Letters to the Editor

The ‘hype’ in hyper-acute stroke

SIR—The national stroke strategy consultation document ‘A New Ambition for Stroke’ makes an important point that stroke unit care delivered by a specialist multi-disciplinary team is ‘the single biggest factor that can improve a person’s outcomes following a stroke’ [1]. Despite this, stroke experts seem to be focussing on stroke as an emergency, hyper-acute care, and the delivery of thrombolysis to a very small minority of the 110,000 stroke population in England believing that this leads to better outcomes and saves resources [2]. Similarly, a House of Commons debate about stroke services on 11 July 2007 produced a suggestion from one party that resources should be diverted from rehabilitation towards thrombolysis and hyper-acute stroke services.

The focus of both stroke experts and politicians on hyper-acute stroke in preference to organised stroke care for all ages appears to be heavily influenced by the outcomes and savings figures in the National Audit Office (NAO) 2005 stroke report [3]. The report had headline results that its recommendations would lead to some £20 million savings annually (£16 million from its thrombolysis recommendation based on 9,900 doses being given and a fully recovered rate of 180/1,000 treated), 550 deaths avoided (calculated from an economic research model population of 82,000 stroke patients and an extra 25% accessing organised stroke unit care), and 1,700 fully recovering each year who would not otherwise have done so (1,500 due to thrombolysis and 200 due to the additional 20,500 accessing stroke unit care).

Expert and political opinions about prioritising funding towards acute and hyper-acute stroke care may need to be reconsidered; at the 27 March 2007 Public Accounts Commission meeting, Sir John Bourn, the NAO Comptroller and Auditor General, told MPs that with the NAO stroke recommendations ‘there is no financial payoff for improvement in stroke services’ [4]. The NAO figures do not seem to lack face validity given the number needed to treat with stroke unit care of 33 to avoid 1 death and 20 to enable 1 person to become independent. With the more recent outcome figures for full recovery of 100/1,000 in the Safe Implementation of Thrombolysis in Stroke—Monitoring Study (SITS-MOST) and Boehringer–Ingelheim evidence to the National Institute for Health and Clinical Excellence (NICE) during the alteplase appraisal of a maximum of 5,512 patients being eligible for treatment in England and Wales in 2011 compared with the NAO research model assumption of 9,900 doses, it would appear that the NAO outcomes and savings figures were overestimated and frankly optimistic if not misleading [5].

Geriatricians need to ensure that stroke funding choices and priorities are based not on hype but on the published evidence. There should be no unfair discrimination against older and younger patients who require organised rehabilitation in hospital or in the community through an unjust and unjustified priority use of limited resources on hyper-acute care.

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doi:10.1093/ageing/afm199

Enterobacter sakazakii bacteraemia with multiple splenic abscesses in a 75-year-old woman: a case report

SIR—We read with interest the report of Enterobacter sakazakii bacteraemia in a 75-year-old woman, who presented with tachypnoea, a left-sided pleural effusion and splenic abscess [1]. We previously reported the identification of E. sakazakii in the mouths of 7 of 203 acute stroke patients [2]. In four of our seven patients, an abnormal swallow was present on admission and two of these patients subsequently developed a pneumonia on day six and fourteen post stroke, respectively.

The two patients with an abnormal swallow and E. sakazakii in the oral cavity who did not develop pneumonia had been treated with SDD gel containing amphotericin, tobramycin and polymixin E as part of a...
randomised controlled trial, while studying the role of selective decontamination of the oral cavity, post stroke.

In the remaining three patients who had a normal swallow, but in whom E. sakazakii was found in the oral cavity, two received active SDD gel and one placebo, with no evidence of a pneumonic process or septicaemia. In the report of See and colleagues [1], the bacterium was resistant to cephalaxin. In our 10 oral isolates, all except one was resistant to ampicillin, one was resistant to tobramycin, three to colistin, four to cefotaxime, four to trimethopin and three to ciprofloxacin. In the case report, the 75-year-old woman deteriorated after an initial clinical response, with the authors surmising that the organism had developed cephalosporin resistance. In one of our patients, in whom E. sakazakii was isolated on four separate occasions, we found that the antibiotic sensitivities altered, probably as a result of the SDD gel.

We would like to speculate that the patient may have had oral colonisation with E. sakazakii, which subsequently resulted in a pneumonia complicated by a splenic abscess. We agree with the authors that E. sakazakii should not be treated with a cephalosporin and that E. sakazakii must be considered in older individuals who fail to respond to traditional antibiotic administration.

We hope that, by highlighting a possible pathogenesis of the E. sakazakii splenic abscess, clinicians caring for older individuals with impaired oral hygiene and abnormal swallow or immunosuppression due to age, disease or treatment, will consider E. sakazakii as an aetiological agent if early treatment fails to result in a clinical response.

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doi:10.1093/ageing/afn006

Integrated services for people with dementia

SIR—We discussed the thought-provoking editorial ‘Can we afford not to have integrated dementia services?’ from Roger Bullock, Steve Iliffe and Peter Passmore [1] at a recent meeting of the West Midlands Memory Clinic Network [2].

Colleagues from several disciplines working in Memory Services across the West Midlands felt alarmed by the drift of the arguments presented by these respected colleagues. We would caution against adopting their conclusion that: ‘There is need to stop providing dementia services across multiple agencies.’

Their assertion that ‘... there are no integrated dementia services in the United Kingdom ...’ is false. We all work in integrated services which engage with appropriate resources across a range of agencies. This, we believe to be entirely appropriate. The alternative which Bullock et al. espouse is a segregated or exclusive service—setting apart people with dementia as a special or sub-population who will receive all their needs as subservient to their dementia label.

Contrast this with the direction of services for people with life-long learning disability, where the thrust is all toward ‘normalisation’ to ensure that individuals receive a proper share of expert help from across the complex range of health and social care [3]. This leaves the experts in learning disability (or dementia) to work effectively to inform, educate and support all parties to gain optimal care for every individual. We commend this approach and hope that it will be advanced through initiatives which the government is contemplating in response to the several reports published recently, and quoted helpfully by Bullock et al.

The need is to improve the quality and capacity of services for people with dementia across multiple agencies.

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doi:10.1093/ageing/afn018

Acetylcholinesterase inhibitors and cardiovascular disease

SIR—We read with interest Malone et al.’s research letter on cholinesterase inhibitors and cardiovascular disease [1]. It comes as no surprise that there is wide variation in the prescribing of cognitive enhancers to people with cardiovascular co-morbidity. They rightly state the need for consensus guidelines for prescribing to this group of patients.

Rowland et al. [2] have recently published a proposed guideline in Advances in Psychiatric Treatment to aid the