Preventing Pressure Sores in Elderly Patients: A Comparison of Seven Mattress Overlays

SIR—There were some interesting aspects to Dr Bliss's study [1], and I was not surprised that the AP mattress (large cell ripple mattress) seemed more successful than the other overlays. However, I was rather surprised that plastic drawmacs and drawsheets were allowed to be used on top of the various overlays that were tested. It was even more surprising that this 'usually' occurred. In other words, it is not clear how often drawsheets were used, and whether or not they were used equally between the different overlays.

As long ago as 1973, Fernie [2] showed that the use of a drawsheet (with its drawmac) would double the peak interface pressures measured on a hospital mattress. In 1983 I was able to show that this also applied when a 'Domed' indenter was used for the pressure tests [3]. Surely, in the light of this evidence, the patients in Dr Bliss's study should either have had no drawsheets on their beds, or they should all have had them? As her study stands, it seems impossible to tell what influence the use of these drawsheets had on the outcome of the trial.

If we could assume that most patients, on all the overlays (as well as those on the 'Vaperm' mattress alone), had drawsheets on their beds, then we could make some assumptions about drawsheet effects on the various supports. In particular, if the drawsheet could not be tucked well under the mattress, as would occur with the thicker overlays, then it would be more easily pulled out (loosened) by the weight of the patient. This is because the patient's weight, in the centre of the mattress, would not be anchoring the ends of the drawsheet as well as it would be on a shallow mattress (e.g. the 'Vaperm'). In consequence, patients on the thicker overlays would likely have less time under the higher ('hammocking') pressure that the drawsheet produces.

In addition, it is not clear how many patients were nursed in semi-recumbent positions when in bed. This latter position, on an ordinary hospital bed, is a potent cause of pressure sores. There should have been some indication of whether this factor influenced the trial results.

Finally, as one of the designers of the Vaperm mattress, I must point out that it was not designed for spinaly injured patients. It was designed as a general purpose hospital mattress.

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Self-reported Functioning and Well-being in Patients with Parkinson's Disease: Comparison of the Short-form 36 and the Parkinson's Disease Questionnaire

SIR—We read with much interest the recent paper by Jenkinson et al. in Age and Ageing [1] which suggests that the Short Form 36 (SF-36), is a suitable measure of health status for use with patients with Parkinson's disease (PD).
While we agree that the SF-36 can provide valuable information on the impact of PD, we would argue that the SF-36 may not be suitable as a self-report measure for older adults or PD patients. We have employed the SF-36 in two postal surveys with PD and stroke patients and we have consistently found an unacceptable level of missing information in returned questionnaires of around 20%. The missing items in the SF-36 were concentrated on questions relating to vigorous activities or work. Hayes et al. [2] similarly found in their study with elderly patients that omissions in the SF-36 were concentrated in these questions and detected an age-related increase of omissions for those aged 75 years or more. Jenkinson et al. do not mention in their study if their respondents' questionnaires had any missing information nor did they indicate if any support or help was available for those with visual or writing difficulties.

Mean scores over the eight dimensions of the SF-36 reported in this study are quite low, suggesting significant floor effects. It is not surprising that Jenkinson et al. found that those suffering from PD had poorer perceived health status than those without a serious illness. What is more important is the question of how sensitive the instrument is at picking up changes after clinical interventions. We have found in our own studies that there was no significant correlation between disease severity using the Hoehn and Yahr scale [3] and score in the domains in the SF-36 in patients attending a specialist movement disorder clinic.

Hayes et al. have suggested that some revisions to the format of the questions may be needed to make the SF-36 more acceptable as a self-report instrument for older adults. This may suggest that the SF-36 in its present form is perhaps ageist in that its questions tend to address a younger age group. We are currently re-evaluating the SF-36 with the changes as proposed by Hayes et al. with a group of PD patients.

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Outcome in Patients who Require a Gastrostomy after Stroke

Sin—The article by Wanklyn et al. [1] is very interesting, though in small numbers. I would just like to comment on the last reason (at the end of the article) why a percutaneous gastrostomy may be considered appropriate, which states: 'to improve nutrition to allow rehabilitation and increased function'. Wanklyn suggests that there is no evidence to show that improved nutrition will aid rehabilitation. There is a time-consuming venture. The alterations to the SF-36 suggested by Hayes et al. may well produce a questionnaire that is more suitable for use in elderly people, but the possibility of comparison of elderly patients' scores with those in younger age groups is subsequently lost. This may not matter in surveys of the over-65s, but will make analysis of data from, for example, a study of patients presenting with rheumatoid arthritis very difficult. RA patients over 65 would have to be given an essentially different questionnaire from those under 65. As such, the usefulness of the notion of generic measures is somewhat lost. It is for this reason that in our original paper [4] claimed it is important that carefully chosen measures suitable for specific treatment groups are used in the evaluation of medical care. Indeed, it is worth noting that such an approach, i.e. using disease specific and generic measures, has been advocated by the designers of the SF-36. This on the one hand should overcome the concerns of Hobson and Meara whilst providing SF-36 data that, although not complete, will give some grounds for comparison with other populations and patient groups. Furthermore, the designers of the SF-36 do suggest scoring algorithms that can be used even if data are not entirely complete [5].

We would stress that we do not believe that the SF-36 is appropriate for all patient groups. As we have noted previously, pilot studies should be undertaken with measures to determine whether they can be both understood and completed by any particular group to which it is intended they be applied [3]. This may indicate that some measures, even generic ones such as the SF-36, may be inappropriate. In such instances it seems to be a more profitable undertaking to select appropriate measures than to create a half-way house by adapting existing generic ones.

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