Advances in Precision Medicine, 2026, Volume 11, Issue 8
https://bbwpublisher.com/journal/APM
Online ISSN: 2424-9106
Print ISSN: 2424-8592

Observation on the Clinical Effect of Secondary Prevention Intervention Using Integrated Traditional Chinese and Western Medicine in Outpatient Ischemic Stroke Patients

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Abstract: *Objective:* To analyze the specific content of secondary prevention intervention using integrated traditional Chinese and Western medicine to explore the application value for outpatient ischemic stroke patients. *Methods:* Composition of research subjects: Ischemic stroke patients were all from the outpatient department of our hospital, a total of 70 cases. After grouping according to the random number table method, 35 cases were included in each group. After investigation, the above patients were selected from June 2025 to June 2026; during the treatment phase, conventional Western medicine secondary prevention measures were used in the control group, and combined Chinese and Western medicine secondary prevention measures were used in the experimental group to compare the effects. *Results:* (1) After sorting out the research data of patients with ischemic stroke, the difference in NIHSS scores before intervention was small, $P>0.05$; after intervention, the experimental group was lower than the control group, $P<0.05$; (2) FMA scores and Barthel index were compared, and the difference before intervention was small, $P>0.05$; after intervention, the experimental group was higher, $P<0.05$; (3) In terms of total effective rate, the calculated data of ischemic stroke patients in the two groups were: 77.14% (27/35), 94.29% (33/35). The comparison results showed that the experimental group was higher, $P<0.05$; (4) The incidence of adverse reactions and stroke recurrence rate were compared, the experimental group was lower, $P<0.05$. *Conclusion:* In the outpatient treatment stage, the application of integrated traditional Chinese and Western medicine for secondary prevention has significant advantages in many aspects. For patients with ischemic stroke, it is beneficial for improving the degree of neurological deficits, promoting the early recovery of limb motor functions and daily life activities, and ensuring the best efficacy. More importantly, the implementation of this measure can reduce the incidence of adverse reactions and stroke recurrence rates in patients. It is safe and deserves further promotion.

Keywords: Integrated traditional Chinese and Western medicine; Secondary prevention intervention; Outpatient ischemic stroke patients; Effect analysis

Online publication: August 26, 2026

1. Introduction

Ischemic stroke is a cerebrovascular disease that has a high clinical incidence and high harm. From the perspective of specific symptoms, patients with ischemic stroke will face hemiplegia, coma, central hyperthermia and functional impairment. After hospitalization in the acute phase, many complications will remain, causing great trouble in their own lives [1]. In view of the above phenomenon, it cannot be ignored clinically. After careful analysis, effective management strategies must be introduced. In this process, conventional Western medicine secondary prevention mainly focuses on drug intervention. Although the effect is obvious and can improve the degree of neurological deficit in patients, it is poorly targeted. Moreover, long-term medication will also lead to an increased risk of adverse reactions in patients, and the overall effect is poor [2]. The assistance of traditional Chinese medicine conditioning can take into account the root cause of the patient's disease and clinical symptoms, effectively make up for the shortcomings of a single plan, and promote the patient's early recovery [3]. This study will select ischemic stroke patients admitted to the hospital's outpatient department from June 2025 to June 2026 as a reference. After randomly grouping them, the application value of secondary prevention intervention using the combination of traditional Chinese and Western medicine will be explored. The details are reported below.

2. Clinical data and methods

2.1. General information

After approval by the hospital, patients with ischemic stroke admitted to the outpatient department were selected for analysis. After investigation, the inclusion period was between June 2025 and June 2026, with a total of 70 patients. After grouping according to the random number table method, the data are as follows. Control group: 35 cases. After counting male and female patients, the ratio was 16:19. In terms of age, the minimum and maximum survey results were 44 and 75 years old, with an average of (59.58 ± 2.33) years old. Experimental group: 35 cases. After counting male and female patients, the ratio was 17:18. In terms of age, the minimum and maximum survey results were 46 and 74 years old, with an average of (60.05 ± 2.41) years old. There is no difference in the above information, $P > 0.05$.

Inclusion criteria: (1) Ischemic stroke has been clearly diagnosed and the patient's personal information is relatively complete; (2) Patients with ischemic stroke have no drug contraindications; (3) Patients and their families highly recognize the internal regulations of this study and voluntarily sign relevant agreements.

Exclusion criteria: (1) Patients with cancer disease; (2) Ischemic stroke patients with severe organic lesions after liver and kidney examination; (3) Patients with abnormal indicators after coagulation function examination; (4) Ischemic stroke patients who dropped out of the study midway due to the influence of subjective and objective factors.

2.2. Method

Control group: Provide conventional Western medicine secondary prevention measures, including:

(1) Drug treatment. For the investigation of patients with ischemic stroke, during the clinical treatment stage, aspirin enteric-coated tablets and atorvastatin calcium tablets can be provided. The oral dosages are: 100mg/time, once/day; 20mg/time, once/day; for patients with hypertension and diabetes, clinical staff can instruct them to take corresponding antihypertensive and hypoglycemic drugs regularly;

(2) Behavioral guidance. During the outpatient treatment process, the staff should proactively inquire

about the patient's living habits, and then correct them and provide rational suggestions to the patient, such as: quit smoking, quit drinking, and not stay up late; in terms of diet, strictly follow the principles of low-salt and low-fat, appropriately increase the intake ratio of foods rich in vitamins and dietary fiber to ensure balanced nutrition; in terms of physical exercise, the focus should be gradual, and it is recommended that patients carry out relatively mild aerobic training, such as walking, climbing stairs, baduanjin exercises, etc., and control the specific time and intensity based on their own tolerance, and not be too impatient.

(3) Health education. During the outpatient review, staff also need to patiently introduce the knowledge, efficacy, and principles of action of ischemic stroke to patients, answer their questions carefully, and correct misconceptions.

Experimental group: Provide secondary prevention by integrating traditional Chinese and Western medicine, including: (1) Prevention by traditional Chinese medicine and (2) Western medicine prevention, where the specific measures are the same as those in the control group. The intervention time for both groups was 6 months.

(1) Oral administration of traditional Chinese medicine: For patients with qi deficiency and blood stasis, during the clinical treatment stage, the staff can provide them with Buyang Huanwu Decoction. The internal medicine composition is: astragalus, angelica, safflower, chuanxiong, red peony root, peach kernel, earthworm; when treating patients with wind, phlegm and blood stasis, use Banxia Atractylodes and Gastrodia decoction. Mainly, the specific medicines include: *Pinellia ternata*, Atractylodes, Gastrodia, Poria, Tangerine, and Licorice. When treating patients with excessive liver yang, Zhengan Xifeng Decoction can be provided clinically. The specific medicines include: *Achyranthes bidentata*, raw ocher, raw keel, raw oyster, raw turtle shell, Artemisia, Soupelandia, and licorice. In practice, the staff can analyze the specific conditions of the patient, then select the corresponding traditional Chinese medicine, mix it with water and boil it, take 200 mL of the concoction and drink it in 2 times, 1 dose per day;

(2) Acupuncture: For the investigation of patients with ischemic stroke, the staff can select Baihui point, Fengchi point, and He Intervention at Gu point, Shou Sanli point, Zusanli point, Sanyinjiao point, and Taichong point. In practice, the above points need to be disinfected correctly with the help of alcohol. Secondly, disposable filiform needles are used to insert and perform needle operations. The needles are retained after the patient feels soreness, numbness, swelling, and pain. The specific time is: 30 minutes, 3 times/week.

(3) Acupoint massage: During clinical intervention, staff can select the above-mentioned acupuncture points as well as Jianjing, Waiguan and Yanglingquan points for massage. In specific practice, the thumb pulp can be used to intervene clockwise for 2 minutes on a single acupoint, once a day. During the massage, staff should take the initiative to inquire about the patient's self-feelings and strictly control hand strength.

2.3. Evaluation indicators

(1) Degree of neurological deficit, namely: NIHSS score;

(2) Clinical indicators: limb motor function scores and activities of daily living, namely: FMA score and Barthel index.

(3) Total effectiveness: divided into significantly effective, generally effective, and ineffective;

(4) Incidence of adverse reactions and stroke recurrence rate (6-month follow-up).

2.4. Statistical analysis

After all the data in this study were sorted, they were analyzed using SPSS 25.0 software. Among them, the t-test was used for measurement data, and the chi-square test was used for count data. The above information was represented in the form of mean ± standard deviation (SD) (%). When $P < 0.05$, it was shown that the difference between the groups was statistically significant.

3. Results

3.1. NIHSS score

Comparing the NIHSS scores of patients with ischemic stroke, there was no difference before intervention P > 0.05; after intervention, the experimental group was lower $P < 0.05$. **Table 1**.

Table 1. Comparison of NIHSS scores between the control group and the experimental group (mean ± SD)

Group	Before intervention (points)	After intervention (points)
Control group (n=35 cases)	8.61 ± 2.03	5.48 ± 1.69
Experimental group (n=35 cases)	8.52 ± 2.11	3.75 ± 1.14
T	0.182	5.021
P	0.856	0.000

3.2. Clinical indicators

Comparing the FMA score and Barthel index, the difference in data before intervention was small, $P > 0.05$; after intervention with different programs, the above indicators of patients with ischemic stroke improved, and the experimental group was higher, $P < 0.05$. **Table 2**.

Table 2. Comparison of clinical indicators between the control group and the experimental group (mean ± SD)

Group	FMA score (points)		Barthel index (points)	
	Before intervention	After intervention	Before intervention	After intervention
Control group (n=35 cases)	62.38 ± 4.11	75.68 ± 5.42	64.85 ± 5.17	78.98 ± 4.67
Experimental group (n=35 cases)	62.46 ± 3.97	83.16 ± 4.97	64.92 ± 5.03	85.04 ± 3.92
T	0.083	6.018	0.057	5.880
P	0.934	0.000	0.954	0.000

3.3. Total efficiency

Compared with the control group, the total effective rate of ischemic stroke patients in the experimental group was higher $P < 0.05$. **Table 3**.

Table 3. Comparison of the total effective rate (%) between the control group and the experimental group

Group	Significantly effective	Generally effective	Invalid	Total effectiveness (%)
Control group (n=35 cases)	15 (42.86)	12 (34.29)	8 (22.86)	27 (77.14)
Experimental group (n=35 cases)	18 (51.43)	15 (42.86)	2 (5.71)	33 (94.29)
χ^2	-	-	-	4.200
P	-	-	-	0.040

3.4. Incidence of adverse reactions and stroke recurrence rate

The incidence of adverse reactions and stroke recurrence rate were lower in the experimental group, $P < 0.05$. **Table 4**.

Table 4. Comparison of the incidence of adverse reactions and stroke recurrence rate (%) between the control group and the experimental group

Group	Adverse reaction incidence rate (%)				Stroke recurrence rate (%)
	Dizziness and fatigue	Gastrointestinal discomfort	Abnormal liver function	Total	
Control group (n=35 cases)	4 (11.43)	3 (8.57)	2 (5.71)	9 (25.71)	7 (20.00)
Experimental group (n=35 cases)	1 (2.86)	1 (2.86)	0 (0.00)	2 (5.71)	1 (2.86)
χ^2	-	-	-	5.285	5.081
P	-	-	-	0.022	0.024

4. Discussions

Ischemic stroke is relatively common in clinical practice and is the result of the interaction of multiple factors, including large artery atherosclerosis, small artery occlusion, cardioembolic embolism, hypertension, hyperlipidemia, diabetes, etc. Once the disease occurs, it will cause the patient's quality of life to plummet and pose a greater threat to the patient's physical and mental health [4-5].

The results of this study show: (1) Before clinical treatment, there was no difference in NIHSS scores between the control group and the experimental group, $P > 0.05$; after intervention with different protocols, the index in the experimental group was lower, $P < 0.05$; (2) In comparison of FMA scores and Barthel index in patients with ischemic stroke, there was no difference before intervention, $P > 0.05$; After intervention, compared with the control group, the experimental group was higher, $P < 0.05$; (3) The total effective rate was compared, the experimental group (94.29%, 33/35) VS the control group (77.14%, 27/35), the calculated data was high, $P < 0.05$; (4) After the incidence rate of adverse reactions and stroke recurrence rate were counted, the experimental group was lower, $P < 0.05$. The specific analysis is as follows: During the treatment stage of ischemic stroke, drug treatment in conventional Western medicine secondary prevention can help patients stabilize arterial plaques, regulate blood lipid levels, and reduce thrombosis; behavioral guidance and health education can help correct patients' bad living habits, rebuild patients' self-perception, and improve treatment cooperation. When the above measures are combined for intervention, although the effect is obvious, it can easily lead to a variety of adverse reactions and has a low safety factor [6]. During the intervention period of traditional Chinese medicine, the oral administration of traditional Chinese medicine after syndrome differentiation can be fully analyzed according to the actual condition of the patient, and then effectively regulate the function of the patient's internal organs, which can fundamentally improve the patient's overall condition [7]. In addition, acupuncture treatment and acupoint massage measures are characteristic therapies of traditional Chinese medicine. In practice, they can play a role by stimulating relevant acupoints, which can dredge meridians, reconcile qi and blood, and balance yin and yang [8]. When combined with Western medicine and traditional Chinese medicine, the synergistic effect is significant. For patients with ischemic stroke, it can better improve the degree of neurological deficit and promote early recovery.

5. Conclusion

To sum up, in the outpatient treatment stage of patients with ischemic stroke, the application of combined traditional Chinese and Western medicine for secondary prevention has a definite effect, which is beneficial to improving the patient's neurological deficit, improving the patient's limb motor function and daily life activities, and ensuring the best curative effect. At the same time, the implementation of the above treatment measures can also reduce the incidence of adverse reactions and stroke recurrence rates in patients, and has high clinical safety and high promotion value.

Disclosure statement

The author declares no conflict of interest.

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