

## IN THIS ISSUE

### Improving your stroke

A suspected stroke was once a ticket to languish in the emergency department waiting for “more urgent” cases to be seen. Not any more! Donnan's editorial (*page 309*) heads this issue of the Journal with a précis of proven stroke interventions, while four research articles build a picture of stroke management in Australian hospitals today.

One therapeutic advance is thrombolysis with tissue plasminogen activator (tPA), which can greatly enhance recovery from ischaemic stroke if given to selected patients within three hours of onset. Szoeki and colleagues report their hospital's experience with tPA (*page 324*). Meanwhile, Broadley and Thompson (*page 329*), assessed the time it took for such patients to be admitted, revealing deficits in community awareness.

Duffy and colleagues (*page 318*) report on behalf of co-investigators of a multicentre audit called Stroke in Hospitals: an Australian Review of Treatment (START). They examined the use of evidence-based stroke interventions in over 2000 Australian patients, comparing management and outcomes in the different types of medical units.

What can a stroke unit that provides both acute care and rehabilitation services offer? Ang et al put such units to the test (*page 333*).

### Topical topic

An older woman with a complicated medical history develops recurrent generalised seizures. The clue to the cause lies in her medication list, but it takes many months to pinpoint the

culprit. Orr and Rowe draw out the lessons from this case on *page 343*.

### Mountain or molehill?

In rural areas, doctors from “competing” practices may need to collaborate to form rosters so that they can provide continuous medical services. Strictly speaking, argues Pengilly (*page 337*), this could be seen as anticompetitive and in breach of the Trade Practices Act. Gerber (*page 341*) can't fault the legal argument here, but wonders if it has any practical implications. Meanwhile, Mildenhall (*page 341*) gives a rural doctor's perspective of working in the shadow of the long arm of the law, in the form of the Australian Competition and Consumer Commission.



### Letter from America

Late last year Australia received a visit from the “top brass” of California's highly successful Tobacco Control Program. While they were here, Bal and his colleagues didn't mince words about the current sorry state of Australia's antismoking efforts, so their candid approach in their Editorial (*page 313*) comes as no surprise. Like many of their compatriots, they shoot from the hip. Perhaps we should put their four-point plan into action to see if their aim is as good as their rhetoric.

### Trial talk down under

Late last year Sydney's Darling Harbour played host to a flotilla of local and international experts in the design, conduct and ramifications of clinical trials. Topics discussed included whether every patient

should be enrolled in a clinical trial and the need for a comprehensive register of all Australian trials. On *page 316* Pike et al present an overview of the conference, and explain how clinical trials have “come of age”.

### Go with the flow

Have you ever been reading a research paper and wondered how a large number of potential participants became a small group who completed the trial? Might the dropouts have introduced bias, or is there a less sinister explanation? Enter Item 13 of the CONSORT checklist. As Cakir et al explain (*page 347*), participant flow diagrams are the way to go.

A four-armed trial of diet and exercise for the prevention of type 2 diabetes, conducted in China, had very few dropouts, but there were some other threats to its generalisability. Mackerras examines the trial in detail on *page 346*.

### No respecter of persons

David Niven, Stephen Hawking, Mao Zedong, Dimitri Shostakovich — motor neurone disease (MND) has affected many distinguished yet disparate individuals. This enigmatic condition also has different clinical manifestations and appears to encompass heterogeneous aetiologies. Kiernan's editorial (*page 311*) coincides with Motor Neurone Disease Awareness Week (6 to 12 April) and is a useful update on the diagnosis and management of MND.

What happens when a neurologist is diagnosed with MND? Mackenzie's compelling *Personal Perspective* (*page 344*) is told from both sides of the examination couch.

### Another time ... another place ...

*[I] waked and sat up ... when I felt a confusion and indistinctness in my head ... I was alarmed and prayed God, that however he might afflict my body he would spare my understanding ... Soon after I perceived that I had suffered a paralytick stroke and that my Speech was taken from me.*

Samuel Johnson, 1783

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