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clearly labelled. They also ensured that within the containers, no mixing of tablets had occurred. Nurses were not expected to identify individual tablets (for example, by the use of charts).

The nurses would sign the protocol form and then the same procedure would be followed by the admitting doctor. During the first week, the ward pharmacist would check the medication and also sign the protocol form. Because of staff shortages, it was not possible to ensure that the pharmacist would make the check on day 1. The patient’s medication was recorded on a prescription chart and the nurses distributed this medication from a drugs trolley.

We have analysed 74 respite episodes. We did not enter 16 cases into the trial because they either did not bring any drugs with them or brought an insufficient medication. In three cases, medication was brought in but the container labels were unclear and subjects therefore not entered into the trial. In one case, mixing of tablets within a container was evident and the patient was excluded from the trial. Excluded patients were given medication from hospital supplies.

In the 54 subjects who passed the above checks, there were no instances where incorrect medications were given to patients during the trial. The trial has now run for over a year and no such incidents have occurred. We have made savings in the drug budget. This is difficult to quantify precisely, as the respite wards also have resident a variable number of continuing-care patients, who receive medication from hospital supplies. This dilutes the drug budget savings for these wards. The total drug budget for two successive years on the two respite wards has fallen from £22 270 to £19 390.

Replying to a questionnaire, most nurses found no increase in workload during the trial. They felt it helped cause less confusion to patients about what drugs they were receiving.

We feel that the potential savings, combined with the confidence that patients’ safety is not compromised, support this change of practice on respite wards.

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Patent foramen ovale and survival in old age

SIR—Anatomical closure of the foramen ovale occurs shortly after birth. However, an incomplete seal may still exist in adults, and prevalences of 20–25% have been found [1]. At systematic post mortem cardiac examination of 3430 patients who died between 1975 and 1997 in the Geriatric University Hospital of Geneva, Switzerland, we were surprised to detect no more than seven cases of patent foramen ovale (PFO), a prevalence of only 0.2%. The mean age at death was 86.9 ± 4.8 years among those with PFO and 81.4 ± 8.2 years in the control group. The prevalence of history of strokes was 29% in the PFO group and 16% in the control group. At brain autopsy, ischaemic infarction was diagnosed in 43% of the PFO group and in 25% of the controls.

Paradoxical embolism in the presence of a PFO is an important cause of strokes in younger individuals, but the situation in elderly people is less clear. Using contrast echocardiography, Lechat et al. [2] detected a PFO in 54% of stroke patients under 55 with no identifiable cause or risk factors and in 10% of controls with no history of stroke \( (P<0.001) \). Reviewing published echocardiographic findings from 1990 to 1995, Beattie et al. [3] determined an average PFO prevalence rate of 41% \( (\text{range } 24–73\%) \) in patients younger than 45 years and an average rate of only 9% \( (\text{range } 3–15\%) \) in patients over 45 years. Vella et al. [4] used contrast echocardiography to investigate PFO in 38 elderly patients (mean age 80 years) who had had a stroke with no obvious cause and 33 controls (mean age 81 years). They detected only one PFO (in one of the patients), and proposed several plausible age-related physiological and technical explanations for the low prevalence of PFO; their results accord with our post mortem findings in a large series of autopsied elderly subjects of comparable age.

Although PFO may be compatible with old age, we hypothesize that its extremely low prevalence in elderly people indirectly reflects the persisting risk of paradoxical embolism in subjects with this cardiac pathology. The importance of the impact of the inverse relationship between PFO prevalence and ageing on the survival of affected patients remains to be evaluated. Optimal treatment to prevent recurrence in cryptogenic stroke patients with PFO is not clearly defined. PFO is repairable, but closure does not consistently prevent recurrence of ischaemic events, particularly in older cryptogenic stroke patients [5]. Further research is needed to evaluate therapeutic approaches to improving the survival of PFO patients in advancing age.

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1. Fowler Noble O. Cardiac Diagnosis and Treatment, third ed. Hagerstown, MD, USA: Harper & Row, 1980.
Several respondents highlighted case-mix as a problem that affected time allocation. This was felt to be particularly important in clinics dealing with both younger medical patients and older patients who often had multiple system and complex problems.

The subjective opinion of consultants on their ability to provide a consistently good standard of care is open to bias. There were wide variations in appointment times, which may reflect the case-mix encountered. It was not possible to confirm or refute this from the data.

Many consultants do not meet the College recommendations and some feel unable to deliver consistently a good standard of care if the recommendations are met. One explanation is that the recommendations are set at a too ambitious level and do not fully consider the wide case-mix variation in some clinics. The College indicated in the report that “it is self-evident that elderly patients require considerably more time in clinical diagnosis and treatment”, yet the recommendations of 6–8 new patients or 15–20 follow-up patients per clinic exceed those of, for example, cardiology, neurology and rheumatology, where a maximum of 6 new patients or 15 follow-up patients per session was recommended.

A Government aim is for patients to be more informed about their care and treatment choices [2]. The satisfaction of consultation is partially dependent upon time. Longer consultations are required for patient enablement. Patients over 65, those with multiple problems and those with both social and psychological problems require a longer consultation [3, 4]. There are no published data on the effects of participative practice on the duration of clinic appointments to deliver an agreed standard of care. Research is required if allocation of time is to be made objectively, taking case-mix into account.

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Does frailty predispose to adverse drug reactions in older patients?

SIR—In patients 70 years and older admitted to hospital, a history of falls, gastrointestinal bleeding or