Letters to the Editor

Hip fracture with correctly positioned external hip protector

SIR—The widespread use of external hip protectors in the prevention of hip fractures in frail older people is supported by the studies of Lauritzen [1] and Ekman [2], who reported significantly reduced rates of hip fractures in Scandinavian nursing homes by the use of these devices. As non-compliance was common, residents with hip protectors also suffered hip fractures, but no fracture occurred in hips protected by hip protectors.

In 1997, Cameron [3] published a case of hip fracture in a 89-year-old woman with Alzheimer’s disease who was wearing the hip protector at the time of the fall. In this case, the hip protector appeared to have been around the knees rather than in correct position. We wish to present a case of hip fracture where the external hip protector was in the correct position when the patient fell.

An 84-year-old woman with vascular dementia (Mini-Mental State Examination score 14) and Parkinsonism was admitted to our geriatric rehabilitation unit after surgical repair of a left-sided proximal femoral fracture. She was provided with an external hip protector as she repeatedly walked around alone with an unsteady gait and without using her walking aid. On the ward she fell four times within 2 weeks without signs of fall-related injuries, but with the fifth fall she sustained a proximal femoral fracture on the right side. The nurses found her lying on the floor near her bed with the hip protector in the correct position. She had tried to undress, but was not able to undo the well-fitting hip protector (Safety Pants). So when trying to remove her underwear from underneath the hip protector, she lost balance and fell.

External hip protectors reduce, but do not eliminate, impact on bone during a fall. They can play an important role in the prevention of hip fractures in frail older people, even if they cannot provide full protection. The everyday use of these devices however is limited by non-compliance and difficulties related to the management of urinary incontinence. More attention should be paid to the fact that some frail elderly people might be unable to take off the hip protectors safely, which may contribute to falls.


Outcomes of percutaneous endoscopic gastrostomy feeding

SIR—We welcome the article by James et al. on the long-term outcome of percutaneous endoscopic gastrostomy (PEG) tube feeding in patients with dysphagia after stroke [1]. Of particular interest is that while some patients recover swallowing ability in the immediate weeks after the stroke, others take months to do so (19 out of 126 after 6 months). This delayed recovery has been observed previously [2, 3]. Furthermore, the study highlights that most patients surviving admission (74 out of 91) are discharged to long-term care, either in hospital or nursing home. There are reasons why removal of a PEG tube, may benefit patients whose swallowing recovers later:

1. There is continuing morbidity with PEG tubes, especially in nursing home patients [4].

2. The acceptability of PEG feeding to patients is questionable. A study of a hypothetical case scenario put to 68 non-demented elderly people suggested that only 50% would accept future PEG feeding [5].

3. The financial cost of PEG feeding is considerable, in terms of feeds (about £3500 annually), and staff workload.

4. Perhaps most importantly, a return to the pleasures of oral feeding in these patients, who are often frail and dependent, may be of great benefit in improving quality of life.

Locally we still have many continuing care beds. After speech and language therapy review, we have successfully removed long-standing PEG tubes in patients with dysphagia after stroke, allowing restoration of full oral nutrition. Our concern is that with the changes in arrangement for long-term care, many frail patients will be in nursing homes at the time that ability to swallow recovers.

Regular follow-up presents problems. Clinic attendance may be burdensome and disruptive to patients and staff. Frequent review by hard-pressed community speech and language therapists may be difficult. One alternative is for attending nursing staff, trained in simplified swallowing tests, to periodically review swallowing ability. This would require heightened awareness of the possibility of late recovery of swallow. Any improvement in swallow could elicit formal speech and language therapy review—which should be undertaken before any permanent removal of a PEG tube.

1. Specht-Leible N, Peter Oster. Geriatriesches Zentrum Bethanien am Klinikum der Universität, D-69126 Heidelberg, Germany Fax: (+49) 6221 319408
Letters to the Editor

The undoubted success of PEG tubes in the management of elderly patients with dysphagic stroke may lead to more patients being discharged with the tubes, appropriately, still in place. Regardless of the most effective means of long-term assessment of swallowing ability in these patients, we hope that increased awareness of the potential for recovery will result in more elderly patients regaining the pleasure of eating normally.

JOHN HARPER, MARION E. T. McMURDO
Section of Ageing and Health, Department of Medicine, Ninewells Hospital, Dundee, DD1 9SY, UK
Fax: (+44) 1382 660675; Email: m.e.t.mcmurdo@dundee.ac.uk

AILEEN ROBINSON
Department of Speech and Language Therapy, Royal Victoria Hospital, Dundee, UK


Endoscopic retrograde cholangiopancreatography in elderly patients

SIR—In their study of 59 patients with choledocholithiasis [1], Ashton et al. did not highlight presentation with bacteriemia or acute pancreatitis. Nor do they mention the risk of missed diagnosis if there is doubt about whether to proceed to endoscopic retrograde cholangiopancreatography (ERCP) when liver function tests improve; this can give the impression that the common bile duct calculus has undergone spontaneous expulsion, and that ERCP is therefore no longer justified.

In my personal series of 63 patients (mean age 82, range 65–99, 44 female) with ERCP-proven choledocholithiasis, 11 presented with Escherichia coli septicemia. One woman presented with E. coli septicemia in the absence of bacteriuria on three occasions, with various ultrasonographic abnormalities reported, including hepatic hemangioma and calculi in the gallbladder (but not in the common bile duct). On her third admission, ultrasonography was waived in favour of ERCP, which confirmed a common bile duct calculus. Presentation with acute pancreatitis was a feature in three other patients with choledocholithiasis.

Potentially misleading changes in biochemical measures, including a reduction of >50% in serum bilirubin from peak levels beyond the normal range, featured in 19 patients before ERCP. The initial serum bilirubin level was on average 64.2 mmol/l (13–21), falling to a mean value of 16.05 mmol/l. This was associated with a fall in serum alkaline phosphatase and γ-glutamyl transferase concentrations from mean initial levels of 298.6 IU/l (25–125) and 543 IU/l (10–45), to nadir levels of 215 IU/l and 295.5 IU/l respectively, although the presence of common bile duct calculus was subsequently validated by ERCP in every instance.

This testifies to the difficulty in distinguishing between the biochemical response to spontaneous expulsion of a common bile duct calculus and spontaneous fluctuation in liver function tests (which may occur while the common bile duct calculus remains in situ). Four patients proceeded to ERCP without ultrasonography, supporting the proposition that if suspicion of choledocholithiasis is high, one should avoid the delay and expense of ultrasonography—especially when there are urgent indications for endoscopic sphincterotomy, such as ascending cholangitis [2, 3] and acute pancreatitis [4].

Biliary endoprosthesis is a safe alternative for frail patients who have common bile duct calculi too large to be expelled by endoscopic sphincterotomy [5, 6]. Even when the gallbladder remains in situ, long-term follow-up after endoscopic sphincterotomy has revealed a complication rate of only 9.7% (comprising stone recurrence, cholangitis or acute cholecystitis, all non-fatal) in 103 of 110 patients [7]. After biliary endoprosthesis 20 out of 25 remained free of biliary symptoms for a mean follow-up of 52 months, or died earlier of unrelated illness [6].

(My thanks to D. Martin and his team at Withington Hospital, South Manchester for his skilful and safe interventional management of 55 of the 63 patients reported herein.)

O. M. P. JOLOBÉ
Department of Medicine for the Elderly, Tameside General Hospital, Fountain Street, Ashton under Lyne, OL6 9RW, UK
Fax: (+44) 161 3315222


Authors’ reply

SIR—We were interested to read Dr Jolobe’s experience with 62 patients who had choledocholithiasis. In our article we concentrated on the symptoms with which the patients who had gallstones presented, such as abdominal pain and jaundice, whereas Dr Jolobe uses presentation to describe underlying conditions which can be caused by gallstones, such as septicaemia and acute pancreatitis.

Dr Jolobe details one patient who, in the absence of bacteriuria, had an Escherichia coli septicaemia on three occasions over 10 years. An abdominal ultrasound assessment showed a gallbladder stone on the first but not on later occasions, while subsequent endoscopic retrograde cholangiopancreatography (ERCP) demonstrated a stone in the common bile duct; no follow-up information was given. It would seem ultrasound failed to detect a stone in the common bile duct. Our paper reported the sensitivities for detecting dilated common bile ducts and stones within the common bile duct to be 86% and 69% respectively.

Dr Jolobe commented that improvement in liver function tests can occur when stones are present in the common bile duct and that this may erroneously suggest a stone has passed spontaneously, whereas it may simply have disimpacted. It may also mean that while a stone principally responsible for the obstruction has passed spontaneously, residual stones remain within the common bile duct. In five of our patients a stone passed spontaneously, leaving a clear common bile duct on each occasion.

We do not believe Dr Jolobe’s experience of undertaking ERCPs successfully in three patients without having a previous abdominal ultrasound assessment is sufficient to validate such a practice. Ultrasound provides valuable information, is cheap and totally non-invasive, and can be undertaken rapidly without causing significant delay in further management options. Magnetic resonance imaging cholangiography carries no risk and is likely in some circumstances to supersede diagnostic ERCP.

Dr Jolobe highlights use of biliary endoprosthesis for gallstones. This was unnecessary in our patients as the common bile duct was cleared of stones in all patients in whom the common bile duct could be cannulated, although eight patients needed mechanical lithotripsy. Endoprosthesis could not have been undertaken in the two patients in whom the common bile duct could not be cannulated.

CHARLES E. ASHTON
Worcester Royal Infirmary, Worcester, UK

WILLIAM R. McNABB,
Kingston District Hospital, Kingston, Surrey, UK

MARK L. WILKINSON,
Department of Gastroenterology, Guy’s Hospital,
St Thomas Street, London SE1 9RT, UK

ROGER R. LEWIS
Department of Geriatric and General Medicine,
Guy’s Hospital, St Thomas Street,
London SE1 9RT, UK
Fax: (+44) 171 955 4465

Readmission of patients discharged from emergency departments

SIR—Caplan et al. describe an increased risk of readmission of older people after discharge from an emergency department [1]. They identify factors relating to frailty and dependence in activities of daily living which predict readmission. These important results highlight some of the difficulties in elderly patients managed by accident and emergency staff.

We believe that, in addition to problems with functional assessment, older patients pose diagnostic difficulties. In a prospective series of 111 older patients (>65 years) discharged from our accident and emergency department in whom no clear diagnosis had been reached, we found a high rate of readmission. Nine percent were readmitted within the first month and 33% within 6 months. Patients initially presenting with chest pain or dizziness/funny turns were at highest risk [2].

Deficiencies in training of accident and emergency doctors in the care of elderly patients have been recently acknowledged [3]. Involvement of geriatricians in accident and emergency departments has been proposed [4, 5]. As a speciality, we should find ways to improve the care of the increasing numbers of elderly patients presenting to accident and emergency departments. Formal teaching sessions, compulsory training of Senior House Officers in geriatric medicine or active participation in accident and emergency by geriatricians are some ways in which this might be achieved.

PAULA J. PETRIE, ZULFIQAR SADIO, JOHN E. CLAGUE,
MICHAEL A. HORAN
Department of Geriatric Medicine,
Clinical Gerontology Group, Clinical Sciences Building,
Hope Hospital, Stott Lane, Salford, M6 8HD, UK
Fax: (+44) 161 787 4665
Letters to the Editor


