in memory, orientation and concentration. Similarly perseveration often indicates the presence of a severe intellectual barrier to recovery. Apraxia also is a barrier and a bad prognostic sign. Depression is common in all people with stroke and may form a great impediment to co-operation with therapists, and to recovery. It may well be treated by antidepressant drugs. Dysphasia also is a considerable barrier and perhaps the greatest value of speech therapy in stroke is in the speech therapist's ability to overcome the barrier rather than in her ability to add significantly to the vocabulary of the dysphasic patient.

The existence and recognition of any of these barriers to recovery is very important since some may be removed and others give prognostic signs of great value.

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Discussion

Dr Gancz (*Bexley*): The term 'little stroke' was invented by Professor Alvarez and from his description in his book I could not quite make up my mind whether he was telling me to treat a person with little strokes or big strokes at home or in hospital. I would like to hear from Dr Brocklehurst what he actually thinks: Where should a patient with a stroke be treated and how should treatment be phased?

Dr Brocklehurst: This depends on many different factors, but mainly on the home and the availability of hospital beds. No patient, particularly an old person, should be admitted to hospital if it can be avoided. Clearly if there is some doubt as to the diagnosis, the patient should be admitted for investigation. If nursing is impracticable at home or if the patient has malignant hypertension, then again he should be admitted to hospital. In the absence of these things, by and large it is probably impracticable to admit all patients to hospital. Many people can be adequately dealt with at home, perhaps attending at the day hospital if they require physical rehabilitation, as many of them do. Apart from the diagnostic procedures, the possibilities of therapy are so limited that there is no great advantage in having the patient in hospital. If adequate nursing is available, if district nurses can have more instruction in the early treatment of stroke, if physiotherapists can start the early treatment of stroke at home and teach the relatives what to do, many patients can be managed at home.

Dr Wollner: When, if at all, is there an indication for carotid endarterectomy after transient strokes due to carotid stenosis?

Dr Brocklehurst: I am no expert on this, I am afraid, but a few years ago I heard a lecture at the British Geriatrics Society by Professor Irvine who was a great advocate of vascular surgery for all the things I have been describing. Ever since I have been looking hard for patients to send to him and have only found two, neither of whom was operated on. I think vascular surgery is rather going out of fashion now, but no doubt there is a scientific basis for surgery in some of these cases in old age.

***Question*:** Could you say something about hypertensive encephalopathy or hypertensive cerebral attacks? Where does it fit in, what is the pathology, should there be any immediate first-aid treatment and if so, what?

Dr Brocklehurst: Middle-aged hypertensives are particularly prone to hypertensive encephalopathy with transient loss of consciousness; older people may have confusional states associated with it and may develop a variety of symptoms, associated with a transient rise in

blood pressure in someone already hypertensive. In this case hypotensive therapy is undoubtedly something one must consider. In geriatrics we do not see many people with severe hypertension producing symptoms, although we see a good deal of the end result, the type of arteriosclerotic dementia our last speaker was talking about. There are people in late middle-age who have a dementia, which has been regarded in the past as partly due to recurrent attacks of hypertensive encephalopathy, but acute episodes are not common in old age.

Dr Pasmore (*London*): I am thinking of one particular patient, an intelligent woman of about 80, who fell over and sustained a bad cut on the forehead. On going into her background I found that she had been treated in the past for cervical spondylosis and I must admit that I had not realized until this evening that these falls probably resulted from ischaemia and I had not thought of suggesting a collar for her. The important point is that if this is unnoticed and untreated for any length of time, the patient may become an invalid. This particular woman is afraid to move because of these falls and it has been difficult to know what positive measures to suggest. I wonder if Dr Brocklehurst could make any suggestions as to the correct sort of collar to use in this case. One which seems fairly acceptable is a strip of polythene foam put into stockinette which the person can use as a scarf when he goes out.

Dr Brocklehurst: Try a home-made collar first, to see if it is going to be helpful. If it is accepted by the patient, and it does seem to diminish the incidence of drop attacks, then I am sure it is worthwhile getting a proper one made. I do not think it would have to be a great big collar like those used in cervical spondylosis where there is pain in the arm or perhaps a developing weakness in the leg. All that is needed is something simple which prevents backward and forward movements of the head, and this is easily obtainable through the National Health Service.

Dr Lucas: We appreciate the dangers of anticoagulant drugs in stroke but what about the dangers of angiography?

Dr Brocklehurst: Angiography may precipitate further cerebral infarction, and if there is some good reason to use angiography then I think it must always be used with great circumspection. It should probably be ordered by a neurosurgeon rather than by a geriatrician, unless he is a specialist in this field.

Dr Godfrey (*East Grinstead*): What about the use of drugs for the treatment of depression in the elderly patient at home following small strokes?

Dr Brocklehurst: Imipramine is the drug that I would use, giving 25 mg three times a day for a fortnight or so and then reducing it to 10 mg three times a day as a general guide. There are so many drugs that I think we should become familiar with just one and continue to use it.

'G' is for general and geriatric

Dr J. R. Caldwell, M.B., B.S., M.R.C.S., L.R.C.P., M.R.C.G.P. (*general practitioner*)

I am greatly honoured at being asked to speak here in such distinguished company. Indeed I am reminded of a drunk on a Glasgow tram who bent over to the man opposite and said "I know who you are." "Indeed?" "Yes, you're one of the professors from the University who thinks he knows everything." Silence. "But I know something you don't know. My old woman does your washing." "Indeed?" "And I know something else you don't know. This is one of your shirts I'm wearing." Unfortunately I have neither his Dutch courage nor I fear any secret fund of knowledge.

Certainly I do not propose to teach my grandmothers how to suck eggs; I am sure you all know at least as well as I how to treat your patients with cerebrovascular disease.