Letters to the Editor

4.9), but these differences were not statistically significant. The proportion of patients presenting with falls 6 months prior to the injury was similar (30.0 versus 32.3%) in patients with or without post-fall syndrome. The functional and mental status before the fracture were also comparable (Barthel index 89 versus 87.4/100; and the Red Cross Hospital Mental Disability Scale [3], 0.5 versus 0.3). Eighty per cent of patients with post-fall syndrome were admitted with a subcapital hip fracture versus 40.3% admitted with the same type of fracture but without post-fall syndrome. The patients with post-fall syndrome had lower rates of preoperative risk measured by the American Society of Anaesthesiologists’ classification (ASA ≥ II 20.0 versus 46.2%), but they had a greater number of complications after surgery (mean 4.5 versus 3.1 per patient).

The mean hospital length of stay was similar in both groups (16.7 days in patients with post-fall syndrome versus 17 in patients without post-fall syndrome). On discharge, the proportion of patients walking independently or with minimal help of one person was almost the same, 60.0 versus 62.5%.

The probability of being able to walk over time with and without post-fall syndrome is presented as a Kaplan–Meier curve. The patients with post-fall syndrome who were unable to walk on discharge did not regain this ability in subsequent months, in contrast to the continued improvement seen in those patients without post-fall syndrome.

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 Geriatria, Hospital Universitario La Paz, Paseo de la Castellana 261, 28046 Madrid, Spain

*To whom correspondence should be addressed: Email: talarcon.hulp@salud.madrid.org


doi:10.1093/ageing/afj046
Published electronically 18 January 2006

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 colonic 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
National Health Service in the UK. We believe that colonoscopy should be the preferred method of colonic examination in the very elderly.

AMIT ARORA1*, PRADIP SINGH2
1School of Medicine, Keele University, Staffordshire, UK
2Staffordshire General Hospital, Stafford, UK
*To whom correspondence should be addressed at: Consultant Physician and Honorary Clinical Lecturer, Springfield Unit University Hospital of North Staffordshire Stoke on Trent, UK


doi:10.1093/ageing/afj047