Much depends on how the choices are presented. I have always advocated the concept of care of congenital heart disease patients to be a continuum. This requires integration of paediatric and adult cardiology for common good of patient and shared management of the transition period of adolescence. It also needs mutual respect; each practising optimum specialist medicine in their areas and arenas but not a take-over of one department by another, using the GUCH problem as a means of further expansion of paediatric cardiology.

I am used to being branded paranoid, a word used twice by Drs Qureshi and Huggon, when I state something unpopular or resented. The accusation is usually uttered in the way schoolboys, when beaten, shout ‘foul’ but it does not deny the correctness of the statement.

The job descriptions of two most recent Consultant Paediatric Cardiology posts in London say the following under Organisation — Directorate of Paediatrics . . . The aim is to incorporate adult congenital services within the department — each Consultant taking relatively specialised roles within the group, i.e., . . . adult congenital heart disease . . .

I wonder has Dr Qureshi confused the words. Perhaps instead of paranoid, ‘prophetic’ would have been appropriate.

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References

TPA in acute stroke
Dr Hommel et al write that additional larger studies are needed before tissue-type plasminogen activator (TPA) is used for the treatment of acute stroke. He bases this on the finding that, in some trials, thrombolytic therapy was not beneficial. He is concerned because of the high haemorrhage rate reported in the MAST-E[1] trial. This trial used a drug, streptokinase, that in the past had been associated with high rates of intracerebral haemorrhage when given to stroke patients[2]. In MAST-E, patients were selected who had more severe strokes. As it turned out, these patients had very poor recovery from their strokes as well as a much higher rate of intracranial bleeding when treated with streptokinase when compared with the results for patients with less severe strokes treated with TPA. Finally, MAST-E included patients that could not be treated until a time after stroke onset, later than most other thrombolytic trials[3-5]. MAST-E is not similar to the other trials.

When viewed in the light of other trials that have recently been completed, it is clear that the combination of severe deficit at onset, high dose of thrombolytic therapy, and late treatment combine to produce a poor results. The ECASS [6] and the NINDS[7] trials had excluded many patients that were included in the MAST-E trial and later found to be most likely to have poor outcome or haemorrhage. Larger trials will only confirm the convincing finding of MAST-E that cardiac doses of streptokinase in patients with severe stroke will not do well when treated late in the course of their stroke. The trial is important because it has defined important limits for safety. At the appropriate dose, carefully selected patients with blood pressure maintained within strict limits do so well with TPA that large numbers of patients were not required to demonstrate an effect in a placebo-controlled trial. Two 3-h trials have already been done by the NINDS investigators. The second confirmed the first. In the 6-h ECASS trial, all outcome events in the target population showed a statistically significant difference that supported the NINDS results and suggest an even longer time to treatment interval. Further trials are needed to determine if the benefit of TPA can be extended to more patients by giving it after 3 h from stroke onset in carefully selected and managed patients. This is already being done in the European ECASS-II trial and the American ATLANTIS trial.

The editorial of Dr Hommel et al emphasizes the poor results of the MAST-E trial without emphasizing the important differences from other trials. He creates the impression that there is some inconsistency or doubt about the use of thrombolytic therapy with tissue plasminogen activator as a treatment for acute ischaemic stroke. In fact the results of the various trials of thrombolytic therapy are very consistent with each other when one considers the differences: the selection by MAST-E of patients with severe stroke, the late time after onset the treatment was given, the high dose, and limited management of blood pressure. When these differences are considered, the conclusions of all of the trials are explained and mutually strengthened.

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References