Cognitive dysfunction after concussion - Authors did not to comment on the single truly significant result

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saries which are directly supervised by—often comparatively junior—programme staff can assume better control and contribute to programme activities in many ways.

The situation in private practice is even more confused. Patients may select only part of the treatment regimen because of the expense involved and may default from treatment after a few weeks, once they start to feel better. Attempts to trace such patients who drop out are rarely undertaken. Cooperation with the control programme—which can help with training, open access to sputum microscopy services, free supplies of drugs, and accompanying monitoring—is essential if there is to be a unified strategy on how to treat the disease.

The national programme incorporating “DOTS” (directly observed treatment, short course) needs to be flexible. In Indonesia, a nominated observer (usually a relative, but it could be a neighbour or influential fellow villager) is briefed carefully and entrusted to be responsible for seeing every home dose taken. This observer can be as effective as a worker based at a health centre. Many patients have their disease diagnosed and documented, receive advice and encouragement, and are started on treatment at a health centre, with their nominated observer in attendance. These patients do not have to go to the district or provincial hospital. We are beginning to see satisfactory cure and completion rates from the rural area. The cities, however, are quite another problem.

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4 Floyd K, Wilkinson D, Gilks C. Comparison of cost effectiveness of differently observed treatment (DOT) and conventionally observed treatment for tuberculosis experience from rural South Africa. BMJ 1997;315:1407-11. (29 November.)

Cognitive dysfunction after concussion

Authors did not to comment on the single truly significant result

Editor—Our finding of an increased rate of cognitive dysfunction among subjects tested within one week of sustaining concussion was unsurprising given the numerous studies pointing to the same conclusion.1 The marginal lack of significance of the binomial test (P = 0.06) is due to a lack of statistical power when only eight subjects are studied. That the lower limit of the 95% confidence interval for the risk ratio should nevertheless lie above unity (1.23) is certainly anomalous, but such discrepancies can arise given the different calculations involved.

Interpretation of significant cognitive dysfunction over 200 days after concussion needed to be deferred until the results for those injured after being tested were examined. It then seemed that there was an increased rate of cognitive dysfunction among those tested either before or after sustaining concussion. This pointed to cognitive dysfunction being a risk factor for concussion. That the risk factor had manifested itself more strongly in those subjects who were injured after being tested could have been due to their being relatively older at injury than those injured before being tested (four fifths of whom were injured more than six months before testing). We found a lower rate of cognitive dysfunction among those injured at age ≥ 18 than those injured at age ≥ 19. Strachan et al suggest that this argument would be strengthened if both groups were subdivided according to whether they sustained concussion before or after being tested. The table shows the relevant data.

The table provides only partial support for our argument in that the age effect appears only among those injured after testing. There is, however, substantial confounding between age at injury and whether testing took place before or after the injury. Furthermore, dichotomising age involves a reduction of information. In a stepwise logistic regression we found age at injury to be significantly related to the test score (dysfunctional/normal) (P = 0.017), and thereafter there was no significant contribution of age before or after testing (P = 0.45). In default of alternative hypotheses, we therefore continue to believe that the poorer performance in cognitive tests of those young men who were tested before they sustained concussion may well be explained by factors related to their relatively greater age at injury.

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Determining prognosis after acute myocardial infarction in the thrombolytic era

Rescue angioplasty after failed thrombolysis may put patients at risk

Editor—Beller brings to readers’ attention the fact that routine invasive procedures after acute myocardial infarction offer no significant benefit over that offered by the routine practice of risk stratification with non-invasive methods.1 We are concerned, however, with the blanket statement that high risk patients should have early angioplasty or rescue angioplasty after failed thrombolysis. This technique should be used with caution.

A meta-analysis by Ellis et al indicated a mortality of 10.6% after the procedure, either

<table>
<thead>
<tr>
<th>Number (percentage) of men who were injured before or after test of cognitive function, by age at injury</th>
<th>Age at injury (years)</th>
<th>Injury before test</th>
<th>Injury after test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dysfunctional</td>
<td>Normal</td>
<td>Total</td>
</tr>
<tr>
<td>≤ 18</td>
<td>150 (24.8)</td>
<td>456 (75.2)</td>
<td>606</td>
</tr>
<tr>
<td>&gt; 19</td>
<td>21 (22.3)</td>
<td>73 (77.7)</td>
<td>94</td>
</tr>
<tr>
<td>Total</td>
<td>171</td>
<td>529</td>
<td>700</td>
</tr>
</tbody>
</table>
from the disease process or as a direct complication of the procedure.7 Furthermore, this procedure fails in 20% of cases and those failed cases have a mortality of 40%. Vigorous clinical assessment is therefore necessary before a patient is classified as being at high risk. Inadequate optimisation of supportive treatment often leads to signs such as hypotension and sinus tachycardia, which, in turn predispose to further chest pain, interpreted as postinfarction angina even in the absence of electrocardiographic changes. Chest crepitations related to aging are often confused with those associated with pulmonary oedema. One prime example is inferior myocardial infarction with right ventricular extension. This is due to an occlusion of the dominant right coronary artery, which carries a relatively good prognosis. Suboptimal fluid replacement and the indiscriminate use of inotropic agents without prior careful assessment of left ventricular function with echocardiography and guidance by Swan-Ganz catheterisation lead to patients being classified as at high risk without having prior or incidental left coronary artery disease.

The fact that rescue angioplasty for right coronary artery occlusion is associated with excessive complications should lead doctors to question whether this form of intervention is putting a patient’s life at risk, turning a relatively benign course into a fatal one.

The main message of my editorial was that a routine invasive strategy for risk assessment before discharge is not superior to a watchful waiting, non-invasive strategy in which patients undergo angiography for high risk clinical findings or for spontaneous or inducible ischaemia within or remote from the infarct zone. Recent data reported from the VA non-Q wave infarction strategies in-hospital trial, in which 920 patients with non-Q wave infarction were randomised to an initial invasive strategy or an initial conservative strategy, support this approach.1 At one year after discharge there was no difference in cardiac death or recurrent infarction between the two groups. Also, new data from Yusuf et al showed no difference in outcome for patients with infarction admitted to hospitals with cardiac catheterisation facilities (catheterisation rate 66%) compared with those admitted to hospitals with no catheterisation facilities on site (catheterisation rate 34%).2

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Number of unexplained symptoms and diseases is decreasing

Editor—In his editorial Mayou explains that the management of patients with medically unexplained physical symptoms is too often inappropriate, even though effective interventions are available.1 He essentially attributes this to the persistence of the idea of “mind-body dualism” in the medical profession, which neglects important interactions between physiological, psychological, and social factors.

I agree with what he says about this socially and economically important subject, but I would emphasise another factor: our social and economic ignorance of the attributes of individual doctors. We need to think imaginatively, to continue the drive for better organisation, to use information technology to the full, to recognise the strengths of patients with McArdle’s disease, who suffer from a genetically determined lack of a muscle enzyme essential for glycogen breakdown and use for energy production (muscle phosphorylase deficiency).

These errors of classification have moral, psychological, and economic implications for patients, their families, and society. Some doctors still seem to be unaware of their own ignorance. We should be modest and cautious, perhaps stating that our conclusions are “to the best of our knowledge” and may not be correct. Even though the list of unexplained diseases and symptoms is slowly decreasing through scientific progress, it is unlikely ever to disappear totally.

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