transformation seems to be higher in cardioembolic stroke.[w38 w39] Whether asymptomatic haemorrhagic transformation significantly influences early or long term outcome is debatable. Conversion of asymptomatic haemorrhagic transformation into symptomatic intracerebral haemorrhage with early anticoagulation, however, would be a legitimate concern. Factors leading to haemorrhagic transformation (for example, duration of ischaemia, speed of recanalisation, baseline neurological status, and demographic and imaging characteristics) may help in the timing of anticoagulation in the future.[w40 w41] There is some information but no randomised controlled trials about resuming anticoagulation in patients with intracerebral haemorrhage and prosthetic heart valves.[24 w42-w44] There is no information on how soon anticoagulation could be started safely, if at all, in patients with atrial fibrillation after intracerebral haemorrhage.

Outcome

After our patient's intracerebral haemorrhage, we identified control of blood pressure and diabetes as the areas needing most attention. Overall compliance rather than truly "difficult to control" hypertension seemed to be the problem.

We started him on warfarin two weeks after the second (ischaemic) stroke while recognising that he was a very high risk both for future thromboembolism and for intracerebral haemorrhage and therefore would need very close monitoring. He did not make any substantial functional recovery and needed care in a nursing home. However, lately he has been showing some signs of improvement. His blood pressure, international normalised ratio, and diabetes are being regularly monitored. Supervision in the care home has improved compliance with medication.

We acknowledge the lack of evidence for prescribing dipyridamole in preference to aspirin. We also recognise that the area is full of uncertainties, and owing to lack of clear evidence we have not been able to manage the dilemmas with full confidence. We hope that the debate generated by this case might focus researchers' attention on this very important area. We need large scale, well designed trials to help us advise our patients more appropriately in this particularly complex situation.

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Corrections and clarifications

Hajj: journey of a lifetime
In this Clinical Review by Abdul Rashid Gatrad and Aziz Sheikh, the dosage given for a vaccine was incorrect (*BMJ* 2005;330:133-7). The article said that pilgrims to the Hajj in Mecca have to be vaccinated against meningitis before attending—but the vaccine named, ACWY Vax, should be given only once (not twice, as was stated).

Researcher fined for shredding records
In this item in the In Brief column of the News section (*BMJ* 2005;331:8, 2 Jul), we said that Christopher Gillberg, an expert on attention-deficit/hyperactivity disorder in Sweden, had been fined for shredding his research data. In fact, he had been fined for "misuse of office" for his role in failing to comply with a court order granting access to his data (see bmj.com, 23 Jul 2005, News Extra).

UK stops short of outright smoking ban in enclosed public places
Devolution has again tripped us up. This News article by Kaye McIntosh, should have clarified that it is England and Wales (not the whole of the United Kingdom) that have "stopped short of banning smoking in all enclosed public places" (*BMJ* 2005;330:1468, 25 Jun). In Scotland a ban on smoking in public places is scheduled to be introduced in 2006. Northern Ireland is planning to introduce a ban on smoking in public places, but is still undecided on whether the ban will be total or partial.

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