Editor’s view

Substance abuse is generally considered to be a problem mainly confined to young people, but a commentary highlights that it is becoming increasingly common in older people (pp. 8–10). Caryl Beynon reflects that older people abusing drugs today generally did so when younger, but have done little to change their consumption as they grow older. She acknowledges that there may be a group of older people who only started to use illicit drugs in later life, but stresses that lack of awareness of drug abuse among older people has largely prevented investigation of this issue. The demographic trend toward an ageing population will inevitably lead to an increase in the number of older people who abuse drugs. We therefore need further research on the effects of substance abuse in older people and should develop strategies for dealing with the resulting problems. In the meanwhile, we need to recognise that advancing age is no barrier to drug abuse and be aware that this may be contributing to our patients’ problems.

Patients with a past history of falls are at increased risk of further falls, which may result in fractures, other injuries and admission to hospital. A cluster randomised controlled trial reported in this issue (pp. 33–40) compared the outcome of multidisciplinary assessment and appropriate intervention in a day hospital with nurse assessment in the community and onward referral to other health care professionals in primary and secondary care in 505 older people with recurrent falls presenting to an Emergency Department. During the subsequent 12 months’ follow-up period, a significantly lower proportion (75%) of the secondary care group fell again, compared with 87% in the primary care group and 84% in the control group. The major difference between the interventions in the primary and secondary care groups was in the review of medication and recommendation for change, which occurred in 52% in the secondary care group compared to only 16% in the primary care group. Although the majority of people in the primary care group were considered to require medication review by the general practitioner, treatment was only changed in a small minority. The authors therefore suggest that there may be a role for independent medication review in primary care.

With the improvements in life expectancy, there has been continuing debate about whether this is associated with a prolongation of morbidity and dependency at the end of life. Data from the 1905 Danish Cohort Survey (pp. 103–105) demonstrate that the average life expectancy between the ages of 92 and 100 years was 2.7 years for men and 3.3 years for women, of which almost 75% was spent in a state of physical independence, with about 50% of the participants reporting good health. This suggests that people who survive to this age may still expect to spend a substantial proportion of their remaining lifetime in reasonably good health. Another study reported in this issue (pp. 51–55) examined the social and psychological predictors of mortality in people aged between 65 and 85 years and those over the age of 85 years over a 20-year follow-up period. As expected, mortality was higher in the older than the younger participants and in men compared with women. Social participation and subjective sense of well-being was associated with lower risk of mortality, even after adjustment for health status, age, sex, marital status and housing tenure. The authors conclude that social participation and subjective well-being both influence survival in old age, but suggest that they may be mediated through independent pathways.

Most clinicians are aware of the major causes and complications of hypercalcaemia, but much less is known about a low serum phosphate. A Research Letter examines the associations and consequences of hypophosphataemia in 125 older women admitted to hospital (pp. 112–115). Almost 30% of patients had at least one low serum phosphate during their admission. Multivariate regression analysis showed that hypokalaemia, cancer, low body mass index and laxative use were independently associated with hypophosphataemia. Mortality was higher in patients with hypophosphataemia than in those with a normal serum phosphate, and multivariate Cox regression analysis demonstrated that vomiting, serum creatinine, low phosphate, peak C reactive protein and diabetes were independently associated with mortality. Although this is a small retrospective study from a single centre, the authors conclude that hypophosphataemia is common in older women admitted to hospital. They highlight the need for further research to investigate the physiological consequences of hypophosphataemia in older patients and establish if correction of the biochemical abnormality can improve clinical outcome.

In this issue we publish a letter from Dr Paula Nenn offering a personal view of Dr Jed Rowe, who tragically died in September (pp. 128–129). This complements the formal obituaries of Jed published in the BGS Newsletter and the British Medical Journal and highlights his passion for geriatric medicine and compassion for his patients. As Dr Nenn highlights, it is a cruel irony that one of the great geriatricians will not reach old age. As she suggests, we should not only grieve our loss, but also celebrate his life!

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