

Dealing with the Disadvantaged

Helping patients with strokes

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In Britain the incidence of cerebral infarction and haemorrhage (strokes) in the total population is two new cases per 1000. In the elderly population—those aged from 65 to 74—it rises to around 20 and in the over 75s is as high as 45. At least 30% of patients who suffer a stroke will be dead in a month. Of the survivors, only one-third will recover sufficiently to be

fully independent. Many victims are left with a devastating hemiplegia, some will also be aphasic, and the risk of further stroke is high. Within three to five years after the stroke, half the survivors will be dead also (though not necessarily of a further stroke). Around 75% of patients with acute strokes are admitted to hospital and of these about 40% are discharged home—the remainder requiring residential care for their rehabilitation. With motivation and the help of good nursing, physiotherapy, and family support, most survivors will recover sufficient motor function in their affected side to be able to walk again. Function of the arm is much less likely to be regained.

In each year, a general practitioner with an average-sized list can expect to see five new patients with acute strokes, and to be consulted by another eight or nine with residual hemiplegia.

Points to bear in mind

(1) Understandably, most consultations with patients who have had a stroke take place in their homes, but some considerably handicapped people still struggle to the surgery, often braving the hazards of public transport, because the doctor or receptionist did not suggest a home visit or insisted that a minor symptom did not warrant one. Marking the records of your patients with a coloured sticker might help the receptionists, who are left to decide when domiciliary calls are necessary.

(2) Ideally, patients with a disability should be seen in a ground-floor consulting room. If patients have to be seen on an upper floor, the receptionist should ask them if they can manage both climbing and descending stairs, and offer help where necessary. Remember, if a staircase has only one hand rail a patient with a defunct arm will have to negotiate steps in one direction without anything to hold on to.

(3) Upstairs rooms should have waiting space on the same level and preferably close to the room itself. Most patients are flummoxed if they find themselves peremptorily summoned to a distant consulting room by a voice on the public address

system. Elderly patients obviously walk more slowly. Look at the patient's records and note any disability before you repeat the call or assume you can send for the next patient on your list. You could spare someone the anxiety of feeling they are wasting your time by allowing an extra minute for them to reach you.

(4) Aphasic patients will hopefully have someone with them to present their symptoms. Even so, try to direct your explanation to patients themselves. Those with expressive dysphasia do not necessarily have a receptive aphasia. Even the normally fluent can find that words fail them in the stress of seeing a doctor; bear in mind also that an evident language confusion is not necessarily a reflection of a mental confusion and it is distressing to be shouted at like the deaf, addressed like an imbecile, or ignored altogether, when you understand perfectly well. Some patients can write down what is bothering them, so offer a pen and paper if necessary.

(5) If you need to ask patients to remove clothing, offer them your help before either leaping to their assistance or leaving them alone in an examination room to get ready. Some patients resent any implication of helplessness and have devised ingenious ways to dress and undress independently. Others find being one-handed makes even a simple action, such as taking off a jacket, a major undertaking.

(6) It is obviously easier for patients to roll up the sleeve of their paralysed arm to have their blood pressure measured but it is probably better to do this on the sound arm. Some patients find that disordered sensation in the paralysed arm makes the procedure painful.

(7) You may think that there is little you can offer a patient who has had a stroke that will directly affect the hemiplegia. Even so, sympathetic counselling is more help than bland reassurance that nothing remains to be done or that a course of hospital physiotherapy will have the patient "running around in no time." Many patients are subsequently bitterly disappointed when this proves not to be the case.

(8) The patient with a long-established stroke, his spouse, or both may consult more often for minor symptoms for covert reasons. They may be anxious about the possibility of a second stroke and may need reassurance; the patient himself may be isolated because he is afraid or unable to venture far afield; or his spouse may be isolated because the patient is so demented that he cannot be left alone. The confused elderly victim of a stroke may constitute an enormous source of anxiety and irritation, and, if prone to falls and incontinence, a physical burden also.

(9) When nothing apparently remains for you to do for your patients with stroke, remember you are still their first obvious point of contact and can offer what they have probably come for—support, both your own and perhaps that of the social services or voluntary organisations. For example, in some areas care attendant schemes are established that will help relatives cope by supplying practical help, or simply by giving them a few hours break; incontinence services in some places will help out with laundry or loan a washing machine; and, lastly, there is now a growing network of groups where patients and their families can be put in touch with others who share their experience, and

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who meet regularly for friendship, recreation, remedial therapy, and the salutary effect of expressing problems and feelings to people coping with circumstances like their own. If services like these are not to be found in your area, you should be pressurising for their creation.

Useful addresses

The Chest, Heart and Stroke Association, Tavistock House, Tavistock Square, London WC1, tel: 01 387 3012. Contact

Jenny Spreadborough for details of your nearest "stroke club" or information on how to start one, and for other self-help literature on stroke.

The Crossroads Care Attendant Scheme Trust, 11 Whitehall Road, Rugby, Warwicks CV21 3AQ, tel: 0788 61536. Contact Director, Pat Osborne, for details of care attendant schemes operating in your area or how to start setting one up.

The Disabled Living Foundation, 346 Kensington High Street, London W14, tel: 01 602 6491. Contact for information and advice on the management of incontinence and aids for the disabled.

MATERIA NON MEDICA

Diogenes and Aladdin

For those of us who worked in the east end of Glasgow an unwashed old person in a dirty house was a frequent occurrence. This is now known as the Diogenes syndrome, after the ancient Greek philosopher who lived in a barrel and who scorned personal cleanliness. Such incidents were difficult to resolve, usually unpleasant, and sometimes memorable. Perhaps one day I will write of the old lady who spent her life savings on tins of cat food and, after leaving instructions for milk and rolls to be delivered daily, locked herself and her three cats inside her flat. Some six months later her neighbours—distraught, despairing, and desperate—broke the code of tenement life and sent for me, the public health medical officer. To this day, the smell of a cat has a strange effect on me.

However, we also encountered another peculiar condition, the compulsive hoarder. In time, some of these houses became like Aladdin's cave, crammed full of various objects which took the owner's fancy. One which I visited contained upwards of three thousand milk bottles; another had hundreds of tins of food neatly stacked in different rooms. One old man had so many old books, magazines, and newspapers that his house resembled a second-hand bookshop. A lady in a fashionable suburb hoarded money. After I removed her to hospital with malnutrition, senior officials had the unenviable task of counting the hundreds of bags of coins, along with banknotes found under carpets and mattresses and which fluttered quietly from the pages of books and magazines.

My most unusual experience of the Aladdin syndrome was two elderly sisters who had collected like magpies for over 30 years. The resultant accumulation defied description but included newspapers, magazines, books, tins, clothes, ornaments, furniture, household utensils, and an enormous quantity of bric-à-brac. Each room was filled to capacity; indeed, the front two could not be entered at all as the contents had fallen back on the doors. The other rooms had a series of paths through mountains of rubbish. It took a cleansing department team two days to remove the unwanted material. Later I was criticised by the local antiquarian society for destroying items of historical interest.—WILLIAM THOMSON (chief administrative medical officer, Lanarkshire).

Smokers and anters

One cold November afternoon I saw a kestrel fly through the gaseous effluent billowing from the stack of a chemical plant. I expected the bird to fly off at speed after this exposure but, instead, it returned to sample the brown fumes again and even hovered nearby for a while. That kestrel must have inhaled a considerable concentration of oxides of nitrogen on that occasion and one can only speculate why it had behaved in that way. If it had feather mites as parasites the irritant gases could have had an effect in dispersing them. Or the kestrel might have had some satisfaction from chemical stimulation of its skin; alternatively, the sniffing of the acrid gases might have provided some pleasure for that particular bird.

Not uncommonly birds may be seen on smoking chimney pots, allowing the smoke to ascend around them and, apparently, enjoying the process. Then, swallows or house martins will occasionally dive and swoop through the smoke from cottage chimneys or garden bonfires. Should birds become overattracted by smoke, however, there may be danger; sparrows and starlings have been suspected of taking smouldering bonfire material or cigarette ends to incorporate in their nests. Village arsonists are not all human.

There are also birds which obtain contact with chemicals by the help of insects. A starling may be watched anting during summer: an ant is seized with the bill and deposited under a wing and then the procedure is repeated. Other birds merely squat where ants are frequent and permit them to climb over them. These ants are ones which eject formic acid when threatened, so the bird's skin gets bathed by the chemical.

It may well be that certain birds get a thrill from diving through smoke, while others prefer to inhale it. Similarly, the smell of formic acid or the feel of its contact with the skin beneath the feathers may be the lure for individuals of a different character; it is unlikely that all these birds are seeking something to soothe symptoms arising from feather parasites. People become addicted to smoking tobacco while others go in for glue sniffing. Humans get challenged to undertake difficult climbs, flights, or voyages. Really it is not surprising that some birds become smoke bathers or formic acid sniffers.—PHILIP RADFORD (West Bagborough, Somerset).

Outpatients and the Beaker People

Hitler and the Beaker People may not have much in common, but musing after watching the television play the other night about Hitler and his "pure race" theories made me realise how the average outpatient clinic makes nonsense of such philosophies.

The farmers who settled in Cornwall 3500 years ago or so built Carn Brea, believed to be the oldest settlement known in Britain, and there have been countless other migrations into the county since then. A nonagenarian schoolmaster patient of mine was given his external MA by Birmingham University when he was in his 80s because of the quality of the thesis he wrote on the Anglo-Saxon migration into the west. He did it by studying place names and surnames, and he told me that they never reached down here. Nor did the Romans either to any significant extent, but the Phoenicians traded here for tin, and many Spaniards are thought to have swum ashore from ship-wrecked Armada galleons. The local girls married them and the surname Jose is common enough hereabouts.

So when I look at my outpatients I believe I can see descendants of at least three migrations coming to consult me; whatever their origins, they all get the same patterns of arthritis. First of all you can recognise the Celts—big men with dark hair. They were always dark, despite popular myth: they dyed their hair blonde with lime to look fiercer in battle, into which they rushed naked, though fortunately they come clothed to the hospital these days. They have light skins and do not sunburn very well. Their ancestors were of the La Tène civilisation and they conquered their Beaker People predecessors. They conquered them but did not eliminate them—I think they are the darker smaller men: quieter and less like Caesar's men than the Celts, but they still exist. And then there are the little men like gnomes, cunning and gentle and rarely fat. They remind me of the little people the Irish have such tales about. They must be cunning to have survived so many waves of upstarts coming to deprive them of their lands. Half a mile from my house up the valley in the Forestry Commission woodland is an Iron Age hill settlement, and the descendants of those people 3000 years later live here still. Knowing my own ancestry, I am proud to number myself among them.—A K THOULD (consultant rheumatologist, Truro).