Editor’s view

Orthogeriatrics is increasingly recognised as an important sub-specialty of Geriatric Medicine. In part, this reflects the excess mortality, substantial morbidity and vast health and social services expenditure associated with hip fracture. The recent Royal College of Physicians Audit of Falls and Bone Heath in Older People showed marked variation in the management and outcome of hip and other fragility fractures, with only a minority of patients offered falls assessment or osteoporosis management after fracture. This issue includes an editorial (pp. 128–129) highlighting two joint initiatives by the British Geriatrics Society and British Orthopaedic Association, which should improve the care of older people with hip and other fragility fractures. The new edition of the ‘Blue Book’ on the care of patients with fragility fracture provides a comprehensive guide for the multidisciplinary management of hip fracture, including pre-operative assessment, surgery, post-operative care, models of orthogeriatric care and secondary prevention of further fractures, involving the assessment and management of osteoporosis and falls. The National Hip Fracture Database (NHFD) builds on the success of the Myocardial Infarction Audit Project and offers a Web-based audit system for generating case-mix adjusted data on hip fracture management, outcome and secondary prevention measures. Opinder Sahota and Colin Currie argue that although there is a cost involved in collecting data for the NHFD, this is likely to be offset by the cost saving resulting from the improvement in care and outcome. As they conclude in their editorial ‘... looking after hip fracture patients well is a lot cheaper than looking after them badly’.

A commentary by Denis O’Mahony and Paul Gallagher (pp. 138–141) underlines that inappropriate prescribing is common in older people and leads to an increased risk of adverse drug reaction (ADR). They suggest that regular medication review is a logical way of minimising inappropriate prescribing and the resulting ADRs in older people, but highlight that this should be carried out in a systematic way. They then explore the limitations of two validated screening tools for inappropriate prescribing in older people, Beers’ Criteria and Inappropriate Prescribing in the Elderly Tool (IPET), before concluding that there is a need to develop and validate new, user-friendly, screening tools for inappropriate prescribing in older people.

This issue contains a systematic review of the prevalence of elder abuse and neglect by Claudia Cooper and colleagues (pp. 151–160). In general population studies, 6% of older people reported significant abuse in the past month. Almost 25% of vulnerable older people reported psychological abuse. The authors conclude that older people, their families and carers are willing to report abuse and should be asked about it routinely. They also suggest that valid, reliable measures of abuse are required.

Katy Ladbrook has written a report on the International Longevity Centre Global Alliance Conference on ‘Human Rights in an Ageing World’ (pp. 136–137). This highlights the global improvement in life expectancy and the need to uphold the human rights of older people in an ageing world. As she concludes, older people should be central to creating a culture of care and human rights. By meeting the needs and maximising the potential of older people, other groups will benefit and better relations will be built between the generations.

Clinicians in Geriatric Medicine have long been aware that older people may have a ‘normal’ serum creatinine, but have impaired renal function, as measured by glomerular filtration rate (GFR). Under the quality outcomes framework (QOF) of the General Medical Services (GMS) contract, general practitioners are offered financial incentives for the identification and management of adults with Stage 3–5 Chronic Kidney Disease (CKD), where the estimated GFR (eGFR) is less than 60 ml/min/1.73 m². Paul Roderick and colleagues (pp. 179–186) have investigated the prevalence of CKD, and examined its association with morbidity and functional status in a large population of people above 75 years of age. They report that over 50% had an eGFR <60 ml/min/1.73 m², but only 17.7% had an eGFR <45 ml/min/1.73 m². The association with measures of morbidity and functional impairment increased as eGFR fell, particularly when it was less than 45 ml/min/1.73 m². These results call into question the value of identifying and investigating the large number of older people with an eGFR between 45 and 60 ml/min/1.73 m².

R. M. Francis
Editor, Age and Ageing