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Dear Sir,

The “hype” in hyperacute stroke.

The national stroke strategy consultation document “A New Ambition for Stroke” makes the important point that stroke unit care delivered by a specialist multidisciplinary team is “the single biggest factor that can improve a person’s outcomes following a stroke.” [1] Despite this, stroke experts seem to be focussing on stroke as an emergency, hyperacute care, and the delivery of thrombolysis to a very small minority of the 110,000 stroke population in England believing that this leads to better outcomes and saves resources.[2] Similarly, a House of Commons debate about stroke services on 11 July 2007, produced a suggestion from one party that resources should be diverted from rehabilitation towards thrombolysis and hyperacute stroke services.

The focus of both stroke experts and politicians on hyperacute stroke in preference to organised stroke care for all ages appears to be heavily influenced by the outcomes and savings figures in the National Audit Office’s 2005 stroke report.[3] That report had headline results that its recommendations would lead to some £20 million savings annually (£16 million from its thrombolysis recommendation based on 9900 doses being given and a fully recovered rate of 180 / 1000 treated), 550 deaths avoided (calculated from an economic research model population of 82,000 stroke patients and an extra 25% accessing organised stroke unit care), and 1700 fully recovering each year who would not otherwise have done so (1500 due to thrombolysis and 200 due to the additional 20,500 accessing stroke unit care).

Expert and political opinions about prioritising funding towards acute and hyperacute stroke care may need to be reconsidered; at the 27 March 2007 Public Accounts Commission meeting, Sir John Bourn, the NAO’s Comptroller & Auditor General, told MPs that with the NAO’s stroke recommendations “there is no financial payoff for improvement in stroke services”. [4] The NAO’s figures do seem to lack face validity given the number needed to treat with stroke unit care of 33 to avoid one death and 20 to enable one person to become independent. With the more recent outcome figures for full recovery of 100 / 1000 in the SITS-MOST study and Boehringer-Ingelheim’s evidence to NICE during the Alteplase appraisal of a maximum of 5512 patients being eligible for treatment in England and Wales in 2011 compared with the NAO’s research model assumption of 9900 doses, it would appear that the NAO’s outcomes and savings figures were overestimated and frankly optimistic if not misleading.[5]

Geriatricians need to ensure that stroke funding choices and priorities are based not on hype but on the published evidence. There should be no unfair discrimination against older and younger patients who require organised

rehabilitation in hospital or the community through an unjust and unjustified priority use of limited resources on hyperacute care.

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