Editorial

STROKES

CEREBROVASCULAR disease now rates third in the ranks of the captains of death. How many suffer from cerebrovascular accidents is hard to say. At a recent conference on rehabilitation after stroke held at the Hospital Centre under the auspices of King Edward's Hospital Fund, Dr H. Yellowlees, deputy CMO at the Department of Health and Social Security, estimated that between 100,000 and 125,000 people in England and Wales were afflicted annually; a quarter of these were under 65. In view of the difficulty of diagnosing the minor haemorrhages into the cerebral hemispheres this estimate is probably on the low side. Of those not admitted to hospital 50 per cent died within the first month, and of those admitted to hospital 30 per cent were dead at the end of the month. Half the number who survived the first month were still alive after five years and a quarter after seven years. How many of these had recovered, how many were living a wheelchair existence is not known. Dr Yellowlees estimated that 50,000 to 60,000 new patients needed rehabilitation every year.

The impression is gradually gaining ground that the best chances for a patient with a major stroke is early admission to hospital. The attitude so often expressed by the doctor and endorsed by the relatives that there is nothing to do to help the unconscious hemiplegic is no longer tenable. This belief stems from the days when semiconscious and incontinent, the patient was allowed to linger sodden in his bed rather than to attempt treatment—" It would be unkind to let him recover ". Well, it still is sometimes, but we have all seen the miraculous, full recovery of patients from deep hemiplegic coma. With the advances in neurosurgery, diagnosis has become more accurate; some tumours can be treated, and recurrence of haemorrhage from the circle of Willis can be prevented by surgical intervention. Antibiotics and diuretics have made the immediate prognosis of the classic stroke better and anticoagulants are still acceptable by many physicians in the treatment of suitable cases. Tentative experiments with corticosteroids to reduce the degree of ' inflammatory ' reaction around the area of the haemorrhage are now being made, and who knows what the future may bring.

The patient with stroke is an acute medical emergency who should be admitted without hestitation to the acute medical wards of the hospital. Many can be safely investigated and treated by the general practitioner in hospital when he has the advice of a consultant physician or geriatrician to call upon and where early physiotherapy may be instituted. Where there is no general-practitioner hospital or hospital with general-practitioner beds, the district hospital has a clear duty to admit these cases without hestitation. Dr John Fry, in a contribution to the same conference, produced evidence to show that the average general practitioner could expect to see from five to ten new cases a year and to have continuing care for some 20 to 25. He argued that this was too small a number to enable the family doctor to become sufficiently expert in their treatment; but experience comes not only with numbers, but also with the use made of our opportunities. To nurse the acute hemiplegic at home requires more constant nursing

skill than it is usually possible to call upon. The constant changes of the patient's position and the perpetual changing of the bedding which are necessary to prevent bedsores developing, are only part of the skills required in the early treatment.

There are many minor ' strokes ' forming part of the atherosclerosis syndrome for which the hospital has little to offer and which will recover in part at least without any interference. Dr Fry estimated that 20 per cent of all strokes fall into this category. These may alternate with small infarctions in other regions,—the heart—the lungs—the pancreas. Speaking at the same conference, Dr G. F. Adams of Belfast, reported that 18 per cent of his cases showed evidence of prior conornary infarction. Evidence of earlier cerebrovascular accidents may be adduced from a history of sudden transient blackouts, or sudden transitory changes of mood when the patient's relatives will be the first to remark that they are sure that something has happened to make him so unlike himself. Often the syndrome is heralded by intermittent claudication sometimes not recognized by the patient as other than one of the aggravations of ageing. These patients may or may not be suffering from hypertension, that so-called symptomless condition even now little understood. As the late Dr Charles Baker[1] characteristically noted in this context " Many patients have no symptoms until they are treated ". Certainly the treatment of hypertension may lead to unpleasant symptoms—called side-effects—arising. When to treat to prevent disaster is one of those subtleties still requiring the practice of the art of medicine. Nevertheless prevention is one of the most important functions of the family doctor and it is here that his best service to his patients can be achieved. We know too little about this subject; it is one especially suited for investigation by general practitioners.

REFERENCE

Baker, Charles (1970). *Conybeare's Textbook of Medicine.* Fifteenth edition, p. 488.

A SIGN IN GALL-BLADDER DISEASE

Case histories reported by the patient himself are always of interest; but when the patient is a medical man his experience has often a very special value; Heberden's angina, Sydenham's gout and Thomsen's myotonia congenita are a few classic examples. Sir Zachary Cope has all his long life been an acute observer of the signs and symptoms of abdominal disease, and now he has had the misfortune to be the observer of the acute abdomen in himself. There are not many who could turn so painful an occasion to such good purpose. In a short memorandum in the *British Medical Journal* he reports his experiences. He remarks that in his long clinical career he had never seen the very beginning of an attack of acute cholecystitis. He thinks that few doctors do see the initial stages of acute abdominal disease.

Sir Zachary's illness was heralded by occasional nocturnal attacks of profuse sweating and increased pulse rate. The onset of the acute episode was 'a dull severe, deep pain in the middle of the epigastrium'. He retired to bed and then palpated his abdomen to find a rounded, tense, firm swelling, about the size of a golf-ball in the right hypochondrium: it was not tender or painful. In the next few hours the pain lessened and the swelling disappeared. The pain later returned and acute cholecystitis developed. The leader writer in the *British Medical Journal* remarks on the fact that general practitioners in referring patients to hospital sometimes describe a swelling in the right hypochondrium which is not present when the patient is examined after admission.

REFERENCE

British Medical Journal 1970. **3**, 147.