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
we, today, call Geriatric Medicine but with wider knowledge and experience to deal with general patients of all ages. Many of my General Practitioner colleagues tell me that they are waiting for some of their patients to get older so I can see them. As the late R. E. Irvine (the founder of orthogeriatrics) used to put it, ‘What is good for older people is good for younger people but what is good for younger people is not always good for older people.’

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Re: Predictors of 1-year mortality in patients discharged from the hospital following acute exacerbation of chronic obstructive pulmonary disease

SIR—We read with great interest the paper by Yohannes et al. on the predictors of 1-year mortality in patients discharged from hospital following acute exacerbation of chronic obstructive pulmonary disease (AECOPD) [1]. The main findings of their study were that: (i) 1-year mortality after AECOPD admission was high (36%); and (ii) the activities of daily living, assessed by the Manchester Respiratory Activities of Daily Living scale, was the strongest marker in terms of mortality prediction for individuals. Disability as an independent mortality predictor has been described previously in COPD and in community-acquired pneumonia (CAP) in elderly patients. Torres et al. showed that functional status was an independent predictor for short- and long-term mortality in hospitalized patients with CAP, whereas severity of CAP predicted functional decline [2]. Therefore, the results of Yohannes et al. and those of Torres et al. taken together strengthen the importance of functional status as a prognostic factor in infectious and/or respiratory diseases in elderly patients.

However, we disagree with Yohannes et al. when they suggest that, given the high level of 1-year mortality after AECOPD, palliative care should be provided to patients with advanced COPD. Is it not the primary goal of physicians to lengthen patients’ lives and improve quality of life? Therefore, should patients with advanced COPD only be referred to palliative care teams or, on the contrary, should physicians optimize patient management (with monitoring of therapy compliance, prevention of infections—by vaccination and attention to nutritional status—and education in medication management)? In our opinion, it is difficult to answer these questions today, in the absence of evidence of the superiority of one option over the other. For ethical reasons, a therapeutic trial comparing palliative care with ‘intensified’ medical treatment would not be feasible for these patients. However, it would be of interest to evaluate the psychological acceptance of an ‘intensified’ therapy for patients with advanced COPD. This attitude could lead to a substantial benefit in terms of both life expectancy and, perhaps, quality of life.

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Reply

SIR—We are grateful to Baptista et al. for their interest in our paper. However, we feel that they have misinterpreted our suggestion that the accurate prediction of mortality in end-stage chronic obstructive pulmonary disease (COPD) could be useful in targeting palliative care.

First, we entirely agree that a mortality predictor is likely to be useful in targeting active therapy in an attempt to reduce mortality, and indeed we make this point in the introduction to our paper. We would therefore support the suggestion of Baptista et al. of carrying out an evaluation of the psychological acceptance of ‘intensified’ therapy for patients with advanced COPD. Secondly, we do not suggest that patients should ‘only’ be referred to palliative teams. Palliative care is not necessarily synonymous with terminal care, and can be offered at the same time as active medical treatment.

Thirdly, and most importantly, we stand by our decision to highlight the issue of palliative care in COPD. This group of patients, despite having a prognosis worse than that of many cancers (and greater disability, lower quality of life and higher levels of anxiety and depression than age-matched subjects with terminal non-small cell lung cancer [1]), at present seldom receive holistic care from palliative care services, medical services and social services [2–4]. Accurate prediction of impending mortality is a first step towards planning (by the patient, physician...