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 elderly 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 predication 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