

Post stroke seizures are typically focal. It has been estimated on the basis of epidemiological studies that generalized seizures are diagnosed in 16%, partial seizures with secondary generalization in 25%, partial complex in 48% and partial simplex in 11%.

Prevalence of epilepsy among elderly may be even higher than it has been shown in official statistics because of common difficulties in differential diagnosis. In elderly symptoms due to complex partial seizures often are diagnosed as disorders of cerebral circulation, dementia or metabolic dysfunction.

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The vascular contribution to dementia

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Primary degenerative dementia (PDD), prototypically represented by Alzheimer's disease (AD) is usually distinguished from vascular dementia. The primary criteria are clinical and neuroimaging. It is becoming more recognized that many cases represent an overlap between the different etiologies, with a different contribution responsible for each case.

Nevertheless, theoretical and practical problems face this distinction. There are no gold standards, since even autopsy examination of demented persons cannot reveal definitely whether the cause of the cognitive decline is degenerative, vascular, or combined. Indeed, pathological criteria for vascular dementia have changed over the past few decades, and this was further complicated by the recognition of small vessel disease as a frequent contribution to cerebral pathology, particularly dementia in old age. It is unclear when vascular lesions (or AD pathology) should be regarded as coincidental and when it should be considered causative. Essentially, the same problem relates to neuroimaging data.

Lacking diagnostic gold standards, the clinical differentiation between vascular and degenerative dementia is established on clinical guesswork. Recent data suggest that the distinction is largely artefactual and lacking validity. Moreover, available evidence suggests overlap between dementia also in basic processes, e.g. cholinergic deficiency. The presumed distinction between vascular and degenerative dementia leads to attempts to discover different treatments for the two disorders, although the basic assumption may be incorrect. The implications for drug studies will be discussed.

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Strategies to reduce the burden of stroke

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This presentation is based on the Helsingborg Declaration 2006, which reflects research achievements in stroke care. Declaration describes targets to be achieved by the year 2015 although local resources for stroke management differ widely between European nations and thus all countries will not achieve these optimal targets.

Stroke patients should be evaluated as soon as possible in hospitals that can provide acute stroke care and are equipped with adequate imaging modalities such as CT or MRI.

Streamlined multidisciplinary stroke care starts from the emergency call centre, which identifies a potential stroke patient. The emergency call centre should dispatch an ambulance for fast transportation to the nearest hospital with appropriate resources for acute stroke management.

Although resources currently differ between countries, all such efforts need to be made that each country will be able to provide a stepwise development of the essential infrastructure and personnel resources, namely multidisciplinary teams, stroke units and imaging facilities.

The outcome of patients managed in a dedicated stroke unit has been shown to be superior compared to that of patients managed in general medical wards. A stroke unit offers an organized approach to in-patient care through multidisciplinary care by a dedicated stroke team.

Minimum criteria for an appropriate stroke unit include the following items:

- Dedicated beds for stroke patients.