Reviewer’s report

Title: Lifestyle counselling as secondary prevention in patients with minor stroke and transient ischemic attack: Study protocol for a randomized controlled pilot study

Version: 0 Date: 08 Dec 2019

Reviewer: Jannette Blennerhassett

Reviewer's report:

General.

This is an important study exploring feasibility of a preventative approach to modify risk factors associate with stroke in people with new diagnosis of TIA/ mild stroke. Examining the steps to pilot suitable research design is important.

The manuscript was mostly clear. A few points that could be made clearer, and some other suggestions and comments are provided below.

Abstract:

P3/ line 30. "4 weekly" follow up could be better term than "frequent". Or perhaps outlining that people will have 3 follow up sessions (if you need to have flexibility in how the follow up will be delivered). Please revise.

Background: The content presented is clear and sets up the rationale and aims for the study.

Methods:

The details of the purposive sampling and selection of people for interviews needs more detail. (p6/ line 16; Also in p11. Line 38)

Who Performance Status &gt;2. "Mobilized less than 50% of the day" does not seem to outline the salient characteristics, (ie., walking and capable of self-care, and up and about &gt;50% of the waking day) (p6, line 52). This needs to be modified for clarity.

Intervention:

P7, line 33-34. Is "motivate" the best word? Engage, encourage, support, foster, inspire, assist, etc may be more suitable words. Please reconsider.
Regarding design: I appreciate the concept of capturing people early following stroke/TIA. This seems a very sensible approach, as outlined in the window of opportunity. Will the health service permit adequate time to undertake the counselling and assessments? The health service (public, and in a different country) that I work in tends to have a very short hospital stay and follows people up as an outpatient. In such settings, person can be "rushed to get out" of hospital (to manage hospital beds). They have just had a serious medical event (and likely to be in an "emotional state of shock") and may not be able to take in and complete the intervention (as outlined in the manuscript: - information / counselling & all the assessments). This aspect of feasibility for this study is important to consider. Early intervention seems good, but will this be "too early" for the people to "take the intervention in". Please supply some information about your current healthcare service. This will help the reader understand when the study will start, and explain how long the patients are kept in hospital.

Who will conduct the fitness testing and the spirometry: p8, line 23-28? Is this testing needed for a feasibility study? The intervention is delivered by a nurse-led targeted lifestyle counselling. Thinking ahead, is a comprehensive aerobic assessment part of usual nursing practice. (it is not in my country and health setting). Will this testing be essential to deliver a goal based, lifestyle counselling approach, which is based largely on self-reports, reflection, and counselling? Does including this make the intervention not feasible for other health settings to deliver? (I am thinking about reach and broader application for this important topic).

P 8 line 1-21:

Will the summary of the initial counselling be provided in a written format? What additional strategies will be incorporated to assist participants who may have mild cognitive, fatigue or have limited ability to take a lot of information in so soon after their stroke / TIA. Please outline briefly.

P 8 line 20-21:

What is meant by follow up appointments? Will that be the smoking cessation program, dietitian, physio-exercise physiology; hypertension clinic etc; or the usual care programs? Please supply addition information and put this into the context of your health care setting.

P 8 line 30-32: The follow up schedule is not presented consistently in the manuscript. Ie., the method differs to the abstract. Please present this more clearly. Would it be helpful to say the actual number of sessions (? 3) that are delivered between d/c and 12 weeks, at around 4 weekly intervals.

Activity tracking: P 8. line 37-44: This aspect is not clearly outlined: ie, how it will be used, is it provided to all in intervention group, will the researchers monitor activity/ calories burned? Is this aspect needed for the study? Does including activity monitoring confound the counselling approach that will rely on self-reports and non-technically orientated parameters? If a person has their own device, eg Apple phone, can they use that? More detail is required; Considering
feasibility for longer term application also seems important, to enable a program to be rolled out to health care settings who are not able to supply this type of intervention.

Data:

P9, line 24-45: Most seems reasonable. Main comments relate to how deliverable this intervention will be in the acute hospital setting and within usual timeframe for hospitalization.

The current presentation does not outline how the aerobic testing and activity tracking will be used. Why collect information you may not use?

P10, line 5-10: Details of the satisfaction and qualitative interviews should be provided. (also p11, 38-56)

Discussion:

Prevalence of people with cognitive impairment is important to present, but the implications and approach to selection, or strategies to manage these are not well explained. This needs to be elaborated upon.

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