

Neurological rehabilitation and continuity of care after stroke

Neurorrehabilitación y continuidad en los cuidados tras el ictus

Dear Editor,

Rehabilitation is probably one of the areas that remain pending in the treatment of neurological diseases. The review article recently published in *Neurología*¹ provides an in-depth and up-to-date analysis of neurorehabilitation in stroke patients, for which we congratulate the authors.

Neurorehabilitation is included in the current strategies for Continuity of Care in individuals with acquired brain damage. Continuity of care in the chronic phase of stroke involves a change in both the training received by neurologists, as well as their lines of action.

Specific training in neurorehabilitation is needed and should be contemplated as part of the training programmes in Neurology during residency and super-specialist training (the equivalent would be fellowship in the Anglo-Saxon training model).² Departments of Neurorehabilitation, multidisciplinary by nature, should include a neurologist as a member of the treatment team and probably as department co-ordinator. The needs of the multidisciplinary team include neurologists and rehabilitators, neuropsychologists, physical and occupational therapists, speech therapists, nursing staff, as well as psychopedagogues, social workers, and hospital professors. The neurologist has an important role to play in training this multidisciplinary team and should be prepared for neurorehabilitation teaching and training responsibilities.

Continuity of care must address the clinical complications of the chronic phase of stroke and, on the other hand, the psychosocial repercussions for both stroke survivors and their main caregivers. Post-stroke depression, behavioural and dysexecutive syndromes, and cognitive alterations often limit the outcomes of rehabilitation in stroke.³ Post-stroke depression is the number one factor, with a high prevalence, and must be diagnosed and treated early in neurorehabilitation departments. On the other hand, the repercussions of stroke for the main caregivers' physical and emotional health are considerable.⁴ Neurorehabilitation teams should be prepared to evaluate the degree to which caregivers are overburdened and assess their social support and should have the capacity to carry out appropriate social intervention strategies.

Likewise, continuity of care requires the creation of home-care teams that can evaluate patients' clinical, emotional, cognitive, and functional status following their strokes, as well as the degree of compliance with prescribed pharmacological treatments (medication to lower blood pressure, anti-coagulants, anti-aggregants, anti-epileptic drugs, etc.). In this regard, pioneering programmes have been carried out in France (*Hospitalisation à domicile*) and England (*The Early Supported Discharge model*).

Continuity of care makes it possible to identify those patients in the chronic stage of stroke that can benefit from pharmacotherapeutic interventions (post-stroke depression,

coagulation disorders, vascular dementia), and rehabilitation. Likewise, neurorehabilitation actions in the community should include outside socialization activities, actions aimed at assessing the impact of disability in the real world, for example, going up escalators in a department store, or evaluating limitations for patients' return to work.

A gap in the continuity of care is often seen in neurological patients; this leads to disabled patients being discharged without guaranteeing long-term continuity of neurological care and neurorehabilitation. Likewise, various neurological complications that might be detected in the chronic post-stroke phase with adequate clinical follow-up (dysphagia, neurogenic bladder, spasticity, chronic pain, affective disorders, etc.) may go under-diagnosed or under-treated.

Early, intense, multidisciplinary rehabilitation is very necessary in the context of stroke. Moreover, some patients might also benefit from new rehabilitation programmes aimed at reaching new goals months after having suffered a stroke. Studies carried out in the chronic stage of stroke have shown that these patients can benefit from new rehabilitation programmes.⁵ However, if there is no assurance of a health-care and social network that can evaluate and guarantee continuity of care, many stroke patients and their caregivers may find themselves headed for some degree of neglect as regards care.

Neurologists should become more involved in the continuity of care following stroke. It is taken for granted that diseases such as Parkinson's, Alzheimer's, or epilepsy are chronic. However, follow-up programmes in the chronic stage of stroke are scant and have thus far failed to address the multidisciplinary, holistic treatment that should surround stroke. At present, some Regions of Spain such as Castilla-La Mancha are designing Care Plans for Acquired Brain Damage that will attempt to focus on continuity of care following strokes as one of their ambitious aims.

References

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