Letters to the Editor

Grip strength predicts outcome

Sir—I was pleased to read the Research Letter of Kerr et al. in the January issue of this journal [1]. In it, they report a relationship between the grip strength and discharge disposition of elders admitted to hospital. Their research, though informative, is not the first to investigate ‘the link between grip strength and outcome in non-surgical settings’. For a primarily aged cohort of patients hospitalised with pneumonia, we have reported a significant correlation (−0.226) between the grip strength and a ‘bad acute outcome’; that is, an in-hospital death or a length of stay of nine or more days [2]. We also found grip strength to correlate significantly with the length of stay (−0.269), discharge home (0.545) and 30-day survival (0.285) [3]. In a follow-up study, we showed that death within a year of hospitalisation was correlated with grip strength (−0.272) [4]. Grip strength was a stronger predictor than any other measured variable, including pneumonia severity, co-morbidity load, age or preadmission residence in an extended care facility.

Considering Kerr et al.’s results in combination with our own, I would definitely agree that grip strength should be measured routinely ‘alongside the measurement of blood pressure’ [1]. Grip strength and other physical performance measures can ‘serve as easily accessible “vital signs” to screen older adults in clinical settings’ [5].

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Reply

Sir—We thank Professor Bohannon for bringing to our attention his research showing a link between grip strength and a range of adverse outcomes including prolonged length of stay in a group of people hospitalised with community-acquired pneumonia. The finding that grip strength was a stronger predictor than factors such as pneumonia severity, co-morbidity or age supports growing evidence that the loss of muscle strength lies on the final common pathway of a number of adverse processes including illness, functional impairment, inadequate nutritional status and ageing. As such, it acts both as a good single marker of physical frailty and as a potentially powerful predictor of future outcome. We hope that this additional evidence will further encourage clinicians to include the measurement of grip strength in the clinical setting.

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The future of geriatric medicine

Sir—That the paying public is not as embarrassed by Geriatric Medicine as Metz and Labrooy [1] is shown by the rapid increase in private practice in the specialty. Twenty-five years ago, there were a handful of geriatricians with significant private practices in central London. Now every private hospital throughout the affluent areas of England has access to geriatricians with substantial private caseloads.

Their comments, however, should not be ignored, although there is another future for the specialty in the environment that they describe. The development in the UK of most physicians as protocol-driven organ specialists leaves space for the continuation of the specialty of General Medicine. Current physicians accredited in ‘General (Internal) Medicine’ are good at managing medical emergencies but have little experience in less acute disease. Patients of all ages with non-specific symptoms, mixed medical and psychiatric problems and multi-system disorder may have problems finding an appropriate specialist. Older people do not always benefit from care driven by protocols worked out on younger people [2].

The General Physician of the past had little or no knowledge of the most important part of General Medicine, Geriatric Medicine. The public needs a new generation of General Physicians, most of whose training and practice is in what