Reviewer's report

Title: Ideal timing to initiate interdisciplinary inpatient stroke rehabilitation: an exploratory study.

Version: 1 Date: 30 June 2006

Reviewer: Salvatore Giaquinto

Reviewer's report:

General
The study was aimed at examining the influence of short, moderate and long onset-admission intervals (OAI) on rehabilitation outcomes across homogeneous subgroups of patients who were admitted to a standardized interdisciplinary inpatient stroke rehabilitation program after a first ever stroke.

The Authors reach an apparently provocative conclusion, i.e. inpatient rehabilitation outcome is not influenced by OAI. Indeed, the impact of OAI on stroke rehabilitation outcomes was offset, when controlling for the degree of severity, gender, and age. These results would challenge the opinion that stroke patients must be soon admitted to inpatient rehabilitation potentially, because they can reach more favourable outcomes than those admitted later. These results would also challenge the opinion that delayed inpatient stroke rehabilitation may hamper outcome.

The research is very serious and accurate, but it would be dangerous to spread a wrong information. Patients after the acute cerebrovascular episode should not kept idling, while they wait for their admission to a stroke rehabilitation centre. If rehabilitation begins soon after stroke and does not stop, OAI loses importance. By contrast, if rehabilitation is delayed, OAI becomes critical, because uncontrolled adverse effects may arise in that interval. The Authors acknowledge this criticism in the Conclusion paragraph. The weak part of the study is the lack of information about the kind of rehabilitation offered throughout the stay in acute care facilities and later on, during OAI. The weakness is due to the retrospective design of the study.

Political and fiscal issues should be clarified. About stroke rehabilitation length of stay (LOS), the Authors say that the publicly-funded and universal-access health care system permits a more prolonged LOS during inpatient rehabilitation than what is reported in the United States of America. By contrast, OAI is shorter in US. But, it should be acknowledged that the US system places several constraints at admission and severe cases (for example, cases with a FIM below 40) may not be admitted. Yet, there is the evidence of a slow recovery of the survivors. Each system has its own drawbacks and this article has the ideal background for a general criticism.

Last comment. The Authors often say “nonmedical bed days”. It can be misleading. Indeed, a delayed discharge from acute care wards can be due to acute or chronic comorbidity, which represents a medical intervention.

Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)

Discretionary Revisions (which the author can choose to ignore)