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Letters to the editor

OVERVIEW

Please submit letters for the editor's consideration within three weeks of receipt of *Clinical Medicine*. Letters should ideally be limited to 350 words, and sent by email to: clinicalmedicine@rcplondon.ac.uk

The latest national clinical guideline for stroke

Editor – The recent *Clinical Medicine* CME review of stroke is very welcome.[1] May I make three comments?

1 Rudd *et al* discuss the late effects of stroke purely in terms of the need for further research,[1] but the series of reviews lacks any discussion of these late effects, which can be devastating for those left with severe impairments following one or more strokes. Rodgers and Price discuss inpatient rehabilitation and early supported discharge, but the management of the late effects of stroke is discussed in terms of a referral to 'other community services'.[2] This is regrettable as it gives no guidance to the primary care team about the management of stroke following the withdrawal of the early discharge team. Late symptoms of stroke that are amenable to medical intervention include the monitoring of blood pressure, management of fatigue and depressed mood in addition to the ongoing rehabilitation needed to optimise participation. This should be provided by a community-based rehabilitation team when this service is not provided by a hospital-based service.

2 For those experiencing a stroke at working age, a return to work strategy must start in hospital with a preliminary discussion relating to the nature of the patient's work, advice to remain in contact with their employer and to avoid premature prognostication about potential return to work.[3] Patients should be advised that there are many ways of assisting those with residual impairments in returning to employment[4] although stroke-specific vocational rehabilitation services are notably deficient in the UK.

3 The reviews made no reference to the role of assistive technology in the rehabilitation of those with residual stroke impairments. This is surprising as powered wheelchairs (available through the NHS for those fulfilling specific criteria) can be used for the following aspects of stroke care as described in Box 1 by Rodgers and Price:[2] activities of daily living, driving, work and leisure, arm function, communication (with communication aids attached to the wheelchair), fatigue, mobility, reduced psychological distress related to immobility, pain management, spasticity, swallowing and vision. Thus, about 6% of 544 users of electric-powered indoor/outdoor wheelchairs provided by a specialist wheelchair service had cerebrovascular disease. Powered wheelchairs are now seen as powerful therapeutic tools[5] and examples of their use in other chronic neurological conditions have recently been reported.

The recent World Health Organization report provides 'evidence-based, expert-informed recommendations and good practice statements to support health systems and stakeholders in strengthening and extending high-quality rehabilitation services'.[6] It is therefore regrettable that a CME section lacks any significant content on the needs of community residing individuals with residual impairments following episodes of cerebrovascular disease. ■

Conflicts of interest

The author has no conflicts of interest to declare.

ANDREW FRANK
Retired consultant physician in rehabilitation medicine

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Response

Editor – The author makes some very valid comments about the importance of rehabilitation, particularly late after stroke, and the importance of making it patient centred and making the best use of assistive technology. All of these issues are addressed in the full guideline which is available online.[1] Necessarily, the brief articles published in *Clinical Medicine* had to be very selective in their content but the guideline itself covers the whole range of issues from prevention to life after stroke. ■

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The author has no conflicts of interest to declare.

TONY RUDD
Professor of stroke medicine, Kings College London; Consultant stroke physician, Guy's and St Thomas' NHS Foundation Trust; National clinical director for stroke, NHS England; London stroke clinical director, London, UK

Reference

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Portal vein thrombosis – a primer for the general physician

Editor – I was surprised to find the authors of 'Portal vein thrombosis – a primer for the general physician' strongly advocated an extensive search for thrombophilic conditions.[1] While these conditions undoubtedly increase the risk of portal vein thrombosis, the question is does knowledge of these mutations alter the subsequent management of the condition or the duration of treatment?

There may be a justification in testing for some thrombophilic conditions, eg identifying myeloproliferative disorders with the *JAK2* mutation, and some thrombophilias convey a higher risk of recurrence than others,[2] but there is certainly little justification in screening for factor V Leiden and prothrombin gene mutations.

The 2012 National Institute for Health and Care Excellence guidelines for venous thromboembolism (VTE), which are surprising supportive of thrombophilia screening, do not include factor V Leiden and the prothrombin mutation as they do not increase the risk of recurrence to a clinically significant extent.[3]

In contrast, the 2010 British Society of Haematology guidelines state 'testing for heritable thrombophilia after a first episode of intra-abdominal vein thrombosis has uncertain predictive value for recurrence. Grade C evidence – as no studies have investigated how the finding of a heritable thrombophilia should influence management'.[4]

Analysis of the large multiple environmental and genetic assessment study showed that testing for inherited thrombophilia did not reduce recurrence of venous thrombosis.[5]

The American College of Chest Physicians guidelines on VTE, which recommend ongoing anticoagulation after an unprovoked VTE, list thrombophilias among factors that predict risk of recurrence, 'but not strongly enough to influence recommendations on duration of therapy'.[6] And US guidelines have an equally clear message of 'do not perform thrombophilia testing in patients following an episode of unprovoked VTE'.[2]

In summary, thrombophilia is commonly evaluated in patients without a clear indication for testing and not only that, but frequently during times when the results may be unreliable. ■

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The author has no conflicts of interest to declare.

ANDREW THOMPSON
Consultant physician and trust thrombosis lead, Musgrove Park Hospital, Taunton, UK

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An unusual case of orthopnea

Editor – I read with interest the case of diaphragmatic paralysis presented by Keelan *at al*.[1] As they stated in their article, an iatrogenic cause should be considered; however, one they failed to mention, which is important for the physician to be aware of, is following pulmonary vein isolation for the treatment of atrial fibrillation.

The number of pulmonary vein isolations being performed is steadily increasing.[2] At present, two main strategies exist: point by point ablation with radiofrequency energy or freezing using an expandable balloon catheter (cryoballoon). Although both are associated with phrenic nerve palsy, cryoballoon ablation has the higher complication rate reported over a number of studies (4.6–11.2% versus 0–0.3%).[3] The majority of complications result in a temporary paralysis with an average recovery time of 4 months; however, permanent paralysis has been recognised.[4] A right-sided unilateral palsy is the commonest reported because of the proximity of the right phrenic nerve to the right-sided pulmonary veins (especially the right superior vein). Intra-procedural phrenic nerve stimulation to monitor for complications during cryoballoon ablation has cut the rates of injury significantly[5] and is routinely used at our centre.

Iatrogenic phrenic nerve palsy following pulmonary vein isolation can be easily overlooked as a potential cause both by the patient and clinician, particularly when the presentation is weeks after the procedure and our medical admissions units are frequented by breathless patients with exacerbations of chronic lung disease (personal experience). A higher index of suspicion should be employed, with earlier use of appropriate investigations. ■

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The author has no conflicts of interest to declare.

NATHAN DENHAM
ST6 in cardiology, Liverpool Heart and Chest Hospital NHS Foundation Trust, Liverpool, UK

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