

Letters to the Editor

Age-related geriatric medicine or integrated medical care

SIR—The suggestions that geriatricians should be proficient in acute work as well as rehabilitation [1] and that any physician looking after older people should have training in geriatric medicine [2] are well argued. However, the idea that geriatric medicine should abandon age-related working is not. The article states that service organization in geriatric medicine *may* incorporate rehabilitation, respite, long-term care and community involvement. Surely these are the core of a geriatric service, using the specialist skills of a geriatrician and distinguishing it from general medicine. Acute care was a necessary add-on in the development of geriatric services, so that early rehabilitation and inter-disciplinary planning could take place during the hospital admission of older disabled people to hospital. To add responsibility for younger acutely ill patients will result in neglect of the central responsibilities of the geriatrician.

The editorial [1] makes the point that 85% of older people presenting as a medical emergency have clinical characteristics suggesting the need for specialist geriatric medical care. Surely this argues for a largely age-related service, with flexibility for older patients who will benefit from the skills of organ-based medical specialists and flexibility also for the small number of younger patients with multiple pathology and disability who need a geriatric service.

I see no reason for geriatricians to influence patients in early and middle life in order to prevent later multiple pathology and disability—this is the role of organ-based specialists and general practitioners. Our expertise is in the management of established multiple pathology and disability.

The associated article [2] on the attitudes of patients to integrated medical care does not tell us if patients feel differently about integrated or age-related care, as it is not possible for patients currently experiencing one type of service fairly to compare it with something else. Patients are usually content with existing service provision, in whatever form. A randomized trial is the only scientific way to compare patient views on these two systems. In my view, this article does not resolve which type of service is preferred by patients.

The advantages of specialist wards with specialist nurses are well known to doctors who have worked in both systems. Indeed, this is probably why these types of services show reduced duration of stay and better discharge planning. I have found it almost impossible to run an effective inter-disciplinary team on an integrated ward. In my view, integrated wards are only necessary

in smaller health districts that cannot justify specialised wards.

Until we have evidence to the contrary from randomized controlled trials, now is certainly not the time to abandon age-related geriatric medicine. This system has allowed the United Kingdom to lead the world in providing the best quality and most efficient hospital service for older people.

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1. Onafowokan A, Mulley GP. Age-related geriatric medicine or integrated medical care? [editorial]. *Age Ageing* 1999; 28: 245–7.

2. Bene J, Solomon SA. The attitudes of patients to integrated medical care. *Age Ageing* 1999; 28: 271–3.

SIR—The editorial on age-related or integrated care [1] is refreshingly free of dogma. It would have been improved by a discussion of how to enhance inter-disciplinary care on acute wards. The Health Advisory Service review on services for elderly people [2] noted: “In fully integrated systems, older people who were managed on general medical wards frequently did not receive the full multidisciplinary assessment that they required. This was the case even if the consultant caring for them was a geriatrician”.

The opinions of service users are important. Unfortunately, it is difficult for many of them to give their views. Bene and Solomon excluded 32 out of 237 patients of all ages because of an Abbreviated Mental Test score of <8 [3]. Geriatricians would wish to ensure that the wishes of the majority who can be heard does not impede care for those who cannot.

Onafowokan and Mulley are right to suggest that age-related geriatric medicine will be unnecessary when general physicians who manage ill old people have adequate formal training in geriatric medicine. This may take some time. In a short letter to the *Journal of the Royal College of Physicians of London* [4], I explained the advantage of having two parallel consultant-led admitting teams in large hospitals with ever-increasing emergency workloads. I noted that other authors had shown that most emergency medical admissions are of elderly patients and “thus, special expertise in care of the elderly, in which most general physicians are not trained, is an essential skill in emergency medicine”. The words “in which most general physicians are not trained” were removed

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before publication, an unfortunate use of editorial censorship.

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Authors' reply

SIR—We read with interest the points raised by Jolobe, Turnbull and Kafetz following our editorial [1].

In contrast to Jolobe, we believe that *all* doctors looking after elderly people, regardless of specialty, must be able to manage acute as well as rehabilitative aspects of patient care. Indeed, the process of revalidation of doctors will ensure that they can do so.

We envy Turnbull's good fortune in being able to offer his patients a comprehensive geriatric service. However, often (due to location, diminution in bed numbers, health authority policy etc.), there is no facility for respite care in hospitals, no consultant input to older people in residential or nursing homes and little community involvement of geriatricians.

We concur with Kafetz's remarks and appreciate that there is room for improvement in the service provision of both an age-related and an integrated system. We agree heartily that general physicians must be properly trained in the management of acutely ill older medical patients.

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1. Onafowokan A, Mulley GP. Age-related geriatric medicine or integrated medical care? [editorial]. *Age Ageing* 1999; 28: 245-7.

Randomized trials and the use of anticoagulants for atrial fibrillation

SIR—We read Mead and co-workers' paper [1] with great interest. They found an increase in the use of

anticoagulation of 15% over a 6-year period. We have found similar results. Over a 3-year period we entered prospectively into stroke registers patients admitted to two hospitals in two South London boroughs. We noted an increase in the use of warfarin in those patients with ischaemic strokes who had no evidence of previous vascular disease (prior stroke/transient ischaemic attack, ischaemic heart disease and peripheral vascular disease) and atrial fibrillation of 37% (5% in year 1 and 42% in year 3; $P < 0.001$). We found an increase of 20% in those with evidence of previous vascular disease (13-33%; $P < 0.001$) [2].

Mead *et al.* noted a small increase in the use of anticoagulation over a 6-year period and considered this to be due to a fall in the mean age of their patients over time. However, we found a larger increase over 3 years, with no such change in the age of patients. Why has there been such a difference in the uptake of anticoagulation for the management of atrial fibrillation in different parts of the United Kingdom?

The difference may be partly explained by differing health policies—Scotland has always had a different health agenda and may have approached things differently. In England and Wales, the *Health of the Nation* report encouraged the treatment of risk factors to prevent stroke [3] and the over-75-year-old screen was also introduced. General practitioners have been encouraged by health authorities to screen for risk factors in a process of banding, which was accompanied by a fee. Those factors in band 3 (such as the management of atrial fibrillation) carried the greatest remuneration. Sudlow *et al.* [4] have already noted that the use of anticoagulation for atrial fibrillation in the community is low. More recently evidence from East Kent would suggest with that, with the appropriate encouragement, it is possible to reach over 90% compliance with anticoagulation (A. Snell, personal communication).

We suggest that there has been a differential uptake of the trial results into clinical practice. It would be beneficial to examine the differences across regions, to investigate why this difference exists and if the difference most marked in those patients referred to stroke services in differing areas. Further work is required to improve ways of increasing awareness and implementation of trial results.

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Won't drink? Can't drink

SIR—We read with interest the letter from Primrose *et al.* [1] on indices of dehydration in elderly people. We offer our experience of one aspect of hydration in elderly patients in hospital: the ability to take a drink.

Older patients in hospital are vulnerable to dehydration, which exposes them to increased risk of thrombosis and confusion. In a pilot study we assessed the ability of older patients to take a drink, where 'take a drink' was defined as the ability to reach their cup, lift it, move it to the mouth and swallow safely.

We prospectively studied 150 patients on three afternoons (1400-1700 h). We documented the reason for being unable to take a drink. Thirteen patients had been assessed by ward staff as being unsafe to take oral fluids and were excluded from further analysis. Of the remaining 137 patients, 85 were on geriatric wards and 52 on rehabilitation wards.

The mean age was 81.5 years and 67% were women. Of those with a presumed safe swallow, 35 (25.5%) were unable to 'take a drink', the commonest reason (in 60%, 21/35) being that their cup was out of reach. Although most patients (90%, 123/137) had a cup near their bed or chair, only 50% had any fluid in their cup. Few patients had fluid balance recorded (15.3%, 21/137). There was a significant difference in the ability to take a drink in patients confined to bed (15/36 unable) compared with those in a chair (18/101 unable, $P < 0.01$). There was no difference in any of the measures between the different areas of the wards.

One-quarter of older patients in our hospital are unable to take a drink. The commonest reason for this is the inability to reach their cup. This is a particular problem for patients confined to bed and appears to be independent of ward type. While the lack of fluid in half the cups may have reflected the time of day at which the study was carried out (i.e. between lunch and dinner), simply paying attention to positioning of drinks and filling the cup regularly may reduce the risk of dehydration and its attendant complications, as well as promoting patient independence.

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Additional risk factors in atrial fibrillation patients not receiving warfarin

SIR—We read with interest the article by Wensley *et al.* [1] which concluded that most elderly patients with atrial fibrillation were not receiving warfarin. We made similar observations in our audit of 200 elderly (>65 years) patients with atrial fibrillation selected at random in our hospital. Of these, 184 (92%) were in the high-risk group for developing stroke (based on SPAF III study criteria). Only 16 (9%) of these had definite contra-indication to antithrombotic treatment. Of the remaining 168 patients, only 55 (33%) were treated with warfarin to maintain an International normalized ratio (INR) of between 2 and 3, five (3%) were not adequately warfarinized (based on last five INR readings) and 95 (57%) were treated with aspirin, leaving 13 (7%) on no stroke prevention.

Thus, despite the evidence from pooled data analysis (AF Investigators, 1994), less than half receive appropriate treatment [2, 3].

These results show a low morbidity: out of 65 patients on warfarin (263 years of treatment) only four had major bleeds and there were no deaths related to bleeding during this period. Hence anxiety about complications should not affect treatment decisions.

There is variation in the guidelines for anticoagulation treatment in the UK and there is a clear need for the development and dissemination of nationally agreed guideline [4], as anticoagulation in atrial fibrillation is one of the most cost-effective preventive interventions in elderly patients [5].

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The other side of hip protectors

SIR—The prevention of hip fractures is getting more attention [1]. Based upon the results of several randomized controlled trials, hip protectors now play a major role in these considerations [2–4]. Most trials focus on efficacy, and less attention has been paid to side effects and adherence. Cameron and Quine correctly pointed out that old people at home have reservations about using hip protectors that can be classified into cost, odd appearance, discomfort and coping strategies [5]. This has not been systematically examined in nursing home residents and staff.

As part of a multifactorial intervention trial [6] we looked at adherence, withdrawal and nurses' attitudes. (The study was not supported by any manufacturer of hip pads.) During the trial, two different types of hip protectors were offered to 346 residents, 76% of whom could walk with help. Of this group, 37% decided to wear hip protectors. After 9 months, 19% had stopped wearing them (defined by not wearing them at any time).

Besides the above-mentioned drawbacks, we observed other problems that have not been reported before. Several people needed more help with dressing. Those residents with urge incontinence reported additional incontinent episodes related to use of the undergarment. Both issues led to increased staff support. We initially considered three hip protectors per resident to be sufficient but soon found that at least five were needed for incontinent residents, which increases the cost of the intervention. After several months, some protectors are unusable as a result of washing by commercial laundries that use various drying and washing techniques (high frequency rotation, press drying, powerful chemicals). In any case, the biomechanical properties of the pads change with time, even with usual washing. Since only new hip protector models have been biomechanically examined [7, 8], there might be important changes in their properties after only a few washes. All these factors add considerably to the effectiveness or ineffectiveness of an intervention and have to be considered in cost-effectiveness or cost-benefit analyses.

We still consider the use of hip protectors for high-risk patients to be important. They should be used along with environmental adaptations, counselling, training, psychopharmacy and vitamin D and calcium supplementation. However, potential side effects should be discussed, and additional staff time should be taken into account when hip protectors are recommended for use in nursing homes.

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Seasonal effects on cardiovascular mortality in older patients

SIR—Epidemiological studies have shown temperature and seasonal effects on the mortality rate from coronary heart disease in elderly people [1, 2] and a seasonal variation in the onset of acute myocardial infarction (AMI) [3, 4]. It is unclear whether the increased mortality is simply due to temperature-related changes in disease incidence or if it is related to differences in disease severity.

We conducted a prospective investigation on the clinical course of 585 AMI patients aged 65 years and above admitted to a medical centre. Patients' comorbidity, complications, and survival status were documented.

One hundred and sixty-five patients (28.2%) sustained an AMI in spring, 162 (27.7%) in winter, 135 (23.1%) in summer and 123 (21.0%) in autumn. All patients were stratified into two groups: those who had an AMI in spring or winter (seasons with a higher AMI incidence, $n = 327$) and those in summer or autumn ($n = 258$). There was no statistical difference between the two groups in mean age, gender, location of myocardial infarct, incidence of hypertension, diabetes mellitus, hyperlipidemia or

stroke, or in the occurrence of various cardiac arrhythmias whilst in hospital. Patients who developed AMI in spring and winter had a higher prevalence of a previous myocardial infarction than those who developed it in summer and autumn, (27.0% versus 19.8%, $P < 0.05$) and were more likely to develop cardiogenic shock (22.5% versus 13.6%, $P < 0.01$). Using a stepwise Cox proportional hazards regression model, we found that cardiogenic shock was the most important predictor (risk ratio = 6.98, $P < 0.0001$) for 1-month mortality in all of these patients.

These data suggest that altered AMI severity, with a difference in the prevalence of cardiogenic shock, may contribute to the seasonal variation in cardiovascular mortality. Older patients with previous myocardial infarction were more susceptible to adverse effects of weather-related stresses.

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Metformin and ageing diabetic patients

SIR—The incidence of type 2 diabetes mellitus increases with age and leads to significant morbidity and mortality. Of the various anti-hyperglycaemic drugs, metformin therapy has commonly been listed as a contra-indication in elderly subjects [1]. Many physicians are over-cautious in prescribing this biguanide therapy to minimize the risk of lactic acidosis—a rare but serious complication of metformin therapy, with a mortality of 50% [2].

Elderly patients are prone to develop metformin-associated lactic acidosis as they are more likely to be on multiple medication (often including nephrotoxic

drugs) and have co-existing illnesses and decline in renal function. However, age in itself has never been shown to be a risk factor for lactic acidosis related to metformin.

Metformin can be used safely and effectively when doctors adhere to the usual prescribing precautions [3, 4]. In a study which included 40 patients with type 2 diabetes who were aged less than 65 years and 30 who were aged over 65 years, all with normal hepatic and renal function and treated with metformin monotherapy or metformin in combination with a sulphonylurea drug, Chalmers *et al.* showed that there was no correlation between age and post-prandial blood lactate levels [3]. Another study of 76 type 2 diabetic patients, all over the age of 70 years and with normal hepatic and renal function, showed markedly improved glycaemic control without any increase in fasting lactate level after 1 year of adding low-dose metformin to sulphonylurea [4].

Additionally, in the recent United Kingdom Prospective Diabetic Study, metformin monotherapy resulted in a reduction in the risk of diabetes-related endpoints as well as overall mortality—without any increase in incidence of lactic acidosis [5].

Thus, elderly patients with type 2 diabetes should not be deprived of the potential benefit of metformin therapy, provided that prescribing guidelines are strictly adhered to and renal function monitored during treatment [2].

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