nation therapy were instructed to discontinue dipyridamole after two years.

Additionally e-questionnaires were sent to consultants and specialist registrars in elderly care medicine units throughout Wales asking the following questions:

- What antiplatelet do you prefer to use for first ischaemic stroke or TIA?
- What are the reasons if the combination of aspirin and dipyridamole is not being used?
- How long do you use dipyridamole for?

Out of 95 questionnaires only 20 (21%) replies were received, compared to 51% in 2007. Thirteen (65%) doctors used combination therapy while seven (35%) used aspirin alone following first event, compared to 22% and 30% respectively in 2007. Reasons for not prescribing combination therapy included non-inclusion in hospital formulary (1), lack of evidence (2), adverse side effects (2), and preference to commence combination therapy following a second event.

The results show a significant improvement in the use of the combination therapy following an ischaemic event between 2007 and 2008 in Withybush Hospital (Table 1). However the majority of patients (94%) were not clearly informed about treatment duration. The poor response from the geriatric consultants and specialist registrars in Wales to the questionnaires may be due to a deluge of questionnaires from other studies or could be due to the fact that the same questions were asked previously.

In July 2008, NICE issued guidance suggesting that all patients presenting with an acute ischaemic stroke should be started on 300 mg aspirin within 24 hours and that this should be for two weeks. Definitive long-term antithrombotic treatment should then follow.[3]

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Table 1. Results of the 2007 audit versus the 2008 audit.

	2007 % (n)	2008 % (n)
Number of patients	100 (101)	100 (108)
First episode	74 (75)	82 (89)
Recurrence	26 (26)	18 (19)
First event		
On aspirin	71 (53)	22.5 (20)
Aspirin + dipyridamole	12 (9)	52.8 (47)
Aspirin + warfarin	–	3.4 (3)
Aspirin + clopidogrel	–	4.5 (4)
Clopidogrel alone	4 (3)	2.2 (2)
Warfarin alone	11 (8)	13.5 (12)
Not on any agent	–	1.1 (1)
Recurrence		
On aspirin	23 (6)	21 (4)
Aspirin + dipyridamole	62 (16)	37 (7)
Aspirin + warfarin	–	5 (1)
Aspirin + clopidogrel	–	5 (1)
Warfarin only	–	32 (6)

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Impact of the National Institute for Health and Clinical Excellence and Social Care Institute for Excellence's dementia guidelines in a neurology-led memory clinic

Guidelines on identification, treatment and care of people with dementia were published under the joint auspices of the National Institute for Health and Clinical Excellence and the Social Care Institute for Excellence (NICE/SCIE) in November 2006.[1] These guidelines recommended that psychiatrists, particularly old age psychiatrists, should manage the entire dementia care pathway from diagnosis to end-of-life care, acting as a 'single point of referral' for all cases. Neurologists were mentioned only once in the document, in the context of commencing cholinesterase inhibitor medication, suggesting that the specialist dementia interests of some neurologists had perhaps been overlooked (no neurologist was involved in developing the guidelines), likewise the fact that a significant number of referrals to neurology-led memory clinics come from psychiatrists (>20%).[2]

Compliance with the NICE/SCIE guidelines might be anticipated to erode the number of general referrals to neurology-led memory clinics, and referrals to these clinics from psychiatrists in particular. The impact of the guidelines in a neurology-led memory service was examined by comparing referral numbers and source in the two-year periods immediately before (January 2005–December 2006) and after (January 2007–December 2008) the publication of the NICE/SCIE document.

These data (Table 1) indicate a 79% increase in new referrals seen in the second time period, but with a similar percentage of referrals from psychiatrists (23%, 21%). The null hypothesis tested was that the proportion of referrals from psychiatrists was the same in cohorts referred before

Table 1. Referral numbers and sources before and after the National Institute for Health and Clinical Excellence/Social Care Institute for Excellence (NICE/SCIE) guidelines.

	Before NICE/SCIE (2005–6)	After NICE/SCIE (2007–8)
New referrals seen	213	382
New referrals from psychiatrists (% of total)	49 (23)	80 (21)

and after publication of the NICE/SCIE guidelines (equivalence hypothesis). The result of the χ^2 test did not permit rejection of the null hypothesis (χ^2=0.39, df=1, p>0.5), a finding corroborated by the Z test (Z=0.56, p>0.05). These data indicate that, *pace* NICE/SCIE, neurologists still have a *de facto* role in the dementia care pathway.[2]

While the NICE/SCIE guidelines might possibly have been instrumental in increasing the total number of referrals, by raising awareness of dementia, the evidence from this survey does not suggest that referral practice from psychiatry to neurology has changed in light of NICE/SCIE. The data suggest that psychiatrists continue to value access to a neurology-led dementia service, a supposition confirmed by personal communications. Such a service may be easily integrated into dementia care pathways.[3]

Despite the findings of this survey, managerial judgments on 'compliance with' NICE/SCIE guidelines are, to my knowledge, being used to try to alter the practice of neurology-led memory clinics in some NHS trusts. A broader examination of the impact and implications, if any, of NICE/SCIE guidelines would seem to be mandated by these data before any such changes are made. Moreover, it may be the case that NICE/SCIE guidelines will be rendered entirely obsolete by the implementation of the National Dementia Strategy.

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