Editor’s view

Inappropriate prescribing is common in older people and leads to an increased risk of adverse drug events. In a commentary published in Age and Ageing earlier this year (2008; 37:138–41), Denis O’Mahony and Paul Gallagher highlighted the limitations of two validated screening tools for inappropriate prescribing in older people, Beers’ Criteria and the Inappropriate Prescribing in the Elderly Tool, before concluding that there was a need to develop and validate new screening tools for inappropriate prescribing in older people. In this issue they report the results of a prospective study comparing the results of a validated medicine review system (Screening Tool of Older Persons’ potentially inappropriate Prescriptions; STOPP) with Beers’ criteria, in detecting potentially inappropriate medicines and associated adverse drug events in older patients admitted to hospital (pp. 673–679). They report that STOPP identified significantly more potentially inappropriate medicines than Beers’ criteria, a third of which resulted or contributed to hospital admission. Whether the use of STOPP will improve appropriate prescribing and reduce the morbidity and mortality associated with adverse drug events remains uncertain, but the authors conclude that randomised controlled trials are required to address these important questions.

A Research Paper reports the results of a randomised controlled trial from South Australia, comparing the effect of rehabilitation in a day hospital programme with home-based rehabilitation in 229 older patients discharged from hospital (pp. 628–633). Day hospital based rehabilitation was associated with a longer duration of rehabilitation and more treatment sessions. There was also a two fold higher risk of readmission to hospital compared with home based rehabilitation, possibly due to increased access to admitting medical staff. As discussed in an accompanying editorial (pp. 613–615), the longer period of rehabilitation and higher readmission rate is likely to result in greater expense, which is consistent with the results of a recent Cochrane Review on traditional day hospital care. Nevertheless, the editorial highlights that the development of more flexible day hospitals with outreach services offering multidisciplinary assessment and rehabilitation may secure their future in the modern NHS.

A Research Letter reports the results of a cross-sectional study examining the effect of age on the use, safety and efficacy of opioid analgesia in an Australian teaching hospital (pp. 699–702). Only a third of the 190 participants prescribed opioid analgesia experienced adequate pain control and poor pain relief was significantly associated with the presence of side effects, higher intensity of pain, the use of low doses and the prescription of regular opioids without additional doses as required. Older patients were prescribed lower doses of opioids than middle aged patients, but were less likely to report side effects than younger patients. Although the limitations of this study include the relatively small number of participants, the use of a single centre, the predominance of patients with orthopaedic problems and the timing of the assessment of the use of opioid analgesia and pain control, it highlights the need to carefully consider pain management in patients admitted to hospital. Although older patients in this study were not disadvantaged compared with younger individuals, the inadequate control of pain remains a challenge at all ages.

Lung cancer is now the leading cause of cancer-related death in the UK and most developed countries. A Research Letter reports a retrospective analysis of the effect of age and co-morbidity on choice of treatment and prognosis in 294 patients, with non-small cell lung cancer from Spain (pp. 715–718). The overall prognosis was poor, with survival ranging from 26 to 38 weeks, with a median of 32 weeks. Patients above the age of 70 years and those with co-morbidities were less likely to receive active treatment with chemotherapy, with or without radiotherapy. Multivariate analysis indicated that weight loss and the presence of two or more co-morbidities, were independent predictors of a poor prognosis, but there was no significant effect of age. The authors suggest that treatment decisions in patients with non-small cell lung cancer should be made on the basis of biological rather than chronological age, but emphasise the importance of a thorough evaluation of co-morbidities. Although they used the Charlson index in their study, they highlight that this does not provide information on the severity of concomitant disease.

Finally, a Systematic Review investigated prospective studies of STRATIFY for the prediction of falls in hospital in-patients (pp. 621–627). The authors report that although high values were found for specificity and negative predictive value, the sensitivity and positive predictive value were too low to make STRATIFY clinically useful in falls prevention in hospital. The topic of falls risk prediction tools was also reviewed by David Oliver, the lead author of the Systematic Review, in an editorial published in Age and Ageing earlier this year (2008; 37: 248–50). This concluded with the statement that ‘if we look after all older people in hospital better, it is likely that they will fall less’. Perhaps that, rather than the assessment of falls risk, is the key to falls prevention in hospital.

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