ELECTIVE (SSC5b) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

I spent two weeks with the Stroke Team at Poole Hospital, attending daily ward rounds and assisting with jobs on the wards. This has been an excellent opportunity for learning, and I have developed my understanding of the fundamental stroke classifications and some of the important management points in stroke medicine. I was also glad to develop my organisational and practical skills in preparation for starting FY1 in August.

1. What are the characteristics of stroke patients in Poole? What are the key comparison points with East London? What are the common diagnoses on the Acute Stroke Uard and how are they managed?

Patients with stroke are usually cared for on the Acute Stroke Unit, or Stroke Rehabilitation unit. The patients I saw while on placement were generally older people. Some were previously well and independent, while others had multiple co-morbidities and were dependent for activities of daily living. There was a range of interesting neurological presentations, as well as general medical problems in patients with co-morbidities. Key comparison points with patients in East London include age and ethnicity, as the population in East London has a large young migrant demographic, compared with Dorset.

The majority of patients I saw on the Acute Stroke Uard were older people who presented with problems with vision, speech and motor and sensory neurology, and sometimes more vague symptoms. Stroke describes a rapidly developing focal deficit of cerebral function lasting more than 24 hours, or leading to death. Stroke symptoms can be assessed with the National Institute of Health Stroke Scale (NIHSS) which is an objective measure of stroke impairement, scoring from 0 (no stroke symptoms) to 42 (severe stroke symptoms). Serial assessments can be used to show improvement or deterioration in symptoms.

Common ischaemic stroke diagnoses I saw were classified by the Oxford Stroke Classification, which differentiates Total Anterior Circulation Stroke (TACS), Partial Anterior Circulation Stroke (PACS), Posterior Circulation Stroke (POCS) and Lacunar Syndrome (LACS). This classifies ischaemic stroke by prognosis, based on an assessment of speech, vision and motor and sensory neurology.

The majority of strokes are ischaemic, and the remainder are haemorrhagic. A CT brain within 24 hours of presentation can differentiate these types of stroke as haemorrhage is immediately visible, but ischaemic damage is not initially apparent. If a haemorrhage has been ruled out with a CT brain, acute stroke patients can be considered for Thrombolysis. The inclusion and exclusion criteria are listed in the Poole Hospital Stroke Thrombolysis Protocol document.

Stroke patients should be nil by mouth until their swallow has been assessed as safe by speech and language therapy. An initial assessment should include an ECG (for cardiac arrhythmias, including atrial fibrillation), blood tests (FBC, U&E, clotting, glucose, lipids, CRP), and a chest Xray.

Subsequent investigations depend on the type of stroke. After an MCA stroke include a carotid doppler scan, which may show carotid stenosis , a 24 hour ECG (for paroxysmal or intermittant arrhythmias), and a cardiac echo (as an outpatient), as emboli may originate in the heart in valve

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dysfunction. Subsequent CT or MRI brain scans, or contrast angiography may be requested for some patients. Strokes requiring neurosurgery can be referred to Southampton.

Ischaemic stroke drug management involves 300mg of Aspirinfor two weeks, followed by 75mg for life, and a statin. Lifestyle advice includes stopping smoking, and to stop driving for at least one month.

2. How are the services provided in stroke medicine in Poole? How similar is the provision to East London?

Poole stroke services admit around 530 patients with acute stroke a year. The stroke unit consists of and Acute Stroke Unit and a Stroke Rehabilitation Unit. Patients admitted with a suspected stroke are transferred to the Acute Stroke Unit, which has 8 beds. Care of patients with acute stroke on an Acute Stroke Unit results in improved outcomes, compared with care elsewhere. Patients can then be discharged home from the Acute Stroke Unit, or transferred to the Stroke Rehabilitation Unit, which has 19 beds. Follow up care involves the Specialist Stroke Liason Nurse and Consultant outpatient clinic appointment, usually six weeks after dischardge. I believe that the provision is similar to East London, where I have encountered a Hyper Acute Stroke Unit, but I was not aware of a Stroke Liason Nurse in previous placements.

3. What are the characteristics of the patients in Poole in terms of complexity, multimorbidity and polypharmacy?

Some of the patients on the Stroke Unit with multimorbidity or complex social factors involving care benefit from a multidisciplinary approach to their care. Relatives and carers may also play a significant role in a patients careand be involved in decision-making. Good communication with patients, families and carers is important in supporting them and reducing anxiety immediately after a stroke. Followup care and continuity into the community can also help address any subsequent concerns as they arise. A named contact, such as the Stroke Liason Nurse, or a Nurse Specialist, with written information to take away is a good way to support paitents and their families on discharge home.

Although some patients taks a large number of medications, some have remarkably few. After a stroke, medications such as Warfarin, or Direct Oral Anticoagulants may be stopped due to bleeding. As a result, many patients drug charts do not show polypharmacy, and patients may be taking fewer medications as they have been stopped.

4. What are the characteristics of work in stroke medicine and how to they correspond to my strengths and weaknesses? How has this placement helped with preparation for FY1?

Although I had studied stroke medicine during my course, this was the first time I had been involved in caring for stroke patients in hospital. I was surprised by the diversity of diagnoses and causes of stroke in patients. Stroke pathology is more complex in practice than I had anticipated and I found interesting trying to link neurological deficits to scans, ECGs and blood test results. I was particularly glad to practice the organisational elements of an FY1, such as updating a list, writing in the notes, keeping a jobs list, and completing jobs on the wards. I think this will be of great value on starting work in August.

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References

Poole Hospital Junior Doctors Handbook; Hospital Intranet.

Poole Hospital 24/7 Stroke Thrombolysis Protocol and Workbook, V.4, Jan 2010; Hospital Intranet.

Poole Hospital Acute Stroke Pathway, January 2010; Hospital Intranet.

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