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Post-stroke fatigue: an important yet neglected symptom

SIR—Evidence is emerging that fatigue after stroke is a common and distressing symptom to patients [1, 2], and that it is not just a symptom of depression. In our experience, stroke patients frequently complain about fatigue, and therapists often report that sessions of therapy are limited by fatigue. If the latter is really the case, this might have important implications for rehabilitation and recovery from stroke.

Therefore, as part of a pilot study to assess the feasibility of several different questionnaires to measure post-stroke fatigue in hospital inpatients undergoing rehabilitation, we interviewed patients about fatigue, and asked their physiotherapists whether, in their view, sessions of therapy had been limited by fatigue. We recruited 20 inpatients (median age 78 years), at a median of 62.5 days after stroke onset. All had an abbreviated mental test score of more than seven, and none had significant dysphasia. Fatigue was measured using the Fatigue Severity Score (FSS) [3, 4]; and a score of five or more was used to define fatigue. The Geriatric Depression Scale (GDS) was used to screen for depression.

Of the 20 patients interviewed, eight (40%) had a FSS indicating fatigue, and seven had a GDS score of 7 or more, indicating possible depression. Of the eight patients with fatigue, five had a GDS score of 7 or more. Information from physiotherapists about whether fatigue interfered with therapy was available for 16 patients. Therapists stated that fatigue had interfered with therapy in six patients, of whom three had fatigue on the FSS. Overall, there was no significant association between therapists' and patients' reports of fatigue, though this probably reflects the small number of patients studied.

These data suggest that fatigue is a common symptom after stroke, and that post-stroke fatigue might, to some extent, be associated with depression. This study also suggested that sessions of physiotherapy may be limited by fatigue. Further work is required to investigate the time course and associations of post-stroke fatigue, and to develop tools to measure objectively the extent to which fatigue interferes with participation in therapy.

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Three memorable patients

SIR—I write in the hope that the editor may consider the provision of opportunities for reminiscence therapy to retired geriatricians as one of the legitimate functions of this journal. Clark [1], whose descriptions of such important oddities as the Diogenes Syndrome were an inspiration to at least one recently appointed consultant, drew attention to a patient who abused a substance while in hospital, a practice which may still be prevalent in France. Accompanying a French physician round his ward, we arrived at a lady with alcoholic liver failure. 'I think you are still a little yellow', he told her. 'Of course I am, doctor' she replied with incontrovertible Gallic logic, 'it's because you make me drink nothing but orange and lemon juice—all the other patients have red wine with their lunch, and they are nice and pink.'

Conroy and Luxton [2] suggest that the skills of a geriatrician are sometimes relevant to younger patients. A local general practitioner (GP) wrote to me begging me to see his 35-year-old patient, Cedric the Mountainous Mongol, since no other department had been able to offer any help. His description was as incorrect clinically as it was politically, but although I knew that Cedric did not have Down's Syndrome, I did not know what he did have. My SHO, a GP trainee who had just finished a stint with the paediatric department, wondered whether he might have Prader-Willy Syndrome. Muttering that there were some rather atypical features, I looked it up and sent one of my very rare consultation requests to a paediatrician, who confirmed the diagnosis. Where the GP was correct was in supposing that a geriatrician might have at least the armamentarium (in the shape of the Day Hospital), if not necessarily the skill, to provide ongoing support.

Finally, Colebatch [3] draws attention to ill-fitting dentures as a banal but occasionally overlooked cause of dysarthria, and reminds me of a patient seen on a (comparatively) recent post-take round. He had suddenly developed dysarthria, and the admitting SHO had suspected a small brainstem infarct and was hoping to make a case for an MRI scan. By the time we arrived at the bedside, he had recovered