias (funnel plot) were all assessed.

RESULTS

The search identified 12,505 articles. After deduplication and screening of titles and abstracts, 128 full-text articles were assessed (figure 1). Data were extracted from 27 studies that meet the eligibility criteria and were included in the review (online supplemental S1–S27). Fifteen studies from the 17 papers included in the previous meta-analysis for PSD prevalence were also included (online supplemental S28–S41, S44). Two studies

![Figure 1: PRISMA search flow. PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses.](http://jnnp.bmj.com/)

were excluded due to the method of diagnosis, one study used a screening tool only (online supplemental S43) and the other study, although included in the prestroke analysis, used medical records to identify patients with dementia after stroke (online supplemental S42).

**Study characteristics**

The review included 44 studies conducted in the following countries: Africa (n=5), Europe (n=16), Americas (n=7), Asia (n=15) and Australasia (n=1). The sample sizes ranged from 50 to 215,118. The period of follow-up ranged from 3 months to 25 years, with 3 months the modal follow-up time point (n=18). The average age of participants ranged from 56 years to 79.9 years. Most studies used the DSM IV (n=16) (online supplemental S4, S6–S10, S17, S20, S21, S25, S26, S28, S29, S31, S33–S35, S37, S40, S41) or the ICD-10 criteria (n=8) (online supplemental S11, S12, S14, S15, S22, S27, S34, S35). Online supplemental S1 details the characteristics of the included studies.

**PSD prevalence (excluding prestroke dementia): all timeframes**

Data on the prevalence of PSD excluding prestroke dementia regardless of timeframe were available for 24 hospital-based studies (online supplemental S4, S5, S7, S9, S10, S13, S14, S16–S18, S20–S23, S25, S26, S28, S29, S31, S33–S35, S37, S44) and for 9 population-based studies (online supplemental S1, S2, S6, S11, S12, S15, S19, S24, S36). The reported prevalence of PSD excluding prestroke dementia in the individual studies ranged from 2.6% to 39.2%. Based on the 33 studies included in the meta-analysis, the pooled prevalence was 16.5% (95% CI 10.4% to 25.1%). There were no statistically significant subgroup differences detected (table 1).

### Table 1 Prevalence of poststroke dementia: results of the subgroup analysis (all timeframes)

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<th>Subgroup (studies, n)</th>
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<td>24.0 (20.6 to 27.8), n=15</td>
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<td>Population-based</td>
<td>11.1 (6.3 to 18.7), n=2</td>
<td>12.4 (4.9 to 28.2), n=9</td>
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<td>First-ever stroke</td>
<td>18.1 (13.3 to 24.0), n=5</td>
<td>14.3 (8.3 to 24.0), n=19</td>
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<td>Mixed population</td>
<td>23.8 (20.3 to 27.6), n=15</td>
<td>19.7 (10.6 to 33.6), n=14</td>
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<tr>
<td></td>
<td>P=0.000</td>
<td>P=0.270</td>
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<td>Year of publication</td>
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<td>27.1 (23.7 to 30.7), n=11</td>
<td>19.1 (8.9 to 36.3), n=10</td>
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<td>Contemporary</td>
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<td></td>
<td>P=0.002</td>
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<tr>
<td>Level of income</td>
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<tr>
<td>High</td>
<td>25.4 (21.2 to 30.0), n=11</td>
<td>12.8 (6.9 to 22.7), n=19</td>
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<tr>
<td>High-middle</td>
<td>23.5 (15.3 to 34.5), n=2</td>
<td>19.8 (7.3 to 43.7), n=7</td>
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<td>Low-middle</td>
<td>14.9 (9.3 to 22.9), n=3</td>
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<tr>
<td>Low</td>
<td>10.0 (4.6 to 20.5), n=1</td>
<td>No studies</td>
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<td></td>
<td>P=0.014</td>
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</table>

*The same study can appear in both inclusion and exclusion of prestroke dementia. Inclusion/exclusion prestroke dementia categories are not mutually exclusive.

### Table 2 Prevalence of poststroke dementia: results of the subgroup analysis (1 year)

<table>
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<tr>
<th>Subgroup (studies, n)</th>
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<th>Excluding prestroke dementia</th>
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<tr>
<td>Stroke type*</td>
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<tr>
<td>Recurrent stroke</td>
<td>33.4 (9.3 to 70.9), n=7</td>
<td>23.5 (12.7 to 39.1), n=1</td>
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<tr>
<td>First-ever stroke</td>
<td>117.7 (6.1 to 41.9), n=11</td>
<td>1.0 (6.7 to 17.5), n=2</td>
</tr>
<tr>
<td>Mixed population</td>
<td>28.6 (23.5 to 34.2), n=5</td>
<td>20.4 (41.4 to 60.4), n=5</td>
</tr>
<tr>
<td></td>
<td>P=0.000</td>
<td>P=0.702</td>
</tr>
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</table>

**PSD prevalence (including prestroke dementia): all timeframes**

Data on the prevalence of PSD including prestroke dementia regardless of timeframe were available for 14 hospital-based studies (online supplemental S7, S8, S18, S21, S23, S28, S30–S32, S34, S37, S38, S40, S44) and for 2 population-based studies (online supplemental S3 and S39). The reported prevalence of PSD including prestroke dementia in the individual studies ranged from 8.4% to 41.5%. Based on the 17 studies including prestroke dementia, the pooled prevalence was 22.3% (95% CI 18.8% to 26.2%). Statistically significant subgroup differences were detected for setting (p=0.004), stroke type (first vs recurrent) (p<0.001), year of publication (p=0.002) and income (p=0.014).

**PSD prevalence (including prestroke dementia): at year 1**

Data on the prevalence of PSD including prestroke dementia at 1 year following stroke were available for 13 hospital-based studies (online supplemental S4, S5, S10, S13, S14, S17, S20, S22, S25, S31, S33–S35) and for 3 population-based studies (online supplemental S1, S6, S12). The estimated prevalence of PSD in the first year after stroke ranged from 1.1% to 39.2%. Based on the 16 studies included in the meta-analysis, the pooled prevalence was 18.4% (95% CI 7.4 to 38.7). No statistically significant subgroup differences were detected (table 2).

**PSD prevalence (including prestroke dementia): at year 1**

Data on the prevalence of PSD including prestroke dementia 1 year after stroke were available for four hospital-based studies (online supplemental S21, S30 and S34) and for two population-based studies (online supplemental S3, S40). The estimated prevalence of PSD in the first year after stroke ranged from 1.0% to 31.0%. Based on the six studies included in the meta-analysis, the pooled prevalence was 20.4% (95% CI 14.2 to 28.2). A statistically significant subgroup difference was detected for stroke type (first vs recurrent) (p<0.001) (table 2).

The forest plots for the above meta-analyses are in online supplemental figure S1–S8.

**Prestroke dementia**

The pooled prevalence for prestroke dementia was 7.6% (95% CI 4.0 to 14.0) (n=25 studies). Data on the prevalence of prestroke dementia were available for 19 hospital-based studies (online supplemental S5, S7–S10, S13, S14, S16, S18, S22, S25, S28, S31, S34, S35, S37, S38, S40, S41) and 6 population-based studies (online supplemental S6, S12, S19, S36, S42, S45). Thirteen of the 19 hospital-based studies obtained rates of prestroke dementia.
dementia at an interview with an informant using the Informant Questionnaire on Cognitive Decline in the Elderly questionnaire. The population-based studies used a variety of methods, such as review of medical records and premorbid assessment of cognition. Eight hospital-based studies assessed all patients who had a stroke on admission to hospital, nine assessed only those patients who survived to follow-up and two studies assessed patients at admission and at follow-up. All population-based studies assessed prestroke dementia before or shortly after stroke.

**PSD prevalence by timeframe since stroke**

The studies were classified into the following timeframes: baseline to 3 months, 6 months, 12–18 months, 2–5 years and greater than 6 years. The pooled prevalence increased from 19.1% at 3 months to 19.8% at 6 months and was then lower for each of the later time points (online supplemental figure S9).

**Quality assessment**

Thirty-two studies were categorised as high quality and ten studies were categorised as moderate quality. The majority of studies were assessed to have a truly or somewhat representative cohort. Most studies had no age criteria, with a mean age >60 years apart from two studies (online supplemental S6 and S16). Studies provided detailed descriptions such as vascular risk factors of the cohort and scored at least 1 point for the comparability section of the NOS. The prevalence estimate appeared lower in high-quality studies than in moderate-quality studies, both for studies that excluded prestroke dementia (15.3% (7.9%–27.9%) vs 20.6% (13.7%–29.7%)) and studies that included prestroke dementia (21.3% (17.2%–26.2%) vs 25.4% (22.6%–28.4%)) (table 3).

**Sensitivity analysis**

Eight studies were considered to be outliers and were removed from the analysis (online supplemental S1, S2, S4, S10, S12, S17, S26, S44), which reduced the prevalence to 15.6% (95% CI 14.0% to 17.3%) for studies excluding prestroke dementia and to 21.4% (95% CI 18.2% to 25.0%) for studies including prestroke dementia. Small or large sample sizes (online supplemental S12 and S17) and no specific timeframe for dementia assessment post stroke (online supplemental S1, S2) are likely to be some of the reasons for these outlying results. This reduction of less than 1% indicates that the analysis was robust when outlier studies were removed. Ten studies considered to be of moderate quality were removed from the analysis (online supplemental S1, S2, S9, S11, S15, S16, S30, S31, S38, S44). This reduced the prevalence by 1% for studies excluding prestroke dementia and by 0.9% for studies including prestroke dementia, respectively, indicating that the analysis was robust to the removal of studies of moderate quality (online supplemental table S2).

**Publication bias**

The funnel plot analysis suggests publication bias for studies excluding prestroke dementia. For the rank correlation test, Kendall’s τ is −0.28 with one-tailed p=0.01. For Egger’s test, the intercept is 4.36, with a 95% CI from −4.56 to 13.3, and one-tailed p=0.16. The funnel plot analysis suggests publication bias for studies including prestroke dementia. For the rank correlation test, Kendall’s τ is −0.29 with one-tailed p=0.05. For Egger’s test, the intercept is −3.83, with a 95% CI from −7.81 to 0.13 and one-tailed p=0.03 (online supplemental figures S10, S11).

<table>
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**Cut-off score**

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<tr>
<td>Outcome</td>
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<td>2</td>
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</table>

**Strength of evidence (GRADE)**

The overall strength of evidence for our estimate of dementia prevalence was graded as low due to a high risk of bias and inconsistency (observational heterogeneous studies), publication bias, moderate heterogeneity, and only one study reporting poststroke dementia. The funnel plot suggests publication bias. The overall strength of evidence for our estimate of dementia prevalence was graded as low due to a high risk of bias and inconsistency (observational heterogeneous studies), publication bias, moderate heterogeneity, and only one study reporting poststroke dementia.
Meta-regression

There was no significant relationship between the log event rate for dementia prevalence and year of recruitment of the study for studies excluding prestroke dementia (slope coefficient (SE)=0.03 (0.025), p=0.18). There was a significant relationship between the log event rate for dementia occurrence and year of recruitment of the study for studies including prestroke dementia (slope coefficient (SE)=−0.05 (0.01), p=0.0000). There was no significant association between study quality and year of study recruitment (coefficient=−0.095, p=0.55) (online supplemental figures S12 and S13).

DISCUSSION

This quantitative synthesis of 44 studies suggests that approximately one in five of all stroke survivors have dementia. Risk appears substantial and front-loaded following stroke, with 1-year prevalence similar to the estimate for dementia at any time point. For this update, we found new evidence that allowed us to offer greater precision in estimates than in previous reviews. Some of our findings confirm the results from other analyses, for example, the rates of PSD were highest in the hospital-based studies of recurrent stroke. Other findings are unique to our analyses, for example, the apparent decrease in estimates of all-cause PSD over time.

The primary aim of this review was to provide a pooled prevalence of PSD and not to examine any relationships between PSD and demographic factors, vascular risk factors or stroke characteristics such as stroke severity. However, through various subgroup analyses we explored factors that may contribute to the high prevalence of PSD. Inclusion of prestroke dementia consistently increased estimates of PSD and emphasises the importance of considering the prestroke state when assessing stroke survivors. Recurrent stroke substantially increased PSD, a finding in keeping with other reviews. Several mechanisms may explain this, including the cumulative impact of neurological insult, underlying cerebrovascular disease or common risk factors. Other sources of heterogeneity relating to casemix and study setting were explored; however, no single factor explained the differences in estimates for studies that excluded prestroke dementia.

Dementia is a progressive condition, yet in our analysis as the length of time between the stroke event and assessment increased, the prevalence of PSD showed a modest decrease. Attrition due to mortality is one plausible explanation. In addition, immediately after the stroke event, there are dynamic changes in cognition and attempts at early assessment may overestimate dementia. It is recommended that any formal diagnosis of dementia is not made until several months after the index stroke. These estimates of PSD at fixed time points after stroke provide information that can be used for clinical benchmarking, epidemiology and public health messaging.

Our analysis of temporal change in reports of dementia prevalence suggested no change in incident dementia post stroke, but a decrease in PSD when prestroke dementia was included. The factors underlying this are currently not clear. One plausible explanation is that raised awareness and improved access to diagnosis have increased the rates of dementia diagnosed before or at the time of the stroke, with a subsequent decrease in poststroke diagnosis. Decreases in all-cause dementia incidence in industrialised countries may also be relevant. Alternatively, it has been speculated that the incidence of vascular dementia may have reduced, supported by the improvement in vascular care. Although our meta-regression analyses indirectly support this view, caution needs to be drawn when interpreting the causal implications of these analyses. The age-specific risk of all-cause prevalence in the USA and Europe has declined by about 20% per decade since late 1990s. Other factors will also be important and may become more important in the future, for example, improvements in recognition and diagnosis of dementia and increased survival of patients who had a stroke who are at higher risk of developing dementia. For these reasons, it seems prudent to continue to monitor the incidence and prevalence of PSD. In this regard, we look forward to the results of large observational cohorts that are designed to address the interplay of stroke, dementia and vascular disease.

Strengths and weaknesses of this review

We followed best practice in evidence synthesis and made use of tools such as risk of bias assessment and GRADE to frame our results. There has been a substantial increase in research around stroke and cognition. To keep the review focused and manageable, we limited it to dementia diagnosis, rather than less well-defined syndromes such as poststroke cognitive impairment. A distinct review investigating the prevalence of cognitive impairment no dementia (CIND) has been previously conducted and revealed that in the first year post stroke one in four people present with CIND. The authors also highlighted that there was significant variation in how the CIND was operationally defined, such as the use of different cut-offs for impairment and the use of functional criteria. PSD rather than other cognitive syndromes seems to have the greatest influence on overall prognosis following stroke. Age is the most important risk factor for dementia so stratifying the analysis by age groups may have explained the variation in prevalence estimates between the studies. We did not include studies where the primary population of interest was intracerebral haemorrhage, subarachnoid haemorrhage or traumatic brain injury as all these groups have distinct cognitive recovery profiles and combining the various groups may explain conflicting results in previous research (online supplemental S6 and S8).

Areas of future research

This review has highlighted some important methodological limitations which could be used to inform recommendations for the conduct of future primary research studies in this area, for example, a more inclusive inclusion criteria to overcome the potential underestimation of the prevalence of dementia after stroke. Differing approaches to diagnosis of the dementia syndrome were evident across the papers included in our review. There is ongoing work to standardise diagnosis, such as the consensus statement produced by the Vascular Impairment of Cognition Classification study group. A recommendation based on this review is for researchers to adopt a standard process or to describe the steps used to diagnose PSD. This would improve the internal and external validity of future observational studies and raise potential for inclusion in future meta-analyses.

Cognitive impairment is associated with increased mortality and morbidity, which can lead to sizeable loss at follow-up impacting of the measurable risk of dementia after stroke. Therefore, future research studies should employ alternative strategies to follow-up and the use of face-to-face assessment such as telephone/video assessment, home visits and postal
Neurodegeneration

surveys. Furthermore, while the focus of this review was dementia following stroke, there is a need for more epidemiological data on the cognitive consequences of stroke that do not meet the criteria for dementia.

Implications for research and practice

Our estimates of prevalence allow projections for the future burden of PSD to design appropriate health policy, that is, the allocation of healthcare resources.1 Our findings highlight the need for greater engagement between stroke and dementia care. We would hope that our data on prevalence light the need for greater engagement between stroke and dementia care. We would hope that our data on prevalence of PSD highlight the importance of this condition among policy makers, healthcare professionals and the public. Our estimates can be used for planning research, for example, in planning the sample size of a future interventional trial.

CONCLUSION

At all points in the stroke journey, in all healthcare settings and in all countries of the world, PSD is one of the most common complications of stroke. Certain factors were associated with higher prevalence, for example, inclusion of people with pre-stroke dementia and recurrent stroke, but even when these factors were not present the prevalence remained substantial.

Twitter Terence J Quinn @DrTerryQuinn

Contributors ZLH and TZY extracted data from included papers. Decisions were cross-checked with TlQ at screening for exclusion and data extraction stages. LEC conducted quality assessment and all analyses. LEC wrote the first draft of the paper with contributions from ZLH, TZY, TlQ and JW. All authors read and approved the final manuscript.

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Patient consent for publication Not required.

Provenance and peer review Not commissioned; externally peer reviewed.

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Joanna Wardlaw http://orcid.org/0000-0002-9812-6642
Terence J Quinn http://orcid.org/0000-0003-1401-0181

REFERENCES

Neurodegeneration


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<td><strong>ABSTRACT</strong></td>
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<td>Structured summary</td>
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<td>Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.</td>
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<td><strong>INTRODUCTION</strong></td>
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<td>Rationale</td>
<td>3</td>
<td>Describe the rationale for the review in the context of what is already known.</td>
<td>3-4</td>
</tr>
<tr>
<td>Objectives</td>
<td>4</td>
<td>Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).</td>
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<td><strong>METHODS</strong></td>
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<td></td>
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<td>Protocol and registration</td>
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<td>Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.</td>
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<tr>
<td>Eligibility criteria</td>
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<td>Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.</td>
<td>5</td>
</tr>
<tr>
<td>Information sources</td>
<td>7</td>
<td>Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.</td>
<td>5-6</td>
</tr>
<tr>
<td>Search</td>
<td>8</td>
<td>Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.</td>
<td>5</td>
</tr>
<tr>
<td>Study selection</td>
<td>9</td>
<td>State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).</td>
<td>6</td>
</tr>
<tr>
<td>Data collection process</td>
<td>10</td>
<td>Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.</td>
<td>6</td>
</tr>
<tr>
<td>Data items</td>
<td>11</td>
<td>List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.</td>
<td>6-7</td>
</tr>
<tr>
<td>Risk of bias in individual studies</td>
<td>12</td>
<td>Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.</td>
<td>8</td>
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<tr>
<td>Summary measures</td>
<td>13</td>
<td>State the principal summary measures (e.g., risk ratio, difference in means).</td>
<td>7</td>
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<tr>
<td>Synthesis of results</td>
<td>14</td>
<td>Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., ( I^2 )) for each meta-analysis.</td>
<td>7</td>
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# PRISMA 2009 Checklist

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<tr>
<td>Risk of bias across studies</td>
<td>15</td>
<td>Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).</td>
<td>8</td>
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<tr>
<td>Additional analyses</td>
<td>16</td>
<td>Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.</td>
<td>7-8</td>
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<tr>
<td>RESULTS</td>
<td></td>
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<tr>
<td>Study selection</td>
<td>17</td>
<td>Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.</td>
<td>9</td>
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<tr>
<td>Study characteristics</td>
<td>18</td>
<td>For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.</td>
<td>Table 1</td>
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<tr>
<td>Risk of bias within studies</td>
<td>19</td>
<td>Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).</td>
<td>Table 4</td>
</tr>
<tr>
<td>Results of individual studies</td>
<td>20</td>
<td>For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.</td>
<td>Figures 3-6</td>
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<tr>
<td>Synthesis of results</td>
<td>21</td>
<td>Present results of each meta-analysis done, including confidence intervals and measures of consistency.</td>
<td>9-11 Figures 3-6</td>
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<td>Risk of bias across studies</td>
<td>22</td>
<td>Present results of any assessment of risk of bias across studies (see Item 15).</td>
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<td>Additional analysis</td>
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<td>Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).</td>
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<tr>
<td>DISCUSSION</td>
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<tr>
<td>Summary of evidence</td>
<td>24</td>
<td>Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).</td>
<td>17 &amp; 20</td>
</tr>
<tr>
<td>Limitations</td>
<td>25</td>
<td>Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).</td>
<td>19</td>
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<tr>
<td>Conclusions</td>
<td>26</td>
<td>Provide a general interpretation of the results in the context of other evidence, and implications for future research.</td>
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<td>FUNDING</td>
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<td>Funding</td>
<td>27</td>
<td>Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.</td>
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**PRISMA 2009 Checklist**


For more information, visit: [www.prisma-statement.org](http://www.prisma-statement.org).

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<tr>
<th>Selection</th>
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<th>NEWCASTLE - OTTAWA QUALITY ASSESSMENT SCALE (Modified version)</th>
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<tbody>
<tr>
<td>1) Representativeness of the exposed cohort</td>
<td>a) truly representative of the average ________________ (describe) in the community *</td>
<td>Truly / Somewhat describes a stroke population with dementia</td>
</tr>
<tr>
<td></td>
<td>b) somewhat representative of the average ______________ in the community *</td>
<td>Selected group described (may not represent exclusively stroke population with dementia)</td>
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<td></td>
<td>c) selected group of users e.g. nurses, volunteers</td>
<td>No description</td>
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<td></td>
<td>d) no description</td>
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<td>3) Ascertainment of exposure</td>
<td>a) secure record (e.g. surgical records) *</td>
<td>Clinical diagnosis of stroke and dementia +/- inv. / Interview with subsequent validation</td>
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<td></td>
<td>b) structured interview *</td>
<td>Case Report / Structured interview (with no validation by clinician)</td>
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<td>c) written self-report</td>
<td>Written / Self-reported / No description</td>
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<td>d) no description</td>
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<tr>
<td>4) Demonstration that outcome of interest was not present at start of study</td>
<td>a) yes *</td>
<td>Post-Stroke Dementia clearly defined</td>
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<td></td>
<td>b) no</td>
<td>Post stroke dementia mixed with pre-stroke dementia (no description to separate them)</td>
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<td>No proper description of cohort</td>
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<td>1) Comparability of cohorts on the basis of the design or analysis</td>
<td>a) study controls for ____________ (select the most important factor) *</td>
<td>Description of Age + Sex + Vascular Risk Factor + Additional Factors</td>
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<td>b) study controls for any additional factor* (This criteria could be modified to indicate specific control for a second</td>
<td>Description of Age + Sex + (at least 1) Vascular Risk Factor</td>
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<td>Assessment of outcome</td>
<td>Clinical Diagnosis</td>
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<tr>
<td>1)</td>
<td>a) independent blind assessment *</td>
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<td></td>
<td>b) record linkage *</td>
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<td></td>
<td>c) self-report</td>
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<td></td>
<td>d) no description</td>
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<td>2)</td>
<td>Was follow-up long enough for outcomes to occur</td>
<td>1 year or more</td>
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<tr>
<td></td>
<td>a) yes (select an adequate follow up period for outcome of interest) *</td>
<td></td>
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<tr>
<td></td>
<td>b) no</td>
<td></td>
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<tr>
<td>3)</td>
<td>Adequacy of follow up of cohorts</td>
<td>Complete / &gt;90% accounted</td>
</tr>
<tr>
<td></td>
<td>a) complete follow up - all subjects accounted for *</td>
<td></td>
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<tr>
<td></td>
<td>b) subjects lost to follow up unlikely to introduce bias - small number lost - &gt; ____ % (select an adequate %) follow up, or description provided of those lost) *</td>
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<tr>
<td></td>
<td>c) follow up rate &lt; ____% (select an adequate %) and no description of those lost</td>
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<tr>
<td></td>
<td>d) no statement</td>
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Note: A study can be awarded a maximum of one star for each numbered item within the Selection and Outcome categories. A maximum of two stars can be given for Comparability.
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<thead>
<tr>
<th>Study, Year Country</th>
<th>Date of data Collection</th>
<th>No. of population</th>
<th>Study Type</th>
<th>Exclusion Criteria</th>
<th>Mean Age (SD)</th>
<th>Female (%)</th>
<th>Ischaemic Stroke (%)</th>
<th>Pre-stroke dementia excluded</th>
<th>Pre-stroke dementia quantified</th>
<th>Follow-up Duration</th>
<th>PSD Assessment Method</th>
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<tr>
<td>Alteri et al, 2004, Italy (S27)</td>
<td>1995-97</td>
<td>N=191 L</td>
<td>Y</td>
<td>Severe aphasia or neglect, &lt;5 years’ education, SAH, age &lt;40 years, concomitant neurological disorder, severe comorbidity</td>
<td>71</td>
<td>30</td>
<td>89</td>
<td>Y</td>
<td>N</td>
<td>Annually for 4 years</td>
<td>ICD-10</td>
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<td>Caratozzolo et al, 2016, Italy (S10)</td>
<td>2011</td>
<td>N=105 P</td>
<td>Y *</td>
<td>TIA</td>
<td>72.4 (10.7)</td>
<td>37.1</td>
<td>85</td>
<td>Y</td>
<td>Y</td>
<td>12 months</td>
<td>IQ-CODE</td>
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<td>Delgado et al, 2010, Chile (S13)</td>
<td>2005-2006</td>
<td>N=74 P</td>
<td>Y *</td>
<td>Poor consciousness, TIA, SAH, CNS Disorders, Severely impaired stroke (mRS &gt;3)</td>
<td>72.2 (7.7)</td>
<td>42.0</td>
<td>89.0</td>
<td>Y</td>
<td>Y</td>
<td>12 months</td>
<td>SS-IQCODE</td>
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<tr>
<td>de Koning et al, 1998, 2000 Netherlands (S30, S31)</td>
<td>1993-96</td>
<td>N=300 X</td>
<td>N</td>
<td>Aphasia, sensory impairment, not fluent in Dutch,</td>
<td>70</td>
<td>40.0</td>
<td>71</td>
<td>N</td>
<td>NA</td>
<td>3-9 months</td>
<td>DSM III-III</td>
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<td>Study, Year Country</td>
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<td>de Koning et al, 2005 Netherlands (S31)</td>
<td>2000-01</td>
<td>N=121</td>
<td>X</td>
<td>N</td>
<td>Aphasia, sensory impairment, not fluent in Dutch, reduced consciousness</td>
<td>70</td>
<td>38</td>
<td>63</td>
<td>N</td>
<td>Y (FU only) Interview</td>
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<td>Gur et al, 1994, Israel (S33)</td>
<td>1988-90</td>
<td>N=199</td>
<td>Y</td>
<td>L</td>
<td>Aphasia</td>
<td>73</td>
<td>53</td>
<td>100</td>
<td>Y</td>
<td>N</td>
<td>6 monthly to 5 years</td>
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<td>Henon et al, 2002 France (S34)</td>
<td>1995-1996</td>
<td>N=142</td>
<td>L</td>
<td>X</td>
<td>Non-white, no informant, age &lt;40 years, not fluent in French, not from Lille, history of severe head trauma</td>
<td>72</td>
<td>46</td>
<td>Not reported</td>
<td>N</td>
<td>Y</td>
<td>IQCODE</td>
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<td>Inzitari et al 1998, Italy (S35)</td>
<td>1993-94</td>
<td>N=339</td>
<td>X</td>
<td>N</td>
<td>None given</td>
<td>71</td>
<td>48</td>
<td>83.2</td>
<td>Y</td>
<td>Y (FU only) Interview</td>
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<td>Ihle-Hansen et al, 2010, Norway (S14)</td>
<td>2007-2008</td>
<td>N=184</td>
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<td>Y</td>
<td>SAH, TIA, MCI, Life expectancy &lt; 1 year</td>
<td>72 (12.2)</td>
<td>49.5</td>
<td>76.4</td>
<td>Y</td>
<td>Y</td>
<td>IQCODE</td>
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<tr>
<td>Kumutpongpanich et al, 2017 Thailand (S5)</td>
<td>2006-2007</td>
<td>N=85</td>
<td>X</td>
<td>Y *</td>
<td>Dementia before stroke, Expired or lost to follow up, Unable to perform neuropsychological test, Imaging study was not performed or was lost, Patients with aphasia</td>
<td>69.4 (9.3)</td>
<td>N/A</td>
<td>100</td>
<td>Y</td>
<td>Y</td>
<td>12 months</td>
</tr>
<tr>
<td>Mehrabian et al, 2015 Bulgaria (S17)</td>
<td>N/A</td>
<td>N=74</td>
<td>P</td>
<td>Y</td>
<td>ICH, NIHSS &gt;6, Persistent aphasia, Severe sensory impairment, Malignant disease, Neurological conditions, Psychiatric conditions, History of Pre-Stroke Cognitive Impairment</td>
<td>65.6 (5.6)</td>
<td>21.2</td>
<td>100</td>
<td>Y</td>
<td>N</td>
<td>12 months</td>
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<tr>
<td>Renjen et al, 2015 India (S20)</td>
<td>N/A</td>
<td>N=50</td>
<td>P</td>
<td>Y * TIA, Neurodegenerative disorder, Moderate to severe aphasia</td>
<td>61.8</td>
<td>36</td>
<td>74</td>
<td>Y</td>
<td>Y</td>
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<td>PGI-Battery of Brain Dysfunction (PGI BBD &gt; 30) &amp; IQCODE</td>
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<tr>
<td>Sarfo et al, 2017, Ghana (S21)</td>
<td>2015-2016</td>
<td>N=58</td>
<td>X</td>
<td>N</td>
<td>On sedatives, Aphasia without proxy, Significant physical illness, Motor/Sensory impairment (hearing visual), Neurological or psychiatric illness Systemic disorders capable of impairing cognition</td>
<td>59.9 (13.7)</td>
<td>47.6</td>
<td>66</td>
<td>N</td>
<td>NA</td>
<td>3 months, 12 months, 2-4 years and 5 years</td>
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<tr>
<td>Selim et al, 2009 Egypt (S22)</td>
<td>2007-2008</td>
<td>N=66</td>
<td>P</td>
<td>Y * TIA, SAH, CVT, Seizure history, Severe head trauma history, Neurological surgery</td>
<td>Median age 63</td>
<td>47.0</td>
<td>74.2</td>
<td>Y</td>
<td>Y</td>
<td>18 months</td>
<td>MMSE + Neuropsychological battery</td>
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<tr>
<td>Surawan et al, 2018 Thailand (S4)</td>
<td>2017</td>
<td>N=138 P</td>
<td>P</td>
<td>Y *</td>
<td>Depression, Vitamin B12 deficiency, renal failure, hypothyroid, syphilis, HIV, Pick’s disease, CJD, Huntington’s disease, Parkinson’s, Alzheimer’s Disease, Sensory impairment (hearing/ visual), Communication impairment</td>
<td>Mean 69</td>
<td>46.1</td>
<td>100</td>
<td>Y</td>
<td>N</td>
<td>3 and 6 months</td>
<td>MMSE-Thai 2002 (≤ 23 ) Modified DSM V</td>
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<td>Yang et al, 2015 Hong Kong (S25)</td>
<td>2009-2010</td>
<td>N=1013 P, X</td>
<td>Y *</td>
<td>Severe language impairment, Terminal illness, Psychiatric comorbidity</td>
<td>69.2 (11.7)</td>
<td>44.3</td>
<td>70.1</td>
<td>Y</td>
<td>Y</td>
<td>Not reported</td>
<td>Cantonese MMSE + MoCA (HK Version) DSM IV &amp; CDR</td>
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<td>Akinwumi et al, 2014 Nigeria (S8)</td>
<td>2010-12</td>
<td>N=143 P</td>
<td>P</td>
<td>SAH, Moderate to severe aphasia, Significant physical and sensory impairment, Psychiatric history</td>
<td>60.4 (9.5)</td>
<td>43.4</td>
<td>79.5</td>
<td>N</td>
<td>Y</td>
<td>3 months</td>
<td>CSID + MMSE + V-NB</td>
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<tr>
<td>Arauz et al, 2014 Mexico (S9)</td>
<td>2005</td>
<td>N=110 P, X</td>
<td>Y TIA, SAH, Severe aphasia</td>
<td>56 (17.8)</td>
<td>38.2</td>
<td>84.0</td>
<td>Y</td>
<td>Y</td>
<td>3 months</td>
<td>CASI DSM-IV+ AHA/ASA VCI criteria</td>
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<td>Assayag et al, 2017 Israel (S26)</td>
<td>2008-14</td>
<td>N=507 L</td>
<td>Y Head trauma or brain procedures, ICH, Severe aphasia</td>
<td>67.4 (9.7)</td>
<td>40.6</td>
<td>100</td>
<td>Y</td>
<td>N</td>
<td>24 months</td>
<td>MoCA &amp; NeuroTrax computerised Cognitive Testing DSM-IV</td>
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<tr>
<td>Barba et al, 2000 Spain, (S28)</td>
<td>1994-95</td>
<td>N=251 X, L</td>
<td>N Primary brain lesion, aphasia, comorbidity</td>
<td>69</td>
<td>47</td>
<td>88.4</td>
<td>N</td>
<td>Y</td>
<td>3,6,24 months</td>
<td>DSM IIIR</td>
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<tr>
<td>Censori et al, 2000 Italy, (S29)</td>
<td>1993-94</td>
<td>110 X</td>
<td>Y Age &lt;40 or ≥80 years, other neurological disorder, unusual cause of stroke, comorbidity, depression,</td>
<td>65</td>
<td>35</td>
<td>100</td>
<td>N</td>
<td>3 months</td>
<td>NINDS A</td>
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<td>Desmond et al, 1996 al USA, (S32)</td>
<td>1988–90 1994–97</td>
<td>N=453 X, L</td>
<td>N</td>
<td>Dysphasia, unable to speak English or Spanish, low GCS, age &lt;60 years</td>
<td>70</td>
<td>53</td>
<td>100</td>
<td>N</td>
<td>N (Y in L study)</td>
<td>3 months, annually up to 4 years</td>
<td>DSM III</td>
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<tr>
<td>Gorelick et al, 1993 USA, (S44)</td>
<td>1987–90</td>
<td>N=147 X</td>
<td>N</td>
<td>Aphasia, Parkinson’s disease, possible prior Alzheimer’s disease</td>
<td>72</td>
<td>49</td>
<td>100 (Multiple IS)</td>
<td>N</td>
<td>N</td>
<td>2-3months</td>
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<td>Khedr et al, 2009 Egypt, (S16)</td>
<td>N/A (1 year duration)</td>
<td>N=81 p</td>
<td>Y</td>
<td>Poor consciousness, Persistent Aphasia, Psychosis, SAH, Systemic Disease, cancer, Severe head trauma history, Neurological surgery, Severe sensory impairment</td>
<td>57.7 (5.19)</td>
<td>33.3</td>
<td>84</td>
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<td>Y IQCODE</td>
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<td>MMSE &lt;21 / CASI &lt;67 DSM-IV</td>
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<td>Klimkowicz et al, 2002 Poland, (S37)</td>
<td>2000–01</td>
<td>N=220 X</td>
<td>N</td>
<td>Age ≤40 years, no reliable informant, other brain lesion</td>
<td>66</td>
<td>55</td>
<td>87.2</td>
<td>N</td>
<td>Y IQCODE</td>
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<td>DSM IV</td>
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<td>Tang et al, 2004, China (S40)</td>
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<td>X</td>
<td>Non-Chinese ethnic group, non-Cantonese speaking, age &lt;50 years</td>
<td>71</td>
<td>55</td>
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<td>N</td>
<td>Y (FU only) (IQCODE)</td>
<td>3 months</td>
<td>DSM IV</td>
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<td>Tang et al, 2017 Taiwan (S23)</td>
<td>2014-15</td>
<td>N=172</td>
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<td>Active infection, cancer, renal disease, autoimmune disorder, Current steroid treatment, Poor diabetes control</td>
<td>72.1 (7.5)</td>
<td>35.5</td>
<td>100</td>
<td>N</td>
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<td>85±54.0 months</td>
<td>MMSE &amp; MoCA, NINDS-AIREN, CDR</td>
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<td>Ojagbemi et al, 2017 Nigeria (S18)</td>
<td>2014-16</td>
<td>N=96</td>
<td>P</td>
<td>Unable to communicate reliably, Aphasia, Severe co-morbidities</td>
<td>61.1 (12.9)</td>
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<td>MMSE, NINDS-AIREN</td>
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<td>Pohjasvaara et al Finland, 1997 (S38)</td>
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<td>71</td>
<td>49</td>
<td>100</td>
<td>N</td>
<td>Y (FU only) Interview</td>
<td>3 months</td>
<td>DSM III</td>
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<tr>
<td>Yu et al, 2013, South Korea (S7)</td>
<td>2007-08</td>
<td>N=328 P</td>
<td>Y *</td>
<td>non-resident in Helsinki, reduced conscious level, poor hearing, aphasia</td>
<td>63.9 (12.4)</td>
<td>38.8</td>
<td>100</td>
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<td>K-VCHS-NP protocol + Korean MMSE</td>
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<td>1999-00</td>
<td>N=434 X</td>
<td>N</td>
<td>Concomitant neurological disorder, age &lt;55 years, severe medical comorbidity or sensory impairment, reduced GCS, severe aphasia</td>
<td>68</td>
<td>47</td>
<td>100</td>
<td>N</td>
<td>Y (FU only) IQCODE</td>
<td>3 months</td>
<td>DSM-IV</td>
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<td>Appelros et al 2002 Sweden (S45)</td>
<td>1999–00</td>
<td>N=232 P, X</td>
<td>Y</td>
<td>Aphasia</td>
<td>74</td>
<td>50</td>
<td>73.0</td>
<td>N</td>
<td>Y Interview</td>
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<td>Corraini et al, 2017 Norway (S12)</td>
<td>1982-13</td>
<td>N=215,118</td>
<td>Y</td>
<td>Previous stroke, mild cognitive impairment, amnestic syndrome</td>
<td>Median age 72</td>
<td>47.6</td>
<td>39.2</td>
<td>Y</td>
<td>Y</td>
<td>30 years</td>
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<td>Das et al, 2013 India (S3)</td>
<td>2006-10</td>
<td>N=219</td>
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<td>TIA, Aphasia, Psychosis, Sensory impairment (hearing/visual)</td>
<td>74.5 (8.30)</td>
<td>48</td>
<td>N/A</td>
<td>N</td>
<td>NA</td>
<td>36 months</td>
<td>BMSE (adaptation of MMSE) + Kolkata Cognitive Screening Battery + CDR + DSM III-R</td>
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<td>Kokmen et al, 1996, USA (S42)</td>
<td>1960-84</td>
<td>N=971</td>
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<td>50</td>
<td>100</td>
<td>NA</td>
<td>Records</td>
<td>Up to 25 years</td>
<td>NA</td>
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<td>2002-12</td>
<td>N=2080</td>
<td>N</td>
<td>Previous diagnosis of dementia</td>
<td>74.4 (13.0)</td>
<td>51</td>
<td>64.3</td>
<td>Y</td>
<td>MMSE / MoCA / Telephone Interview for Cognitive Status - Modified</td>
<td>60 months (median 4.2 years)</td>
<td>MMSE (&lt; 24) &amp; MoCA</td>
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<tr>
<td>Srikanth et al, 2004, Australia (S39)</td>
<td>1998-99</td>
<td>N=198X, L, PPS</td>
<td>Y</td>
<td>Aphasia, unable to speak English, inadequate vision or hearing</td>
<td>69</td>
<td>41</td>
<td>93.2</td>
<td>N</td>
<td>NA</td>
<td>3 months; 1, 2 years</td>
<td>DSM-IV</td>
<td></td>
</tr>
<tr>
<td>Qu et al, 2015, China (S1)</td>
<td>2012-13</td>
<td>N=599 X</td>
<td>N</td>
<td>TIA, Existing neurological or psychiatric disorders, Aphasia, Sensory impairment (hearing/ visual), Poor consciousness</td>
<td>67.9 (16.6)</td>
<td>54</td>
<td>86.5</td>
<td>Y</td>
<td>N</td>
<td>Not specified. Assumed 1 year.</td>
<td>MOCA + MMSE with stratification cut-off by education, Hachinski Ischaemic</td>
<td></td>
</tr>
<tr>
<td>Clark et al, 2018, USA (S11)</td>
<td>2000-10</td>
<td>N=68,758 R, L</td>
<td>N</td>
<td>Prior diagnosis of dementia</td>
<td>68 (13)</td>
<td>51</td>
<td>100</td>
<td>Y</td>
<td>N</td>
<td>60 months</td>
<td>ICD-9</td>
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<tr>
<td>Kase et al, 1998, USA (S36)</td>
<td>1982-01</td>
<td>N=74 L, V</td>
<td></td>
<td>Previous stroke or dementia</td>
<td>79</td>
<td>61</td>
<td>68.9</td>
<td>Y</td>
<td>Y</td>
<td>10 years</td>
<td>DSM III, MMSE DSM IV</td>
<td></td>
</tr>
<tr>
<td>Study, Year Country</td>
<td>Date of data Collection</td>
<td>No. of population Study Type</td>
<td>FES</td>
<td>Exclusion Criteria</td>
<td>Mean Age (SD)</td>
<td>Female (%)</td>
<td>Ischaemic Stroke (%)</td>
<td>Pre-stroke dementia excluded</td>
<td>Pre-stroke dementia quantified</td>
<td>Follow-up Duration</td>
<td>PSD Assessment Method</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
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<td></td>
</tr>
<tr>
<td>Portegies et al, 2016 Netherlands (S19)</td>
<td>1990-12</td>
<td>N=993 P</td>
<td>Y</td>
<td>Prevalent stroke, Prevalent dementia</td>
<td>79.9 (8.7)</td>
<td>60.4</td>
<td>N/A</td>
<td>Y</td>
<td>Y MMSE</td>
<td>115 months (+/- 72 months)</td>
<td>3 step protocol: MMSE&lt;26, Geriatric Mental Schedule (GMS)&gt;0 and Cambridge Examination for Mental Disorders in the Elderly Neurologist-led clinical diagnosis/consensus meeting</td>
<td></td>
</tr>
<tr>
<td>Kim et al, 2017 South Korea (S15)</td>
<td>2002</td>
<td>N=2527 P</td>
<td>Y</td>
<td>Non-citizens (Korea), Stroke and dementia between year 2002 &amp; 2003</td>
<td>72</td>
<td>54.8</td>
<td>N/A</td>
<td>Y</td>
<td>N</td>
<td>120 months</td>
<td>ICD-10</td>
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</tr>
<tr>
<td>Tu et al, 2013 China (S24)</td>
<td>2008-11</td>
<td>N=689 X</td>
<td>N</td>
<td>ICH, Alcohol, Severe aphasia, Severe sensory impairment (hearing/visual)</td>
<td>68.6 (11.4)</td>
<td>41.4</td>
<td>100</td>
<td>Y</td>
<td>N</td>
<td>3 months</td>
<td>MOCA-CS + MMSE + FAB-CS</td>
<td></td>
</tr>
<tr>
<td>Study, Year</td>
<td>Country</td>
<td>Date of data Collection</td>
<td>No. of population</td>
<td>Study Type</td>
<td>FES</td>
<td>Exclusion Criteria</td>
<td>Mean Age (SD)</td>
<td>Female (%)</td>
<td>Ischaemic Stroke (%)</td>
<td>Pre-stroke dementia excluded</td>
<td>Pre-stroke dementia quantified</td>
<td>Follow-up Duration</td>
</tr>
<tr>
<td>-------------</td>
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<td>--------------------</td>
<td>-----------------------------</td>
<td>-----------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Zhang et al, 2017</td>
<td>Mongolia (S2)</td>
<td>N/A</td>
<td>N = 444</td>
<td>X</td>
<td>Neurological system disease that may affect cognition (AD), History of psychoactive drug abuse, CO /chemical poisoning, chronic alcoholism, Severe aphasia, Sensory impairment (hearing/visual), History of mental disorder</td>
<td>split into different categories</td>
<td>43.9</td>
<td>87.4</td>
<td>Y</td>
<td>N</td>
<td>Not Specified. Assumed 3 months.</td>
<td>CDR + NINDS-AIREN</td>
</tr>
</tbody>
</table>

Included in previous meta-analysis Y* = included in the pre-stroke dementia analysis only

P - Prospective / R - Retrospective / X - Cross Sectional / L - Longitudinal (studies with multiple follow-ups beyond 12 months).

FES – Studies recruiting (FES) First Ever Stroke Candidates: Y = Yes N = No (Mixed Population Data) Y* = Study recruiting mixed population but with FES and Recurrent Stroke Data available

CVT – Cerebral Venous Thrombosis, ICH – Intra-Cerebral Haemorrhage, MCI – Mild cognitive Impairment, NIHSS – National Institutes of Health Stroke Scale, SAH – Subarachnoid Haemorrhage, TIA – Transient Ischaemic Attack AHA/ASA – American Heart Association/American Stroke Association; BMSE – Bengali Version of Hindi Mental State Examination


TMT-A – Train Making Test – A; TMT-B – Train Making Test – B; SWDFR – 5-Word Delay Free Recall; V-NB – Vascular Neuro-Psychological Battery

*** PSD Data: MIXED : Pre-Stroke Dementia not evaluated/excluded. PSDanalysis includes possible pre-stroke dementia data. PSD : PSDData (Pre-Stroke Dementia Excluded)
<table>
<thead>
<tr>
<th>Study, Year Country</th>
<th>Date of data Collection</th>
<th>No. of population Study Type</th>
<th>FES</th>
<th>Exclusion Criteria</th>
<th>Mean Age (SD)</th>
<th>Female (%)</th>
<th>Ischaemic Stroke (%)</th>
<th>Pre-stroke dementia excluded</th>
<th>Pre-stroke dementia quantified</th>
<th>Follow-up Duration</th>
<th>PSD Assessment Method</th>
</tr>
</thead>
</table>

**PSD Assessment Method - CD-S:** Clinical Diagnosis using standard classification system; **CD-Other:** Clinical diagnosis using other assessment tool; **NPB:** Neuro-Psychological Battery
Table S2  Results of Sensitivity Analysis

<table>
<thead>
<tr>
<th>Outcome</th>
<th>No. of studies</th>
<th>Prevalence % (95% CI)</th>
<th>Prevalence % (95% CI), n= number of studies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Removal of outliers</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevalence any timeframe</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Including pre-stroke dementia</td>
<td>16</td>
<td>21.4(18.2-25.0)</td>
<td>22.3 (18.8 to 26.2), n=17,</td>
</tr>
<tr>
<td>Excluding pre-stroke dementia</td>
<td>26</td>
<td>15.6 (14.0-17.3)</td>
<td>16.5(10.4 to 25.1), n=33</td>
</tr>
<tr>
<td>Prevalence at 1 year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Including pre-stroke dementia</td>
<td>6</td>
<td>20.4(14.2-28.2)</td>
<td>20.4 (14.2 to 28.2), n= 6</td>
</tr>
<tr>
<td>Excluding pre-stroke dementia</td>
<td>14</td>
<td>20.5(15.0-27.4)</td>
<td>18.4 (7.4 to 38.7), n=16</td>
</tr>
<tr>
<td><strong>Removal of moderate quality studies</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevalence any timeframe</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Including pre-stroke dementia</td>
<td>14</td>
<td>21.3(17.2-26.2)</td>
<td>22.3 (18.8 to 26.2), n=17,</td>
</tr>
<tr>
<td>Excluding pre-stroke dementia</td>
<td>25</td>
<td>15.3(7.9-27.5)</td>
<td>16.5(10.4 to 25.1), n=33</td>
</tr>
<tr>
<td>Prevalence at 1 year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Including pre-stroke dementia</td>
<td>4</td>
<td>17.4(9.2-30.4)</td>
<td>20.4 (14.2 to 28.2), n=6</td>
</tr>
<tr>
<td>Excluding pre-stroke dementia</td>
<td>14</td>
<td>17.2(6.7-37.3)</td>
<td>18.4 (7.4 to 38.7), n=16</td>
</tr>
</tbody>
</table>
Table S3  Overall strength of evidence

<table>
<thead>
<tr>
<th>Prevalence of Post-Stroke Dementia</th>
<th>Risk of Bias</th>
<th>Consistency</th>
<th>Directness</th>
<th>Precision</th>
<th>Publication Bias</th>
<th>Effect (95%CI)</th>
<th>Quality of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possibly serious</td>
<td>Serious</td>
<td>Not serious</td>
<td>Serious</td>
<td>Possibly serious</td>
<td>22.3% 95% CI: 18.8 to 26.2  16.5% 95% CI: 10.4 to 25.1</td>
<td>Low</td>
<td></td>
</tr>
</tbody>
</table>
### Figure S1  
**Post-stroke prevalence – including pre-stroke dementia (all timeframes)**

<table>
<thead>
<tr>
<th>Stroke type</th>
<th>Study name</th>
<th>Diagnostic Criteria</th>
<th>Event rate</th>
<th>Lower Limit</th>
<th>Upper Limit</th>
<th>Event rate and 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed</td>
<td>Alpern et al 2014</td>
<td>DSM-IV &amp; AHA/ASA VCI</td>
<td>0.094</td>
<td>0.046</td>
<td>0.142</td>
<td></td>
</tr>
<tr>
<td>Mixed</td>
<td>Bovia et al 2000(1)</td>
<td>DSM III-R</td>
<td>0.299</td>
<td>0.245</td>
<td>0.358</td>
<td></td>
</tr>
<tr>
<td>Combined</td>
<td>Das et al 2013</td>
<td>CDI &amp; DSM-III-R</td>
<td>0.100</td>
<td>0.067</td>
<td>0.141</td>
<td></td>
</tr>
<tr>
<td>Mixed</td>
<td>de Koning et al 1998</td>
<td>DSM III-R</td>
<td>0.277</td>
<td>0.210</td>
<td>0.346</td>
<td></td>
</tr>
<tr>
<td>Mixed</td>
<td>de Koning et al 2001(1)</td>
<td>DSM IV</td>
<td>0.289</td>
<td>0.216</td>
<td>0.370</td>
<td></td>
</tr>
<tr>
<td>Mixed</td>
<td>Donders et al 2000</td>
<td>DSM III</td>
<td>0.263</td>
<td>0.224</td>
<td>0.305</td>
<td></td>
</tr>
<tr>
<td>Mixed</td>
<td>Gorelick et al 1998</td>
<td>DSM III</td>
<td>0.455</td>
<td>0.330</td>
<td>0.586</td>
<td></td>
</tr>
<tr>
<td>Mixed</td>
<td>Hinton et al 2001(1)</td>
<td>ICD10</td>
<td>0.310</td>
<td>0.239</td>
<td>0.391</td>
<td></td>
</tr>
<tr>
<td>Mixed</td>
<td>Ilinichovski et al 2001(1)</td>
<td>DSM IV</td>
<td>0.314</td>
<td>0.256</td>
<td>0.378</td>
<td></td>
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<tr>
<td>Mixed</td>
<td>Oggioni et al 2011(1)</td>
<td>NINDS-AIREN</td>
<td>0.162</td>
<td>0.108</td>
<td>0.229</td>
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<tr>
<td>Mixed</td>
<td>Poljareva et al 1997(1)</td>
<td>DSM III</td>
<td>0.225</td>
<td>0.157</td>
<td>0.297</td>
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</tr>
<tr>
<td>Mixed</td>
<td>Surfi et al 2017</td>
<td>DSM IV</td>
<td>0.204</td>
<td>0.121</td>
<td>0.300</td>
<td></td>
</tr>
<tr>
<td>FES</td>
<td>Schmah et al 2004</td>
<td>DSM IV</td>
<td>0.128</td>
<td>0.079</td>
<td>0.212</td>
<td></td>
</tr>
<tr>
<td>Mixed</td>
<td>Tang et al 2000(2)</td>
<td>DSM IV</td>
<td>0.200</td>
<td>0.137</td>
<td>0.251</td>
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</tr>
<tr>
<td>Mixed</td>
<td>Tang et al 2017</td>
<td>NINDS-AIREN/CDIB</td>
<td>0.209</td>
<td>0.155</td>
<td>0.277</td>
<td></td>
</tr>
<tr>
<td>Mixed</td>
<td>Yu et al 2015</td>
<td>DSM IV</td>
<td>0.127</td>
<td>0.079</td>
<td>0.196</td>
<td></td>
</tr>
<tr>
<td>Mixed</td>
<td>Zhou et al 2004(3)</td>
<td>DSM IV</td>
<td>0.223</td>
<td>0.188</td>
<td>0.262</td>
<td></td>
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</tbody>
</table>

**Note:** Event rate and 95% CI values are shown for each study, with the CI range indicating the confidence level for the prevalence estimate.
Figure S2  Post-stroke prevalence - excluding pre-stroke dementia (all timeframes)

<table>
<thead>
<tr>
<th>Study Type</th>
<th>Study Name</th>
<th>Diagnose Method</th>
<th>Lower Bound</th>
<th>Upper Bound</th>
<th>Overview and SICCE</th>
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</thead>
<tbody>
<tr>
<td>FEIS</td>
<td>Reis et al 2019</td>
<td>CIND-19/SWED-19/ADNEX</td>
<td>0.058</td>
<td>0.070</td>
<td>-</td>
</tr>
<tr>
<td>PFS</td>
<td>Ito et al 2017</td>
<td>DIND-N</td>
<td>0.056</td>
<td>0.058</td>
<td>-</td>
</tr>
<tr>
<td>Mixed</td>
<td>Reichert et al 2000</td>
<td>DIND-N</td>
<td>0.053</td>
<td>0.072</td>
<td>-</td>
</tr>
<tr>
<td>FEIS</td>
<td>Cerga et al 2016</td>
<td>DIND-N</td>
<td>0.052</td>
<td>0.067</td>
<td>-</td>
</tr>
<tr>
<td>PFS</td>
<td>Chaves et al 2015</td>
<td>DIND-N</td>
<td>0.052</td>
<td>0.072</td>
<td>-</td>
</tr>
<tr>
<td>Mixed</td>
<td>Clark et al 2015</td>
<td>DIND-N</td>
<td>0.050</td>
<td>0.075</td>
<td>-</td>
</tr>
<tr>
<td>PFS</td>
<td>Cervera et al 2017</td>
<td>DIND-N</td>
<td>0.049</td>
<td>0.070</td>
<td>-</td>
</tr>
<tr>
<td>Mixed</td>
<td>De Gregorio et al 2009</td>
<td>DIND-N</td>
<td>0.049</td>
<td>0.069</td>
<td>-</td>
</tr>
<tr>
<td>FEIS</td>
<td>Delgado et al 2016</td>
<td>DIND-N</td>
<td>0.048</td>
<td>0.069</td>
<td>-</td>
</tr>
<tr>
<td>PFS</td>
<td>Sun et al 2014</td>
<td>DIND-N</td>
<td>0.045</td>
<td>0.049</td>
<td>-</td>
</tr>
<tr>
<td>Mixed</td>
<td>Heron et al 2011</td>
<td>DIND-N</td>
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<td>0.069</td>
<td>-</td>
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<tr>
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<td>Issac et al 2016</td>
<td>DIND-N</td>
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<td>0.069</td>
<td>-</td>
</tr>
<tr>
<td>FEIS</td>
<td>Ito et al 2016</td>
<td>DIND-N</td>
<td>0.032</td>
<td>0.069</td>
<td>-</td>
</tr>
<tr>
<td>PFS</td>
<td>Ito et al 2016</td>
<td>DIND-N</td>
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<td>0.069</td>
<td>-</td>
</tr>
<tr>
<td>Mixed</td>
<td>Kliner et al 2013</td>
<td>DIND-N</td>
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<td>0.069</td>
<td>-</td>
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<tr>
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<td>Kliner et al 2013</td>
<td>DIND-N</td>
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<td>0.069</td>
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<td>FEIS</td>
<td>Nakamura et al 2016</td>
<td>DIND-N</td>
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<td>0.069</td>
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</tr>
<tr>
<td>Mixed</td>
<td>Alphonso et al 2017</td>
<td>DIND-N</td>
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<td>0.069</td>
<td>-</td>
</tr>
<tr>
<td>Mixed</td>
<td>Pichstone et al 2017</td>
<td>DIND-N</td>
<td>0.026</td>
<td>0.069</td>
<td>-</td>
</tr>
<tr>
<td>PFS</td>
<td>Portinato et al 2016</td>
<td>DIND-N</td>
<td>0.025</td>
<td>0.069</td>
<td>-</td>
</tr>
<tr>
<td>Mixed</td>
<td>Alphonso et al 2017</td>
<td>DIND-N</td>
<td>0.025</td>
<td>0.069</td>
<td>-</td>
</tr>
<tr>
<td>FEIS</td>
<td>Pichstone et al 2016</td>
<td>DIND-N</td>
<td>0.025</td>
<td>0.069</td>
<td>-</td>
</tr>
<tr>
<td>Mixed</td>
<td>Pichstone et al 2016</td>
<td>DIND-N</td>
<td>0.025</td>
<td>0.069</td>
<td>-</td>
</tr>
<tr>
<td>PFS</td>
<td>Quinto et al 2015</td>
<td>DIND-N</td>
<td>0.025</td>
<td>0.069</td>
<td>-</td>
</tr>
<tr>
<td>Mixed</td>
<td>Quinto et al 2015</td>
<td>DIND-N</td>
<td>0.025</td>
<td>0.069</td>
<td>-</td>
</tr>
<tr>
<td>FEIS</td>
<td>Torcios et al 2015</td>
<td>DIND-N</td>
<td>0.025</td>
<td>0.069</td>
<td>-</td>
</tr>
<tr>
<td>Mixed</td>
<td>Torcios et al 2015</td>
<td>DIND-N</td>
<td>0.025</td>
<td>0.069</td>
<td>-</td>
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<tr>
<td>FEIS</td>
<td>Doi et al 2016</td>
<td>DIND-N</td>
<td>0.025</td>
<td>0.069</td>
<td>-</td>
</tr>
<tr>
<td>Mixed</td>
<td>Doi et al 2016</td>
<td>DIND-N</td>
<td>0.025</td>
<td>0.069</td>
<td>-</td>
</tr>
<tr>
<td>FEIS</td>
<td>Ikai et al 2019</td>
<td>DIND-N</td>
<td>0.025</td>
<td>0.069</td>
<td>-</td>
</tr>
<tr>
<td>Mixed</td>
<td>Ikai et al 2019</td>
<td>DIND-N</td>
<td>0.025</td>
<td>0.069</td>
<td>-</td>
</tr>
</tbody>
</table>

Craig L. et al. J Neurol Neurosurg Psychiatry 2021;0:1–8. doi: 10.1136/jnnp-2020-325796
### Figure S3  Post-stroke prevalence-including pre-stroke dementia (one year)

<table>
<thead>
<tr>
<th>Stroke type</th>
<th>Study name</th>
<th>Diagnostic Criteria</th>
<th>Event rate</th>
<th>Lower limit</th>
<th>Upper limit</th>
<th>Event rate and 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined</td>
<td>Caratuazzo et al 2016</td>
<td>DSM-IV</td>
<td>0.352</td>
<td>0.267</td>
<td>0.448</td>
<td></td>
</tr>
<tr>
<td>FDE</td>
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<tr>
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<td>MDIS</td>
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**Figure S4**  
Post-stroke prevalence—not excluding pre-stroke dementia (one year)

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<tr>
<th>Stroke type</th>
<th>Study name</th>
<th>Diagnostic Criteria</th>
<th>Event rate</th>
<th>Lower limit</th>
<th>Upper limit</th>
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<tr>
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<td>CDR &amp; DSM-III-R</td>
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Figure S5  Hospital-based, any (first or recurrent) stroke, including pre-stroke dementia versus Population-based, any (first or recurrent) stroke, including pre-stroke dementia

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<th>Stroke type</th>
<th>Group by</th>
<th>Study name</th>
<th>Diagnostic criteria</th>
<th>Event rate</th>
<th>Lower limit</th>
<th>Upper limit</th>
</tr>
</thead>
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<tr>
<td>Mild H</td>
<td></td>
<td>Addimani et al 2018</td>
<td>DSM IV &amp; AD, ICD-10</td>
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<td>Kothari et al 1996</td>
<td>DSM IV</td>
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<td>de Koning et al 2001</td>
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<td>DSM IV</td>
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<td>Gower et al 1993</td>
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<td>Heyman et al 1991</td>
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<td>Yu et al 2001</td>
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<td>Zhu et al 2001</td>
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<td>Icc et al 2014</td>
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Icc et al 2014: NHMS-AD & ICD-10

---

Figure S6: Hospital-based, any (first or recurrent) stroke, excluding pre-stroke dementia versus Population, any (first or recurrent) stroke, excluding pre-stroke dementia.
**Figure S7** Recurrent stroke versus any (first or recurrent) stroke versus any (first or recurrent) stroke, all timeframes, including pre-stroke dementia

<table>
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<tr>
<th>Stroke type</th>
<th>Group by</th>
<th>Study name</th>
<th>Diagnostic criteria</th>
<th>Event rate</th>
<th>Event lower</th>
<th>Event upper</th>
<th>Event rate and 95% CI</th>
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<td>CDH &amp; DDM 103 II</td>
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<td>DSMTF</td>
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<td>FES</td>
<td>Polypson et al 1995</td>
<td>DSDSII</td>
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<td>Zivie et al 1998</td>
<td>DSDSII</td>
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<td></td>
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Recurrent stroke versus any (first or recurrent) stroke versus any (first or recurrent) stroke, all timeframes, excluding pre-stroke dementia

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<th>Stroke type</th>
<th>Group by</th>
<th>Study name</th>
<th>Designation Criteria</th>
<th>Event rate and 95% CI</th>
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<td>JNNSA, group F</td>
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Figure S9  Prevalence over time

Prevalence (%)

Length of time post stroke

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<tr>
<td>6 months</td>
<td>20.9</td>
<td>16.4</td>
<td>25.6</td>
</tr>
<tr>
<td>12-18 months</td>
<td>25.2</td>
<td>20.6</td>
<td>30.9</td>
</tr>
<tr>
<td>2-5 years</td>
<td>21.6</td>
<td>17.1</td>
<td>26.2</td>
</tr>
<tr>
<td>&gt;6 years</td>
<td>22.6</td>
<td>18.2</td>
<td>27.1</td>
</tr>
</tbody>
</table>

Pooled prevalence
Figure S10  Funnel Plot (PSD all timeframes, excluding pre-stroke dementia)

Funnel Plot of Standard Error by Logit event rate

Logit event rate

Standard Error

0

0.1

0.2

0.3

0.4

0.5

-5

-4

-3

-2

-1

0

1

2

3

4

5
Figure S11  Funnel Plot (PSD all timeframes, including pre-stroke dementia)
Figure S12  Meta-regression of dementia (event rate log scale) occurrence against year of recruitment (all timeframes) for studies excluding pre-stroke dementia
Figure S13  Meta-regression of dementia (event rate log scale) occurrence against year of recruitment (all timeframes) for studies including pre-stroke dementia