

LETTERS TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and can be submitted on disk or sent by e-mail to: Thomas.Allum@rcplondon.ac.uk.

1 National sentinel audit on stroke cognitive assessments

Editor – There is clearly marked variation in the assessment and management of stroke patients around the UK (September/October 1999 pp460–4), particularly the assessment of cognitive state.

In the national audit only 18% of patients had even a simple mental state assessment. Very few stroke services have adequate clinical neuropsychology support to identify and treat the hidden cognitive problems, let alone the emotional difficulties that follow a stroke.

We found in a study of the 95 first-ever stroke patients who underwent active treatment on our stroke rehabilitation unit in 1996 that full neuropsychological assessment was possible in 62 of these. The exclusions were mainly due to severe communication difficulty preventing performance of the tests (29). The others refused the tests.

The cognitive problems would have remained hidden without formal testing. They included significant impairments in full scale I.Q. (41%), performance I.Q. (48%) and Verbal I.Q. (20%) compared to their pre-stroke I.Q. as predicted by the National Adult Reading Test. Prior to the stroke, 97% of our patients had average or above average I.Q. Deficits were also identified in immediate and delayed recall of verbal and/or visual information (42–67%), recognition memory for words (34%) and faces (62%), object perception skills (46%), spatial perception skills (43%), concept formation skills (64%) and 32% also made significant perseverative errors; 61% had difficulty with attention and concentration.

The National Sentinel Audit highlights that it is now time to take these hidden cognitive problems seriously. Some patients with these problems struggle in the community when treatment and help could be provided.

Stroke physicians need to ensure that clinical and neuropsychology services are developed to address this unmet need.

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2 Congestive heart failure can the nephrologist help?

Editor – Kumar *et al*¹ (January/February 2000 pp36–7) propose extending the indications for renal replacement therapies to those with non-uraemic New York Heart Association (NYHA) class III–IV congestive heart failure (CHF). In this era of evidenced-based medicine and particularly in a field littered with as many failed therapies as CHF, it is surprising that they can still maintain that ultrafiltration's failure to improve patient survival is "inconsequential" and that "in the absence of controlled studies to identify subgroups that are most likely to benefit, a trial of dialysis should be considered."

They quote a 30–50% one-year mortality rate for NYHA III–IV CHF. This is now outdated and does present best therapy an injustice. For example, in the Cardiac Insufficiency Bisoprolol Study II (CIBIS-II)², beta-blockade reduced NYHA III–IV CHF mortality from 17.3% to 11.8% (95% CI (CI) 0.54–0.81%; $P < 0.0001$) after 1.3 years. Similar findings have been reported for metoprolol³. Spironolactone also markedly reduces mortality (Relative risk 0.70 [CI 0.60–0.82]; $P < 0.001$)⁴. Whether its benefits are additive to beta-blockade remains to be tested.

The pool of patients truly refractory to medical therapy is small and mainly consists of those with the worse NYHA IV symptoms. Although intuitively, it is perhaps these patients who might benefit most from renal replacement therapy,

they are precisely the ones in whom it causes the most problems. In addition to standard complications, peritoneal dialysis will exacerbate respiratory compromise, an arterio-venous fistula for continuous haemofiltration or haemodialysis will worsen failure and there is also the problem of haemodynamic compromise.

Paradoxically, renal replacement therapies are best tested and of most use in the management of acute deteriorations and particularly as a bridge to more definitive treatment such as cardiac transplantation⁵. An expensive, invasive and complication-prone management strategy for stable CHF is certainly not an approach to be recommended in the absence of persuasive randomised, double-blind trials comparing renal replacement with best medical therapy. Its premature adoption runs the danger that instead of improving quality of life, one would simply swap one set of problems for another.

References

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- 3 MERIT-HF Study Group. Effect of metoprolol CR/XL in chronic heart failure: Metoprolol CR/XL Randomised Intervention Trial in Congestive Heart Failure (MERIT-HF). *Lancet* 1999; **353**:2001–2.
- 4 Pitt B, Zannad F, Remme WJ, Cody R, *et al*. The effect of Spironolactone on morbidity and mortality in patients with severe heart failure. *N Engl J Med* 1999; **341**: 709–17.
- 5 Golper TA, Glasco GB, Canaud BJ. Dialysis and haemofiltration for congestive heart failure. In: Hosenpud JD, Greenberg BH (eds). *Congestive heart failure* (2nd edn). Philadelphia: Lippincott Williams & Wilkins, 2000.

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In response

Editor – Comparatively few patients being treated for heart failure actually receive optimal therapy^{1–3}, and so the number who progress to NYHA III–IV congestive heart failure is larger than