Another case of missing dentures

SIR—I read with interest ‘Mystery of the missing denture: an unusual cause of respiratory arrest in a nonagenarian’ published on 19 June 2005 [1] and have a similar case to report.

Having recently commenced employment as a physical care practitioner working in mental health for older people on continuing care wards, I was asked to see a lady who had suffered a recent choking event. Following the incident, the patient was generally unwell, but the main concern was that she was unable to eat or drink despite being both hungry and thirsty. A local general practitioner saw the patient but could find no reason for her difficulty in eating or drinking and confirmed that she did not appear to have aspirated. Nursing staff had noticed that the patient’s top set of dentures were missing and had enquired if she could have swallowed them, but this was not considered to be possible.

On examination, I found that the patient had recently developed a very hoarse voice. Whilst the patient had the ability to swallow, she then had to expel any food or fluid from her mouth. There was only very mild tenderness in her throat on examination. No foreign body could be seen in the mouth or throat. I discussed the case with an ENT colleague and escorted the patient to the local ENT department. The patient was seen and examined under local anaesthetic, and the initial diagnosis was either a residual food bolus or a tumour. On further examination, the consultant confirmed that he could see teeth and that this was only the second time he had ever seen this. The offending denture was removed under local anaesthetic. The patient developed no complications and was eating and drinking within a couple of hours.

I agree with the author that asking about loose-fitting dentures should be part of comprehensive assessment of all older people and, following this incident, I now include a dental assessment as part of my routine physical assessment. Many older people in long-term care receive suboptimal dental care. Locally, I am leading a working group to improve all aspects of oral care for older people in mental health wards, and I have little doubt that this work should be replicated by all long-term care providers.

LESLEY CHAPMAN
Physical Care Practitioner, Auckland Park Hospital, Bishop Auckland, County Durham, UK
Tel: (+044) 7785304067
Email: lesley.chapman@ccdp.s.northy.nhs.uk

Note: This work was carried out for Mental Health Services for Older People, County Durham, and Darlington Priority Services NHS Trust.


doi:10.1093/ageing/afj034
Published electronically 16 January 2006

Post-fall syndrome: a matter to study in patients with hip fractures admitted to orthopaedic wards

SIR—We have read with pleasure Dr Martín et al’s [1] very interesting paper about fear of falling limiting activity in young-old women being associated with reduced functional mobility. We would like to contribute our experience.

A prospective study was carried out for 2 years (2003 and 2004). All patients with hip fractures admitted to orthopaedic wards of a teaching hospital and referred to the geriatrician were included. The geriatrician makes a daily ward round taking medical control of the patients, and a study record was completed for each of the patients. In this study, all the independent predictive variables of functional recovery after hip fracture in the elderly were collected [2]. One of them was the presence of post-fall syndrome detected by the geriatrician during in-hospital stay. Follow-up outcome data were collected by telephone, 3 and 6 months after injury.

A total of 196 patients were recruited. The mean age was 84 years and post-fall syndrome was identified in 5.1% of patients. These patients were older (86.1 versus 82.7) and had a greater number of past medical diagnoses (5.6 versus...
Letters to the Editor

The proportion of patients reporting falls during the months prior to the fracture was similar to that reported by Martin et al. [1] and other authors [4, 5]. Our patients with post-fall syndrome also showed alteration in their functional status 6 months later. The low prevalence of post-fall syndrome detected in our study is notable in spite of having used for their detection the fear of falling and loss of self-confidence. The need to specify a greater number of characteristics defining or coming along with the post-fall syndrome bring up to us. That may help to an earlier clinical detection during the immediate post-surgical period in elderly patients with hip fracture. The small size of the sample in our study does not allow us to deal with this problem.

Without any doubt, the knowledge of the characteristics that define the post-fall syndrome has a great relevance for the detection of frailty and functional recovery after a hip fracture. Dr Martin’s study helps to improve the scanty knowledge existing in this field of geriatrics.

Teresa Alarcon*, Juan Ignacio Gonzalez-Montalvo, Almudena Barcena, Pilar Gotor
Servicio de Geriatría, Hospital Universitario La Paz, Paseo de la Castellana 261, 28046 Madrid, Spain
*To whom correspondence should be addressed at: Email: talarcon.hulp@salud.madrid.org


Re: Colonoscopy in the very elderly is safe and worthwhile

SIR—The research letter by Syn et al. [1] has once again demonstrated, in a prospective study, that colonoscopy in the very elderly is a safe and worthwhile procedure with a high diagnostic yield. The study has also demonstrated that the overall procedure-related mortality is very low and hence should not be a reason for clinicians’ reluctance in referring very old people for colonoscopic examination.

In their study, Syn et al. reported a colonoscopy completion rate of 56% in older patients. In a similar, prospective study [2] of 924 consecutive colonoscopies, in a nearby district general hospital, we had recently reported failure to reach caecum in 34 of 814 patients aged <80 years and in 12 of 110 patients aged 80 years or more (28 of these 34 and 7 out of the 12 failures were due to impassable strictures). Photographs of unambiguous landmarks such as terminal ileum, ileo-caecal valve or the appendicular orifice were also taken for documentation in our study. This difference could, to some extent, be explained by our use of polyethylene glycol for colonic preparation as we noted only one failure because of poor bowel preparation.

In our study, 12% of patients were aged 80 years or more and, in 20% of them, colorectal cancer was diagnosed on colonoscopy as opposed to 7.4% in patients aged <80 years. In the study reported by Syn et al., 8% of patients were in the age group of 80 years or more and 11% had colorectal cancer. This high diagnostic yield, combined with its potential for diagnostic and therapeutic interventions, is all the more reason why colonoscopy should be the preferred method of colonic examination in older people. We also demonstrated a median total procedure time of 18.5 versus 22 minutes and an anus to caecum time of 8.5 versus 9.75 minutes, respectively, in patients <80 years of age and those aged 80 years or more. Though colonoscopy in patients aged 80 years or more may take slightly longer, it is not significantly more difficult in older people.

Repeated studies have demonstrated that colonoscopy in older people is safe, well tolerated and has a high diagnostic yield. There are still wide variations in colonoscopy referral and performance rates for older people within the