

pendent replications.¹⁰ Yet do same-team approaches ensure independence? Any intermingling of the process for generating and replicating the hypothesis entails the danger of somehow diluting the independence of the replication.

Sample size is also essential. A recent editorial hailed the advent of "small studies with high density of data".¹¹ Well, I think there is no free lunch in good research. Microarrays need evidence and this cannot be obtained from a couple of small studies, no matter how high-tech. Small sample sizes might actually hinder the identification of truly important genes.² Molecular medicine may eventually fulfil its arrays of promises.¹² However, we should aim for many independent studies with a total of several thousand patients, a hundred-fold more than the current standard. If we truly believe that microarrays and molecular research in general are important, we should not settle for less.

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Early supported discharge: a valuable alternative for some stroke patients

In this issue of *The Lancet*, Peter Langhorne and colleagues report the benefits of early supported discharge (ESD) teams as an effective health-service option for a selected group of stroke patients. Since 1997, when Langhorne and his co-workers in the Stroke Unit Trialists Collaboration reported the advantages of integrated stroke care,¹ this care is now embedded in most stroke services worldwide. However, between countries the organisation of stroke care differs; different types of institutions participate, which have their own specific treatment modalities. Several treatment options are usually available, depending on the patient's need for further rehabilitation therapy; each option has specific admission criteria, and consists of some form of inpatient or outpatient treatment in specialised care centres. District sick bays or similar institutions might serve as hotel facilities where the patient can recover from the stroke during a limited period without receiving specific rehabilitation treatment. Some countries have in-hospital rehabilitation facilities, which lengthen hospital stay, while in other countries, transfer to a specialised rehabilitation centre will take place as soon as the patient is medically stable. In their recent meta-analysis Langhorne and his fellow Early Supported Discharge Trialists refer to treatment at home given or coordinated by a multidisciplinary team as ESD;² in today's *Lancet* they evaluate the effects of this new health-service product.

Earlier Cochrane reviews concluded that, compared with standard care, integrated stroke-unit care reduces the odds of death, aftercare in specialised institutions, and dependency recorded at final (median 1 year) follow-up.³ When researchers could not identify a specific factor responsible for the remarkable improvement in outcomes from integrated stroke-unit care, they switched their focus to the organisation of health care. Because of this shift in focus, the Cochrane review from 2000 showed that people who entered the ESD programme and benefited most from it tended to come from a selected group of elderly patients with discrete disabilities.⁴ In the current updated Cochrane review, Langhorne and colleagues conclude that ESD should be considered part of a comprehensive stroke service. They show that a coordinated multidisciplinary ESD team yields the best results in stroke patients with moderate disability; and again they added valuable information to the organisation of health services for stroke patients. ESD might become a new health-service product in many countries.

However, many questions remain. What patients are eligible for ESD? Selection of patients in the studies included in the latest review was based on need (persisting disability), practicability (living within the local area), and stability of the medical condition. Prespecified subgroup analyses

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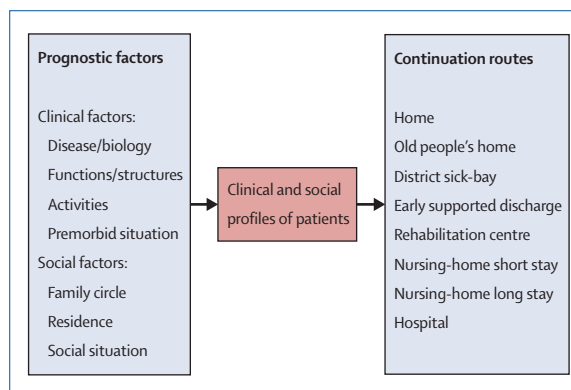


Figure: Stroke unit discharge model
Patient's profile (four clinical and three social subdomains) matched with admission criteria of continuation routes.

were planned for age, sex, presence of a carer, and initial stroke severity. But we have identified four clinical and three social subdomains containing 26 potentially prognostic factors that influence the choice of the rehabilitation services (figure).⁵⁻⁸ Moreover, for patients who have learning impairments, it is important to ascertain whether they need situation-dependent and specific learning strategies. In that case, the learning context and the context in which acquired skills are to be used should have essential characteristics in common.^{9,10} For patients who require situation-dependent learning, the best place to regain skills for activities of daily living (ADL) will be the real-life situation at home. To estimate the benefits of ESD, the Early Supported Discharge Trialists presented odds ratios for clinically relevant outcomes. These results probably lack statistical power; because, if dependency in ADL and death are grouped together in the analysis, they are statistically significant, but if they are analysed separately, they are not. However, the results could indicate the odds that a favourable outcome occurs in the ESD group, compared with the control group.

As for resources, the usual mean length of hospital stay to be expected in the non-ESD situation has not been mentioned. The 8-day reduction in the length of hospital stay in the ESD group could have different causes. Is length of hospital stay shorter for ESD patients because they can enter the ESD without delay compared with other treatment options that have waiting lists? At what time after the stroke are patients discharged from hospital? One is inclined to sup-

pose that length of hospital stay might be reduced only in countries where rehabilitation treatment is continued in hospital after stabilisation of the medical condition.

To clinically interpret Langhorne and colleagues' latest results, admission to ESD services will be the optimum choice for patients who: no longer need medical and nursing treatment that only a hospital can provide; have moderate stroke severity; can return home because they can care for themselves or they have the help of professional care, family care, or both; need rehabilitation that can be provided at home; do not need rehabilitation that cannot be provided at home; live at a considerable distance from the hospital or rehabilitation services and for whom the combination of travelling to an outdoor service with exercise could be too tiring; or who would benefit most from situational learning instead of trying to generalise learned skills.

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Screening for chlamydial infection: are we doing enough?

Chlamydia trachomatis is the most common bacterial sexually transmitted infection. In women, chlamydial infection causes significant reproductive-tract morbidity, including pelvic inflammatory disease, tubal infertility, ectopic pregnancy, and chronic pelvic pain.¹ In men,

chlamydia has also been implicated in infertility.² The significance of these complications, coupled with the high prevalence of asymptomatic infections, has led to the development of screening programmes to detect and treat chlamydia.