Tips for GP trainees working in stroke medicine

INTRODUCTION

Stroke units make a big difference to the lives of your patients and their families, following what is generally an earth-shattering event. While working in a stroke unit, you will see a vast spectrum of patients, some who make a full recovery, some who subsequently deteriorate, and the majority who fall somewhere in between. You may work on a hyperacute stroke unit, a stroke rehabilitation unit, or an integrated unit, which combines both.

Stroke medicine is a subspecialty of geriatric medicine, however stroke is not just a condition of older people. Practising stroke medicine relies on a good core working knowledge of general medicine and neurology.

You may have heard of multidisciplinary teams (MDTs) before. In no other field of hospital medicine will you have the opportunity to work so closely as a member of an MDT and see what positive effect they can have.

Expect to be working as part of an MDT comprising of nurses, occupational therapists, physiotherapists, speech and language therapists, and neuropsychologists. All are integral to an effective stroke unit. Together, you will participate in complex discharge management. Communication underpins stroke medicine; failure to communicate well with patients and within the MDT will result in poor outcomes for your patients.

You will see people with life-changing conditions, be sensitive to this. No one expects a stroke to happen. Working in a stroke department will allow you to develop transferable skills to the field of rehabilitation medicine.

This article provides a guide to help you through a typical job on a stroke unit that will allow you to feel more prepared for the days ahead, the expectations on you as the FY2, as well as covering your educational needs.

THE BASICS

1. Understand how stroke presentation relates to neuroanatomy.
2. Revise how to conduct a full neurological examination: cranial nerves, peripheral nerves, speech, and cerebellar function.
3. Learn about the Face.Arms.Speech. Time tool, ROSIER (Recognition of Stroke in the Emergency Room), and the ABCD2 score (as a risk stratification tool for a transient ischaemic attack [TIA]).
4. Learn about the NIH Stroke Scale used in the assessment of an acute stroke.
5. Make sure you know the indications for urgent CT scanning, how to organise one, whatever the time of day or night, and how to get it reported (National Institute for Clinical Excellence [NICE] guidelines).
6. Remember a patient who has had a stroke must be nil-by-mouth until they have passed a swallow screen performed by a trained member of staff. If the patient is nil-by-mouth, don't forget their hydration and nutritional needs.
7. Get used to writing up medicine as oral (PO) or nasogastric (NG) rather than simply PO. This will make sure that the patient gets their medicine on time as well as saving you time.
8. Understand the role that thrombolysis, antiplatelet, and anticoagulation therapy play in acute stroke. Find out about local arrangements for stopping them prior to percutaneous endoscopic gastrostomy (PEG) insertion and carotid endarterectomy.
9. Get used to the routine blood tests and medications which are used for stroke.
10. Think homeostasis. Stroke can knock the body severely off balance; monitoring of blood glucose, blood pressure, and oxygen saturation are all important.
11. Familiarise yourself with the helpful stroke guidelines produced by NICE,

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Scottish Intercollegiate Guidelines Network (SIGN), and the Royal College of Physicians.

12. Just because a patient is unable to speak does not mean that they lack capacity.
13. Think about the Liverpool Care Pathway and the role of palliative care teams.
14. Don't neglect your wider medical and surgical skills, they may be required on the ward or on the general take when you are on-call. Stroke patients often have comorbidities.
15. Remember that chronic disease causes depression. Screen for depression using HADS (Hospital Anxiety and Depression Scale) and GDS (Geriatric Depression Scale) so that you can involve the clinical psychologists where appropriate.
16. It would also be useful to have a working knowledge of the Modified Rankin Score, Barthel Scale, and cognitive screening tools such as the MMSE and Montreal Cognitive Assessment.
17. Get writing those discharge summaries early so that on the day of going home, you only have to check and make some small amendments. Most units will have an MDT approach to discharge, so work closely with colleagues.
18. Ask your consultant about how they prefer to investigate strokes in the under 60s.

REFERRALS AND TEAMWORK

19. Get to know the radiographers in CT, MR, and ultrasound.
20. Get to know the gastroenterology team who will be responsible for inserting PEGs, as well as the vascular team doing carotid endarterectomies.
21. Get on good terms with your clinical investigations department: you will be providing them with copious echocardiograms and 24-hour tapes to do.
22. Put yourself in the position of the GP receiving the discharge summary of a patient who has been in hospital for 6 weeks. What is important? Medication changes, functional ability, capacity, and social needs are a good starter. Be sure to document what follow-up is planned, even if a clinic date has not been finalised.
23. Patients move around quickly; get used to handing over your patients so that your opposite number does not have to spend hours looking through the medical notes.
24. Make sure you know how to set up

anticoagulation clinic appointments, otherwise discharges can be delayed.

SKILLS AND DEVELOPMENT

25. Mini Mental State Assessments — give your patients every opportunity to score as well as they can.
26. Try a thickened drink; this may provide some insight into what life is like with an impaired swallow.
27. Use both typical and atypical cases as the basis for case-based discussions, especially those that have presented to their GPs.
28. Stroke medicine is readily audited and can make a difference to service provision.
29. Understand the stroke and TIA pathways (both as inpatient and outpatient) where you work.
30. Familiarise yourself with the OSCP (Oxford Community Stroke Project) classification.

COMMUNICATION

31. Patients and their families will want to discuss what has happened and what the plan is. Take time to do this. Familiarise yourself with the notes in advance. Find an appropriate location. If the patient is not present, do you have their consent to talk to the family?
32. Use the nurses, especially specialist nurses in stroke medicine. Their knowledge is invaluable.
33. Speak up in MDT meetings.
34. Do not be drawn on a prognosis by the family. Strokes can lead an unpredictable course; answering questions about what the future holds is firmly the territory of career stroke physicians.
35. Get used to discussing lifestyle change with your patients. A little exercise, a healthier diet, and stopping smoking have incremental and significant benefits for stroke patients. But don't lecture patients. It does not work.

Provenance

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