Long term outcome of stroke: Stroke is a chronic disease with acute events.

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MANAGEMENT OF HAEMORRHOIDS

Symptoms govern treatment

Acheson and Scholefield reviewed the management of haemorrhoids. At our centre, we have adopted an approach whereby symptoms govern the therapeutic decision.

For many patients, bleeding is the principal symptom, and we have used Doppler guided haemorrhoidal artery ligation (DGHAL) since 2004 in those whose condition has not improved after injection of oily phenol in the outpatient clinic. Over this time we have treated more than 400 patients. In 113 with long term follow-up, the rate of symptoms recurring was 19% at 30 months and the rate of complications low.

Although this technique has proved effective in the control of bleeding, it is not effective in the treatment of prolapsed haemorrhoids, with recurrence of prolapse occurring in 64% at 30 months. Many patients experience prolapse of their piles, which can lead to discharge of mucus, pruritus, and occasionally seepage of stool. Contrary to the cover of the BMJ, Acheson and Scholefield did not highlight the most recent advance in haemorrhoidal treatment.

Modification of the DGHAL transducer has allowed for the undertaking of DGHAL together with rectoanal repair (RAR). This technique was introduced at our unit in January 2007 to treat symptomatic prolapsed haemorrhoids. We have adopted an approach whereby the patient as partner.


LONG TERM OUTCOME OF STROKE

Stroke is a chronic disease with acute events

Bruins et al and the accompanying editorial on stroke care make a compelling case for reviewing conventional policy approaches to stroke, which often show a dysequilibrium towards the (very important) front end of stroke, and a relative agnosia for (equally important) aftercare. Although it is clearly very important that all should have access to stroke unit care (and thrombolysis for those for whom it is indicated), most patients will still have residual disability after both of these interventions and will be more prone to further strokes than the rest of the population. Comprehensive national audits of stroke care show alarming levels of neglect in terms of chronic disease management and seem to indicate a collective nihilism about the potential for altering function and wellbeing after the early treatment of stroke, despite evidence of the effectiveness of continuing therapy and support at long intervals after stroke. We need to ensure that the potential for altering functional status and wellbeing is maximised at six months (and beyond). Highlighting the chronic disease aspect of stroke care may best serve this aspiration by promoting a timely focus on prevention, care, and support needs through patient education and empowerment, as well as the development of models of care which bring together primary and secondary care. This may require a reorientation of practice and training for stroke physicians, which do not currently emphasise the chronic course of the illness, or models of chronic disease management, which promote the role of the patient as partner.

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FOLLOW-UP AFTER BREAST CANCER

National randomised controlled trial is needed

Dixon and Montgomery recommend that breast cancer follow-up be evidence based, flexible, and tailored to patients’ needs. Unfortunately neither their proposal to provide only annual clinical review for two years nor the 2002 guideline from the National Institute for Health and Clinical Excellence, which recommends hospital based follow-up for no longer than three years for asymptomatic patients, is evidence based. A recent Cochrane review showed a wide range of recommendations for follow-up practice and identified the urgent need for a large randomised controlled trial to assess the optimum model of care.


