infarcts presumably due to occlusion of the main stem of the middle cerebral artery.[7] It is tempting to speculate that many of these occlusions are due to large fibrin rich emboli from atrial thrombi[15] and that prompt treatment with thrombolytic drugs or at least aspirin or heparin might reduce the early mortality in patients with atrial fibrillation by minimising thrombotic extension or recurrence of thromboemboli.

The roles of all three antithrombotic regimens in acute ischaemic stroke remain to be established by current large international trials.[16] In the subgroup analyses of these trials it will be interesting to see whether patients with atrial fibrillation have a higher ratio of benefit to risk than patients in sinus rhythm. Sandercock *et al* also show that atrial fibrillation is almost as common in patients with intracerebral haemorrhage (11%) as in patients with cerebral infarction (18%), making computed tomography of the brain to exclude intracranial bleeding mandatory before any antithrombotic treatment is started,[16] irrespective of heart rhythm.

Finally, what is the therapeutic relevance of atrial fibrillation in survivors of a first stroke? Sandercock and colleagues show that between 30 days and six years survivors of stroke with atrial fibrillation have a risk of recurrent stroke or vascular death similar to that of those in sinus rhythm.[7] Both groups of patients therefore require secondary preventive measures, including antithrombotic treatment: aspirin in a dose of 75-300 mg daily is currently the recommended regimen.[16] Studies are currently underway comparing anticoagulants with antiplatelet drugs in the secondary prevention of cardiovascular events in patients with previous ischaemic stroke or transient cerebral ischaemic attacks. Results in patients with atrial fibrillation (included in the European atrial fibrillation trial) will be reported next year.[16]

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Stroke rehabilitation: can we do better?

Emphasising physical recovery may be counterproductive

Stroke may have severe and long lasting physical, emotional, and social consequences for patients and their families. Although there is a consensus that patients who have had a stroke benefit from multidisciplinary rehabilitation, there is less agreement about how this should be organised and what it should comprise. Nearly all patients who survive a stroke experience some spontaneous recovery, with about four in five being able to walk independently within six to 12 months.[1] Most recovery occurs within the first few months,[2,3] which is when patients receive the most intensive rehabilitation.

Developments in physiotherapy have emphasised the importance of intrinsic recovery and facilitating normal movement and tone in treating stroke.[4] This approach now forms the basis of accepted practice in Britain despite the lack of evidence that it works. Moreover, its dominance has meant that the expectations of the patient, family, and staff focus mainly on physical recovery. By default, physical recovery has become the most important outcome measure of stroke rehabilitation, dictating, for example, the timing of discharge from hospital, the provision of community services, and the need for respite care.

This emphasis on the recovery of physical function has arguably led to increasing neglect of the emotional and social consequences of stroke. Wade has emphasised that rehabilitation should aim to include helping the patient adapt as well as possible to the difference between his or her desired and achieved role.[5] Evidence suggests that, despite the large amount of money spent on caring for patients with stroke (about 4% of the NHS budget[6]) and the widespread introduction of multidisciplinary rehabilitation, this objective is not being achieved.[7,8]

Many patients, even some with good physical recovery, are socially inactive and have high levels of psychological morbidity. The range of possible emotional disorders is wide and includes anxiety, agoraphobia, and pathological emotionalism.[9] Depressive symptoms are more than twice as common as in age matched controls.[10] Much of this psychological morbidity, however, remains apparently undetected or ignored: few patients who have had a stroke receive antidepressants.[11] Many studies have highlighted the social inactivity of patients. One study found that 90% of patients were able to walk indoors and climb stairs independently, but many of them were effectively housebound.[1]

The patient's family is important in rehabilitation, but the psychological burden is heavy. Many carers suffer from frustration, stress, and frank depression, which increase with time and become progressively unrelated to the patient's physical ability.[12,13]

Several reasons may be suggested for the generally poor longer term outcome for patients who have had a stroke and their carers. Poor liaison between hospital and community services or poor coordination of community services may result in fragmented delivery of services. If the patient receives continuing treatment in an outpatient department or day hospital the family may be unaware of his or her progress, which precludes the important "carry over" effect of treatment. Most patients and carers receive little information about stroke services or support services. Although stroke clubs and other voluntary organisations can have an important long term supportive role, few patients or their carers are aware of them and even fewer attend.[14]

The results of a survey of patients three years after a stroke has emphasised the need for new approaches to rehabilitation, incorporating longer term support (rather than physical treatment).[8] Few patients or carers thought that more rehabilitation was necessary but more than one fifth identified a need for better support after discharge from hospital, counselling, and more information about services for disabled people.

Several studies have tried to improve the long term physical, emotional, and social function of patients with stroke. A small study evaluating the provision of booklets to patients and carers reported that many had found the booklets helpful, though there were no measurable effects on physical or social outcome.[15] The Leeds family placement scheme prevented deterioration of physical function in a selected group of stroke patients but had no impact on social activity.[16] The Bradford community stroke trial showed that either attendance at a day hospital or physiotherapy at home maintained physical function up to six months after discharge from hospital, but many patients and carers remained emotionally distressed and socially restricted.[17]

Physiotherapy at home may have a role even three years after stroke, when a small improvement in mobility can be achieved. Social activities, however, remained unaffected.[18] Translating gains in physical ability to improvements in wellbeing and access to a richer social world remains stubbornly resistant to our conventional attempts at rehabilitation.

Holbrook has postulated that patients with stroke experience four stages in their adjustment to disability: crisis, treatment, realisation, and adjustment.[19] The treatment stage of recovery may currently be overemphasised in the medical model of care. This impedes the patient's progress towards adjustment, and discharge from treatment may create a further crisis as it may leave the patient feeling defeated and abandoned. New studies are investigating other ways of providing support, emphasising psychosocial rehabilitation as a way of easing patients' and carers' progress. Stroke care is progressing, but successful rehabilitation requires a long term perspective and a shift away from the current overreliance on short term physical recovery. More attention should be paid to social and psychological functioning of both patients and carers.

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Sexual behaviour in Britain and France

As in previous research the emphasis is on counting rather than understanding

There has been a remarkable and unprecedented spate of surveys of sexual behaviour in many countries over the past few years.[1] Results from Britain,[2,3] France,[4] and the United States[5] were published in the past few weeks. The most impressive feature in each case is the size; 18 876, 20 055, and 10 630 subjects respectively, each study using acceptable, though different, sampling techniques. Such studies are obviously costly. The French study was funded by the government in an uncomplicated manner. Both the American and British studies met government opposition. Each study is concerned with AIDS related issues, but only the British and French studies lend themselves to direct comparison.

For the most part there are few surprises, and reasonable agreement between the two studies. Recent involvement with more than one sexual partner is more likely in young, unmarried people. There is an age cohort effect, with those in the 25-34 year age group being less likely to have had only one lifetime partner than those in the 45 to 49 group. More surprising, from the British data, is that overall 13% had been tested for HIV, and, of those with 10 or more lifetime partners, more than 20% had attended a clinic for sexually transmitted diseases. In France a third of men and half the women with multiple heterosexual partners had not used a condom during the past year.

To what extent do these data reflect the actual behaviour of the subjects rather than a wish to be seen to conform to the acceptable norms for their particular age and socioeconomic peer groups? This raises crucial questions about methodology. Here we have to refer to other papers from these groups,[6-8] which indicate that a considerable amount of developmental work was carried out in a short period of time. The French and British methods differed in several ways. The French used telephone interviewing and asked some of the most difficult questions, relating to high risk behaviour, within the