Editors' Note: In response to "Cognitive decline after hospitalization in a community population of older persons" by Wilson et al., Dr. Lutwak makes the case for geriatric emergency departments as a way to improve quality of care and decrease hospital readmission rates for the elderly. In reference to "Predicting outcome of IV thrombolysis-treated ischemic stroke patients: The DRAGON score" by Strbian et al., Drs. Bruno and Switzer call attention to a possible limitation of one of the score's parameters, the prestroke modified Rankin Scale (mRS). The authors disagree and clarify their use of the mRS.

Megan Alcauskas, MD, and Robert C. Griggs, MD

COGNITIVE DECLINE AFTER HOSPITALIZATION IN A COMMUNITY POPULATION OF OLDER PERSONS

Nancy Lutwak, New York: Wilson et al.¹ discuss older patients experiencing cognitive decline after hospitalization and suggest that older patients might benefit from care in emergency departments with discharge to their home vs hospitalization.

After care in emergency rooms, however, older patients also have functional decline and are at greater risk of medical complications.² Care in most emergency departments is not well suited to care of the elderly. Rapid triage is not appropriate for older patients who have complex problems. Rapid diagnosis and treatment may be inadequate as well since the acute problem may be subtle and not discoverable under the time pressure of most busy emergency rooms.²

Recent publications have outlined ways to improve quality of care for seniors in emergency departments and reduce hospitalization rates.^{2,3} Implementation of geriatric emergency departments with assessment by an interdisciplinary team of geriatrician, social worker, and nurse discharge coordinator with plans for rapid follow-up by the primary care physician might decrease return rates and need for hospitalization.² In addition, emergency department geriatric observation units that would allow for longer periods for assessment and man-

agement of older patients prior to discharge may decrease admissions to the hospital.³

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PREDICTING OUTCOME OF IV THROMBOLYSIS-TREATED ISCHEMIC STROKE PATIENTS: THE DRAGON SCORE

Askiel Bruno, Jeffrey A. Switzer, Augusta, GA: Strbian et al.¹ discuss the DRAGON score's validity and utility in predicting functional outcome after stroke treated with IV tissue plasminogen activator. Although this scoring system appears to be valid and useful, we would like to consider the following limitation.

One of the DRAGON parameters—the prestroke modified Rankin Scale (mRS) score—is problematic.² Application of the mRS before a stroke is inconsistent with its intended use³ and is not defined. To distinguish between mRS scores 0, 1, and 2, comparison of the patient's functional abilities before and after a stroke (or potentially other brain injury) is necessary. This is impossible before a stroke in most patients, forcing the raters to make subjective and undefined assumptions resulting in suboptimal reproducibility. Strbian et al. do not include details on how the prestroke mRS was scored.¹

This problem does not apply to other disability scales, such as the Barthel Index, which can be scored at any point without a reference to a previous state. We suspect that correcting this problem will improve DRAGON reliability and make it even more useful.

Author Response: Daniel Strbian, Markku Kaste, Turgut Tatlisumak, Helsinki: Although we disagree with their opinion, we thank Drs. Bruno and Switzer for allowing us to further clarify some points.

In an emergency room, it is easy to estimate whether a stroke patient has been totally independent prior to his or her index stroke (i.e., whether his or her prestroke mRS is 0–1). It only takes one face-to-face or over-the-phone question to a family member. In addition, the patient probably has a recent hospital record. A stroke physician would not give thrombolysis treatment to a patient who required constant help in his or her activities of daily living prior to index stroke.

It is also much faster and easier to evaluate prestroke mRS than prestroke Barthel Index. Scoring prestroke Barthel Index by reviewing all the steps either face to face or over the phone is more time consuming, especially when considering that “time is brain.” In our experience, detailed information needed for Barthel Index is rarely found in the patients’ hospital records.

The SEDAN score,⁴ which evaluates the risk of symptomatic intracranial hemorrhage following thrombolysis, together with the DRAGON score, can assist in the estimation of the risks and benefits of thrombolysis.

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Predicting outcome of IV thrombolysis-treated ischemic stroke patients: The DRAGON score

Askiel Bruno, Daniel Strbian, Jeffrey A. Switzer, et al.

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