The authors have rightly included cerebral venous sinus thrombosis, pre-eclampsia, eclampsia, and reversible vasoconstriction syndromes as the possible differential diagnosis of stroke in pregnancy.[1] Other causes of stroke are amniotic fluid embolism, postpartum angiopathy and postpartum cardiomyopathy.

In our experience the three common examinations that are not routinely performed are fundoscopy, blood pressure measurement in both arms and urine analysis for proteinuria.

MRI of the brain without contrast is the preferred imaging option in pregnancy. Time-of-flight MR angiography, which does not require contrast administration, can be used to evaluate the cerebral vasculature. CT brain may be performed if facility for MRI imaging is not available.[5]

Thrombolysis data are lacking as pregnant women were excluded from the clinical trials that validate rt-PA (recombinant tissue plasminogen-activator) in acute ischaemic stroke. Our knowledge about its use in this condition is based on case reports or case series.[3] Data from case studies has shown that thrombolysis is effective in ischemic strokes with a relative low risk to mother and foetus.[3]

Thrombolysis for ischaemic strokes should be considered after discussion with the obstetric team and the patient. The risks and benefits should be explained to the patient before administrating systemic thrombolysis. Thrombolytic therapy complications include pre-term labour, placental abruption, foetal death, post-partum haemorrhage and possible teratogenicity.[3] Acute stroke treatment decision-making is a complex process that must be performed quickly.[4]

With obstetric back-up, intravenous rt-PA should be administered followed by 'rescue' mechanical thrombectomy in situations where no clinical improvement is seen.[4]

In pregnant patients with malignant middle cerebral artery infarction syndrome and impending herniation, early decompressive craniotomy can reduce mortality and increase the likelihood of favourable outcome.

Haemorrhagic stroke also affects pregnant women. Non-contrast CT brain is the imaging modality of choice if SAH is suspected. Lumbar puncture to evaluate for xanthochromia can be useful if the CT shows no detectable subarachnoid blood, yet the suspicion for SAH is very high. Studies have suggested that surgical management of ruptured aneurysms during pregnancy is associated with significantly lower maternal and foetal mortality.

Last but not the least, there is a potential for medico-legal issues with all medical problems in pregnancy, hence the importance of clear documentation in medical notes of all discussions and the rationale for choosing a particular investigation or treatment. ■

Conflicts of interest

The authors have no conflict of interest to declare.

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Editor – We were interested to read the article by Bhaskar Narayan and Catherine Nelson-Piercy, 'Medical problems in pregnancy'.[1] However, in the neurology section we felt that a couple of important safety issues were not addressed clearly enough.

For headache, from an investigation point of view, we have noticed on ward referrals that fundoscopy may be omitted. This is particularly useful in this group given sinus thrombosis is high on the list of differentials.

Additionally, migraine treatment is complex and aspirin is useful, but it should not be used in the third trimester because of its impact on closure of the ductus arteriosus, as noted in the British national Formulary (BNF) as well as elsewhere.[2]

Likewise, propranolol is listed as causing intrauterine growth restriction in the British National Formulary – 'Beta-blockers may cause intra-uterine growth restriction, neonatal hypoglycaemia, and bradycardia; the risk is greater in severe hypertension' – and www.drugs.com also warns that 'this drug is only recommended for use during pregnancy when there are no alternatives and the benefit outweighs the risk' and 'beta blockers may cause decreased placental perfusion, fetal and neonatal bradycardia, and hypoglycemia'.

Furthermore, NICE guidelines counsel against opiates for migraine because they are ineffective – 'Do not offer ergots or opioids for the acute treatment of migraine'.[3]

Topiramate and valproate are both licensed for migraine treatment but should not be offered to pregnant patient as they are teratogenic.

Epilepsy in pregnancy is another complex issue as described; lamotrigine, carbamazepine and levetiracetam account for over 80% of AEDs used in pregnancy. Phenytoin has been falling in use, with less than 2% of women with epilepsy on the register in 2006 using it. With regard to lamotrigine, the commonest drug used, it is known that levels tend to fall in the third trimester; the findings on the register show that some authorities tend to obtain a single drug level early in pregnancy in controlled patients only reassessing this if there is loss of seizure control, rather than monitoring throughout. ■

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Editor – A recent article on acute geriatrics by Conroy and Parker[1] was both clear and relevant.

I was however disappointed (but not surprised) by the first sentence which stated that 'the emergency department is the main portal of entry to emergency care'. The authors also point out that 'geriatricians cannot address the population need alone'.

It is a pity that general practice therefore gets but a passing mention. This is not the fault of the authors but results perhaps from a cumulation of political interference, workforce issues and a near complete fission of primary and secondary care.

A few years ago, as a GP, I developed an interest in acute medicine.[2,3] There are now a number of similar initiatives in different areas, the common qualification of the doctors involved being the desire to dispel the myth that hospitals and the community have different agendas. As Conroy and Parker imply, it is rather important that they don't.

There have been recent discussions between the RCP and RCGP to develop both a skill set and an assessment to accredit such doctors. These discussions have currently been shelved. This is all the more regrettable since, as the authors infer, management should focus on what is appropriate for the individual as opposed to exclusion of the unlikely. This concept lies at the heart of general practice. ■

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The emergence of sarcopenia as an important entity in older people

Editor – The informative article by Offord *et al* highlights the detrimental impact of age-related frailty and sarcopenia on mobility, fracture risk, quality of life, and NHS resources.[1] We were, however, surprised to find no mention of hypogonadism among the recognised causes of sarcopenia (and anaemia) in older males. The anabolic benefits of androgens on skeletal muscle mass are well-documented, albeit also observable with supraphysiological levels achieved by athletes as well as in the context of medically justifiable T replacement.[2] The European Male Ageing study found that hypogonadism affects 2–5% of community-dwelling older men.[3]

Hypogonadism is either caused by deficient testicular function (ie primary hypogonadism) or reduced pituitary luteinising hormone (LH) and follicle stimulating hormone (FSH) secretion (ie secondary hypogonadism). Secondary hypogonadism (low LH, FSH and T) is challenging to diagnose, particularly in the acute setting, as similar biochemical results may be observed in relation to non-gonadal illness, and in healthy men in the evening or post-prandially (T levels have diurnal variation and are suppressed acutely by food intake).[4] By contrast, the biochemical fingerprint of primary hypogonadism is unambiguous, even in the setting of an acute medical or geriatric-rehabilitation ward; serum levels of LH and FSH are elevated, and serum T is low or low-normal. Furthermore, it is important to consider that patients may also present with microcytic anaemia caused by reduced T-dependent haematopoeisis.

T treatment may be given topically or by depot injection. T treatment is not recommended for men with physiological suppression of T secretion as a result of either frailty or obesity of old age.[3–5] However, for older men with true hypogonadism, T replacement is an inexpensive, safe and effective therapy that can reverse sarcopaenia, osteopaenia and anaemia, with expert consensus defining no upper age limit for the initiation of therapy in these individuals.[6]

Thus, when diagnosing sarcopaenia in older men, we urge physicians not to reflexively ascribe this to 'old age', and to also recognise that unexplained anaemia may sign-post hypogonadism. If the patient is subsequently found to have elevated LH and FSH, a trial of T replacement should be considered following an expert review. ■

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