Several respondents highlighted case-mix as a problem that affected time allocation. This 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.

NIGEL DUDLEY

Department of Elderly/General Medicine,
Pinderfields Hospital, Aberford Road,
Wakefield WF1 4DG, UK
Fax: (+44) 1924 814864
Email: nigel.dudley@panp-tr.northy.nhs.uk


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
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haematuria and the use of three or more drugs are associated with a severe adverse drug reaction [1, 2]. A fall before hospital admission may be an indicator or a presentation of a severe adverse drug reaction. We report data which support the association between a fall history and adverse drug reactions in older patients.

We recorded and evaluated defined adverse drug reactions [3, 4] in 228 patients consecutively admitted to five wards of a geriatric clinic, between 1 January and 30 March 1995. We included in the analysis only those adverse drug reactions that were followed by documented therapeutic consequences. We recorded admission and discharge drug prescriptions, applying a system previously used [5]. On admission, all patients underwent a 15-item screening test, including the history of falls in the 3 months before admission, poor nutritional state and chronic pain [6].

There were 53 adverse drug reactions in 42 patients (18.4%), involving 47 drugs: 14 reactions were gastrointestinal, 13 cutaneous, seven central nervous system, six cardiovascular and five were other manifestations. Cardiovascular drugs (16), psychotropic agents (eight), analgesics, non-steroidal inflammatory drugs and steroids (eight), antibiotics (six), and miscellaneous preparations (nine) were the medicines incriminated.

Adverse drug reactions were more frequent in patients with ≥ 5 drug prescriptions on admission (26.8% vs 8.6%, P = 0.0004) and those with a history of falls (n = 30, 36.7% vs 15.7%, P = 0.0006). Furthermore, there was a trend for a higher rate of adverse drug reactions in patients with chronic pain (28.6% vs 16.6%, P = 0.09), poor nutritional state, (26.5% vs 16.2%, P = 0.09) and urinary incontinence (25.4% vs 15.1%, P = 0.09).

The patients with a fall history were older than those without (81.7 ± 76.5 years; P < 0.001), but they did not differ in their mean number of prescribed drugs on admission (4.56 ± 2.49 (95% CI 3.95; 5.16) vs 4.45 ± 2.56 (95% CI 4.07; 4.83)) and discharge (4.18 ± 2.48 (95% CI 3.80; 4.54) vs 4.23 ± 2.57 (95% CI 3.70; 4.90)). We analysed 43 different medication groups and found the only differences in prescribing patterns between patients with and without falls was for antiparkinson medication (10.3% vs 2.9%, P = 0.026) and heparin (41.2% vs 27.5%, P = 0.05). Ten of the patients with a history of falls (33%) fell again during their hospital stay: there were records of one fall in four patients, two in five patients and three in one patient.

The number of patients we investigated was small, and not all results reached statistical significance. However, we conclude that markers of frailty, rather than a history of falls alone, may be useful indicators of an elevated risk of adverse drug reactions in older patients. Low body weight [7], for example, could be one indicator. As a consequence of frailty, minor challenges may compromise an elderly person’s functional abilities [8], and exposure to many drugs may be one such challenge.

WOLFGANG VON RENTELN-KRUSE, NINA THIESEMANN, RÜDIGER THIESEMANN, HANG PETER MEIER-BAUMGARTNER
Reho-Zentrum Reuterstrasse, Geriatrische Klinik, Reuterstrasse 101, D-51467 Bergisch Gladbach, Germany
Fax: (+49) 22 02 127 311
Email: renteln.kruse@mhv-bgl.de
1Albertinen-Haus, Zentrum für Geriatrie, Hamburg, Germany


Tiredness: a feature of coeliac disease

SIR—We report the case of a patient concomitantly affected by Paget’s and coeliac diseases. These are common [1, 2], yet may be undiagnosed in older people. Their association may be more common than is generally appreciated.

An 84-year-old woman was admitted with progressive weakness, fatigue and slight weight loss. Six years earlier, a diagnosis of Paget’s disease of bone was made at another hospital, based on slightly elevated (1.5×) serum alkaline phosphatase concentration, together with characteristic radiographic and scintigraphic findings. Despite reportedly adequate nutrition, a gradual weight loss of about 5 kg was noted in the following years. She consulted her general physician and attended an outpatient clinic on several occasions over this period, but no satisfactory diagnosis was established. She received a 4-month course of cladronate therapy for Paget’s disease 6 months before admission to our hospital.

On examination, she was thin, with a body mass