Letters to the Editor

patients at risk for non-adherence. These preliminary results, however, await confirmation in a larger number of patients.

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Mental capacity assessments and discharge decisions

SIR—I read the article by Stewart et al. on Mental Capacity Assessments and Discharge Decisions with great interest [1].

This particular topic forms a bulk of work for old-age psychogeriatric liaison services in general hospitals. Experience from working in this service suggests that there appears to be an assumption from hospital social workers that only old-age psychiatrists are qualified to make capacity assessments (much to the annoyance of geriatric colleagues!).

Good capacity assessments in relation to discharge decision-making depends largely on the quality of information a doctor gathers regarding a patient’s previous level of functioning in the community (unfortunately, this information is not always easily available, but time must be spent to gather as thoroughly as possible). This can be done by any clinician or social worker and forms the cornerstone for deciding an individual’s insight and appreciation of the risks they have endured in the community before admission to hospital and whether their decision-making takes into account of the same. Most elderly patients naturally desire to return home from hospital but base their choices on how they remember they used to function in the past (often forgetting the dangers they have encountered in recent times).

Decisions must never be made on the basis of a patient’s level of functioning in the hospital only during a period of acute hospitalisation, because it is often not a correct reflection of either their cognitive or their functional ability.

If good quality corroborative information is gathered about patient’s pre-hospitalisation period of functioning, ‘trial discharges’ become unnecessary, because it is often fraught with difficulty later on (excepting in cases where such information is unavailable or unreliable).

Hence, it is the process of how a patient arrives at a decision and not the decision itself that is important in capacity assessment regarding discharge decisions.

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Falls definition—reliability of patients’ own reports

SIR—Your systematic review of methodology in falls trials [1] highlights the complexity of the definition and identification of falls. If such inconsistency even exists within well-designed and resourced research studies, how much more difficult will it prove to develop effective falls-monitoring procedures for day-to-day use in clinical settings.

We have explored the reliability of patients’ own reports as an epidemiological tool. As part of the validation of a study of patients presenting to our Accident and Emergency department, we approached 107 individuals aged over 50 years. Each was initially asked ‘Did you fall?’, and their response was recorded. A detailed history of the events surrounding the fall was then taken.

Mean age was 67.7 (range 50–91) years. Sixty-nine (64.5%) of them were women. Fifty-four patients (50.5%) stated that they had fallen, and on detailed questioning, this appeared consistent with the most widely accepted definition of falls [2, 3].

Of the 53 patients who did not report a fall, five described a ‘slip’ and one had no clear recollection of events on detailed questioning. Thus, the ‘Did you fall?’ question had a sensitivity of 91.5% and a specificity and positive predictive value of 100% as a tool in the A&E setting.

Existing definitions of a fall are impractical for use by the large numbers of staff from different disciplines who work in this and other clinical settings. A reliance on patient reports in response to the simple ‘Did you fall?’ question appears justified for falls monitoring and similar epidemiological purposes.

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Nicorandil-associated anal ulceration

SIR—We wish to highlight the association between nicorandil use and anal ulceration to the geriatric medical community.

Nicorandil is a potassium-channel activator, with adjunct nitrate effect, used in the treatment of severe ischaemic heart disease. Whilst the association between nicorandil use and oral ulceration is well recognised, only recently have a number of published series highlighted the association with anal ulceration [1–5]. To date, 61 cases have been described. In addition, one reported case of small bowel ulceration [6] questions whether the entire gastrointestinal tract may be involved in this phenomenon.

Patients typically present with severe, painful anal ulceration, refractory to surgical management (Figure 1). It may follow iatrogenic injury such as minor anorectal surgery or biopsy [5]. Macroscopically, the ulcers vary in size but are well circumscribed, with undermined edges. Histological examination usually reveals non-specific inflammatory change. The patients have frequently been extensively investigated, and inflammatory bowel disease, neoplasia, tuberculosis, sarcoid and sexually transmitted infection have been excluded. They may have undergone high-risk procedures such as diversion colostomy or perineal skin grafting, which failed to facilitate healing.

The suspicion of the association and cessation of nicorandil led to spontaneous re-epithelialisation of the ulcers in all the described cases. Median healing time has been reported as 12 weeks [5].

Proposed mechanisms of the ulceration include a vascular steal phenomenon because of nicorandil-induced redistribution of arterial and venous flow or a direct local toxic effect of the drug or a metabolite.

Given that this is a group of patients with severe cardiovascular disease, a multidisciplinary approach to their care is essential. Specialist geriatric, medical and cardiology input ensures the safe substitution of nicorandil for other anti-anginal preparations. It is also important that those prescribing nicorandil be aware of this important adverse reaction to the drug.

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Figure 1. Nicorandil-associated anal ulcer.

Differences in end of life care in patients who died with dementia during acute hospital admissions

SIR—We have read with great interest the study of Sampson et al. [1] focusing on the care received by dying patients with and without dementia on acute medical wards to identify differences between them. This issue has also been our concern [2], and we welcome other studies about this poorly analysed problem. Nevertheless, we suggest that next prospective studies should include only terminal patients (i.e. patients who fulfil the criteria of National Hospice Organization Medical Guidelines Task Force to refer patients with selective non-cancer diseases to palliative care programs) [3].