There exists strong evidence that interdisciplinary stroke rehabilitation leads to better functional outcome than does usual care.³ Although there is less evidence regarding the timing of rehabilitation, the need for such services must be determined during acute care to avoid missing this important component of overall stroke care.

We therefore propose that an additional indicator be included for optimal stroke care: timely assessment for rehabilitation when appropriate.

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[Two of the authors and a colleague respond:]

We agree with the comments of Andrew Dawson and colleagues. In fact, organized care in an inpatient stroke unit — which includes early mobilization and rehabilitation — is the first key indicator in our paper¹ and is effective in improving outcomes after stroke.^{1,2} We recognize that there is an overemphasis in the literature on hyperacute stroke treatments relative to the benefits of several rehabilitation therapies, which apply for the majority of stroke survivors.

The Canadian Stroke Quality of Care Study, from which the acute care indicators emerged, is an ongoing multiphase study. Our goal is to build a comprehensive evaluation framework

that measures patients' access to appropriate stroke care, according to their particular symptoms, as well as the flow of patients receiving such care. This model will include indicators that reflect care within each sector along the continuum of care; more importantly, the current work will build the critical indicators reflecting true integration between the points along the continuum, including transition from acute care to rehabilitation, and from rehabilitation to community care and recovery.

We and many other researchers are at work on the development of stroke rehabilitation indicators. This research suggests that tools such as the Functional Independence Measure, the Barthel Score and the Orpington Score may be used to facilitate referral and to measure the transition between acute care and rehabilitation, but the ideal tools for tracking patients from inpatient care into the community are still unclear.

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Are children with type 1 diabetes immunocompromised?

In their clinical report of a 4-year-old child with leukemia and an enlarging arm lesion that proved to have been caused by an opportunistic fungus, Ahmed Mater and associates¹ state that "[these i]nfections generally occur in immunocompromised patients with conditions such as neutropenia, diabetes or hematologic malignant disease."¹ This statement implies that all patients with type 1 or type 2 diabetes mellitus are immunocompromised. Our interest is children (up to 18 years of age) with type 1 diabetes, and we challenge the accuracy of the statement in this context.

Mater and associates¹ cite 2 papers^{2,3} that listed "diabetes," specifically diabetes complicated by ketoacidosis, as a risk factor for opportunistic infections. However, those articles did not provide evidence to support this claim in children with type 1 diabetes. Is there any evidence to show increased rates of infection or prolonged recovery from infection in children with type 1 diabetes? In-vitro data have demonstrated impaired immune function due to hyperglycemia and/or hypoinsulinemia in association with type 1 diabetes.^{4,5} However, those studies did not show that the differences in cell-mediated and humoral immune function translate into significant morbidity or mortality in the clinical setting. In fact, the humoral response to influenza vaccine in patients with type 1 diabetes is no different from that of controls with respect to protection rates.⁶ The incidence of candidal infection is greater