1-3-2008

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

Desmond O'Neill
Trinity College Dublin

Frances Horgan
Royal College of Surgeons in Ireland, byrnesinead48@gmail.com

Anne Hickey
Royal College of Surgeons in Ireland

Hannah McGee
Royal College of Surgeons in Ireland

Citation

O'Neill D, Horgan F, Hickey A, McGee H. Long term outcome of stroke: Stroke is a chronic disease with acute events. BMJ. 2008;336(7642):461.

We select the letters for these pages from the rapid responses posted on bmj.com favouring those received within five days of publication of the article to which they refer. Letters are thus an early selection of rapid responses on a particular topic. Readers should consult the website for the full list of responses and any authors' replies, which usually arrive after our selection.

LETTERS

MANAGEMENT OF HAEMORRHOIDS

Symptoms govern treatment

Acheson and Scholefield reviewed the management of haemorrhoids.[1] 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 treated 92 patients with a symptomatic relief rate of 82% at three months. Although the inclusion of a RAR makes this a more painful procedure than DGHAL, patient satisfaction is high. More recently we have been undertaking DGHAL with or without RAR under conscious sedation, using midazolam and remifentanil. Altogether 48% of patients were entirely pain free during the procedure, with the remaining 52% having a median pain score of 3 out of 10. It is therefore possible to obtain pain free symptomatic relief of bleeding or prolapsed haemorrhoids in the day surgical setting.

Simon B Middleton consultant colorectal surgeon
simon.middleton@royalberkshire.nhs.uk
Richard E Lovegrove specialist registrar in general surgery
Howard Reece-Smith consultant general surgeon, Royal Berkshire Hospital, Reading RG1 5AN

Competing interests: None declared.

1 Acheson AG, Scholefield JH. Management of haemorrhoids. *BMJ* 2008;336:380-3. (16 February.)

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.[1] 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,[2] despite evidence of the effectiveness of continuing therapy and support at long intervals after stroke.[3] 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,[4] as well as the development of models of care which bring together primary and secondary care.[5] 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.

Desmond O'Neill principal investigator **des.oneill@amnch.ie**
Frances Horgan senior lecturer
Anne Hickey senior lecturer
Hannah McGee principal investigator, Irish National Audit of Stroke Care, Royal College of Surgeons in Ireland, Dublin 2, Republic of Ireland

Competing interests: None declared.

1 Bruins Slot K, Berge E, Dorman P, Lewis S, Dennis M, Sandercock P, on behalf of the Oxfordshire Community Stroke Project, the International Stroke Trial (UK), and the Lothian Stroke Register Collaborative Groups. Impact of functional status at six months on long term survival in patients with ischaemic stroke: prospective cohort studies. *BMJ* 2008;336:376-9. (16 February.)
2 Horgan F, Hickey A, Murphy S, Wiley M, Conroy R, McGee H, et al. First Irish national audit of stroke care. *Cerebrovasc Dis* 2007;23(suppl 2):132.
3 Ouellette MM, LeBrasseur NK, Bean JF, Phillips E, Stein J, Frontera WR, et al. High-intensity resistance training improves muscle strength, self-reported function, and disability in long-term stroke survivors. *Stroke* 2004;35:1404-9.
4 Jones F. Strategies to enhance chronic disease self-management: how can we apply this to stroke? *Disabil Rehabil* 2006;28:841-7.
5 Allen KR, Hazelett S, Jarjoura D, Wickstrom GC, Hua K, Weinhardt J, et al. Effectiveness of a postdischarge care management model for stroke and transient ischemic attack: a randomised trial. *J Stroke Cerebrovasc Dis* 2002;11:88-98.

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.[1] 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.[2] A key question in the debate is the rationale for follow-up. A recent survey of 256 breast surgeons and oncologists showed that follow-up was principally aimed at managing treatment related morbidity (93%), alongside detecting new abnormalities (82%), psychological morbidity (81%), and recurrences (80%).[3] Dixon and Montgomery's optimism that (outside the guidance provided by the Quality and Outcomes Framework) timely intervention by primary care doctors will reduce anxiety or that assessment by note review should identify need for input at the time of mammography is not shared by colleagues who expressed concern about