workload figures provided in our study correspond to emergencies.

Unfortunately, the example of acute coronary syndrome is not comparable to stroke since stroke requires neuroimaging studies to provide treatment during the acute phase. Furthermore, types of stroke care other than stroke units, such as stroke teams, have not shown any benefits.[4]

The purpose of a clinician, whether specialised or not, is to provide effective and efficient care to patients. Care must be sustainable, but also equitable; we therefore agree that a 'nodal structure' or other organisational strategies similar to code stroke should be implemented to ensure that neurological patients are transferred to hospitals offering emergency neurological care.[5]

Lastly, the conclusions drawn in our study refer to high-level hospitals such as our own, since we understand that they may not apply to all types of hospitals.

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Neuro-emergencies☆

Neurourgencias

Dear Editor:

We have read with great interest the article 'Workload of on-call emergency room neurologists in a Spanish tertiary care centre. A one-year prospective study' by Rodríguez Cruz et al.[1] There can be no doubt that a preeminent referral centre such as Hospital General Universitario Gregorio Marañón would require a stroke unit and an on-call neurologist. That said, we would like to analyse some of the data provided in the article and qualify some of the statements made by its authors.

It is true that the 3234 neurological emergencies represent 3.48% of the total of 92 762, but it is no less true that this figure amounts to 1.3% of the total emergency evaluations if we include paediatrics, traumatology, surgical, and obstetrical/gynaecological emergencies.[1]

We should highlight that in most Spanish hospitals (91%), emergency care is unified.[2] Several authors have stated that up to 43% of hospitals attend 100 or fewer emergencies per day (small and local hospitals) and some 32% of hospitals attend between 100 and 200 emergencies per day. Only 20% of hospitals attend more than 200 emergencies per day, and barely 5% attend more than 500.[2,3] The first 2 groups (local and medium-sized hospitals) provide healthcare to approximately 50% of the population. It should also be noted that mortality rates and waiting times are lower in the emergency departments in these hospitals.[2]

Hospitals should be classified as primary, secondary, and tertiary care centres for obvious reasons. However, this distinction should not exist in emergency departments. Care provided to a patient at a local hospital's emergency department should be identical to that administered by the emergency department at Hospital Gregorio Marañón. This is the idea behind the principle of equity of access to healthcare.[4] One thing is a patient's final destination once stabilised; the quality of care initially provided by the emergency department is a completely different matter. Medical attention provided in the emergency department to a patient with chest pain (whether due to neuropathy, STE-ACS, pneumonia, diffuse oesophageal spasm, or pneumothorax) is the responsibility of the emergency department doctors.[5] Care received by a patient with any time-dependent disease, referring to initial assessment and stabilisation, diagnostic suspicion, and initial treatment measures,[6] must be provided by these clinicians based on solid training in emergency medicine.[7] This specialty is now clearly defined in many countries,[8,9] and it has contributed significant improvements in the quality of emergency medical care. Subsequent collaborative efforts with other specialties to optimise the care process will depend on the social and demographic characteristics of each area, the available resources, the viability of transportation, and healthcare policies. Information and

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communication technologies may play a crucial role in this step.[10]

In light of the above, we do not agree that every emergency department requires an on-call neurology team that is physically present 24 hours a day. This initiative, which we regard as a praiseworthy attempt to promote a specific medical specialty, cannot be applied in all hospitals for reasons of efficiency and sustainability. Creating nodal reference centres which are well communicated with the other hospitals in the area may be an option.

Finally, we agree that stroke units are necessary but we strongly believe that it is even more necessary to develop interdisciplinary protocols for the different specialties involved in managing such time-dependent conditions as stroke.[11] An example of a huge qualitative step forward in the management of these conditions is 'code ACS', which has been implemented in some Spanish autonomous communities with outstanding results and changed outcomes in STE-ACS.[12] Treatment for stroke should be provided in stroke units when these are available.[13] However, the existence of 'code stroke' is what makes it possible to manage patients in those units. Other viable alternatives to stroke units should be developed to improve morbidity and mortality of stroke patients in hospitals in which stroke units are not available,[14,15] whether for structural reasons or simply because the hospital does not meet minimum requirements.

Conflicts of interest

The authors have no conflicts of interest to declare. The authors transfer the copyright of the present article to *Neurología*.

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