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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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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