

- Dedicated team: stroke physician, trained nurses, physical therapy, speech therapy and occupational therapy.
- Immediate imaging 24 hours (CT or MRI), if not performed at the Emergency Room. It is realized that this criterion may not be met in all stroke units in all countries due to economic constraints.
- Written protocols and pathways for diagnostic procedures, acute treatment, monitoring to prevent complications, and for secondary prevention.
- Availability of neurosurgery, vascular surgery, interventional neuroradiology and cardiology is a part of a comprehensive stroke unit, but not required for a primary stroke unit.
- Immediate start of mobilization after the patient has stabilized and access to early rehabilitation.
- Weekly multidisciplinary team meetings with patient involvement are part of stroke unit care.
- Continuing staff education.
- Continuing education of patients/families/carers.

All stroke patients should have their rehabilitation needs assessed by a multidisciplinary stroke rehabilitation team with medical, nursing, physiotherapy, occupational therapy and speech therapy skills as well as with psychological expertise, when needed. Rehabilitation should be started during the first few days in a stroke unit or on a ward with dedicated stroke beds.

WOJCIECH KOZUBSKI

### *Post-stroke depression*

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Depression is a relatively common psychopathological comorbidity in stroke sufferers – the mean prevalence rate of post-stroke depression, in all stroke victims, ranges from 30 to 50%.

The occurrence of post-stroke depression (both major and minor) increases from 3 months to half a year after the incident. The most encountered types of mood disturbances after stroke are both major and minor depression with the clinical manifestations resembling those of idiosyncratic late-onset depression, with psychomotor retardation more frequently expressed.

Lately, a different form of mood disturbances in CVD had been postulated, i.e. vascular depression, that could be late-onset depressive disorder, found in patients with the overt or silent stroke or subcortical white matter ischemic disease. The symptoms of the disease should consist of: mood abnormalities, neuropsychological disturbances with – especially – executive functions impairment, tendency to psychomotor retardation, poor insight and impaired activities of daily living. It seems that many biological factors might be associated with the presence and characteristics of post-stroke depression (e.g. the stroke focus side, the size of the ventricles), however no firm conclusions can be established by now. Post-stroke depression has undoubtedly negative impact on the recovery of cognitive function and on the activities of daily living; what is more – it increases patients' mortality risk. It is strongly suggested that depression and stroke have bidirectional relationship and influence which means that patients with depression (especially the major one) have 2-fold greater risk of developing a stroke, even after controlling for other risk factors. The post-stroke depression should be treated with such antidepressive drugs as SSRI and tricyclic antidepressants of which fluoxetine and nortriptyline, respectively, have been found to be most effective.

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### *Evidence based motor rehabilitation after stroke*

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Stroke is a leading cause of serious long-term disability in adults. Restoration of walking ability and gait rehabilitation as well as motor rehabilitation of upper extremity functions is therefore highly relevant for stroke patients and their relatives. To restore motor functions, modern concepts of rehabilitation favour a task-specific repetitive approach. In recent years it has also been shown that higher intensities of walking and grasping practice (resulting in more repetitions trained)