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ensure that sufferers and carers can access information, support and treatment as soon as they need it, but the excessive emphasis on early detection distorts the intended message.

Old age psychiatrists are very keen to support people with dementia at every stage of their disease and we certainly want to improve the quality of life of all dementia sufferers. However, we do not want to attract patients to our memory clinics with the false hope that an early detection will arrest the progression of their disease. And this is not just a semantic issue; it can also be argued that an excessive focus on early diagnosis will ‘pathologise’ unnecessarily substantial amounts of elderly individuals with mild cognitive deficits, whose disorder may not necessarily progress to dementia and whose net well-being may perhaps be better preserved by staying away from officious psychiatrists in over-inflated memory clinics.

Conflicts of Interest

I run a Memory Clinic at the Memorial Hospital, London SE18.

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doi: 10.1093/ageing/afp042
Published electronically 7 April 2009

Depression and hospital outcome

SIR—The finding of Cullum et al. [1] that depression is associated with increased likelihood of transfer to community hospitals is interesting, but incomplete. For both clinical significance and generalisability (for instance, of services without access to community hospitals), we really need to know the outcome of the whole illness and its hospital treatment. It is likely that a significant proportion of those transferred to community hospitals would have been discharged to institutional care. Have the authors obtained (or, in these over-regulated days, would they be permitted to obtain) data on the destination of discharge of those patients, depressed and otherwise, who were transferred to community hospitals?

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doi: 10.1093/ageing/afp029
Published electronically 6 March 2009

Reply

SIR—Our correspondent has a reasonable point. Unfortunately, we did not have an access to information regarding final discharge destination for those individuals transferred to community hospitals. Furthermore, unless a very high proportion were discharged from community hospitals to care homes, we would still have very small numbers to look at for the association between the depression score and (eventual) discharge to care homes. However, this is an important outcome to investigate as research evidence suggests that depression is under-identified and under-treated, which may result in unnecessary placement of individuals in residential care.

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doi: 10.1093/ageing/afp033
Published electronically 21 May 2009

Acopia—unable to cope or to copy?

SIR—The term ‘acopia’ is one that appears to have been present in medical parlance for some time now. As mentioned by Kee and Rippingale in their recent article, it is a pejorative term describing the older patient who is ‘unable to cope’ [1]. However, we know that this is not a recognised word in the English language nor is it a recognised disease classification. Yet it is a commonly used term as Kee and Rippingale confirm and one that has aroused much debate in a number of articles [2–4].

It has now become so widespread that the term generates a number of subject headings in medical search engines and perhaps most tellingly of its prevalence, its own Wikipedia page [5].

Although it is clearly a modern term, it sounds very much like established medical terms we use that are generated from the ancient Latin of our medical predecessors and therefore should have some credence in its meaning.

I will take the term ‘afebrile’ as an example; it seems very linguistically similar to acopia and is one that is in everyday usage across the world. The word febrile is derived from the Medieval Latin febrilis—pertaining to fever, and from the Ancient Latin febris meaning fever. The prefix a- is derived from the Latin ab meaning away from and means ‘not’ in this usage. Hence, afebrile means ‘there is no fever’.
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By these means we should be able to derive the origins of acopia, which we have presumed to mean, `not coping'. Once again the prefix a- is from ab meaning not. We would presume copia to be from Latin also and it is. However, copia in fact means `plenty' and is where we also derive copious. In medieval times, copia came to mean `reproduction' or `transcript', eventually leading to our English word `copy'. In essence, acopia likely means an inability to copy and not an inability to cope.

The English verb to cope has in fact evolved from the Greek word kolaphos meaning `to punch' via the old French word coper or couper meaning `to come to blows with' into its current meaning of `handle successfully'.

A patient having difficulty in copying suggests a constructional apraxia, a recognised finding in right hemispheric lesions, particularly parietal strokes [6]. A similar term `dyscopia' has also been used to describe the difficulty in copying experienced by patients who have undergone commissurotomy [7].

I would therefore strongly disagree with Kee and Rippingale in their assertion that acopia is a term we should be embracing. Not only is it a lazy piece of terminology and an unhelpful label, but is also ultimately incorrect in its meaning and should be abandoned altogether.

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do: 10.1093/ageing/afp061
Published electronically 6 May 2009

Reply

SIR—We appreciate your interest in our article. As geriatricians, we share the frustrations felt by our colleagues by the use of the term `acopia’ in daily clinical practice and the dismissive attitudes it encourages towards elderly patients. A questionnaire survey of 93 heath-care professionals showed that 45% of respondents failed to recognise that the term is not a recognised word in the English language, and 82% felt comfortable in its usage as a clinical diagnosis [1].

However, it is encouraging that Ganfyd [2], an open access medical website similar to wikipedia, acknowledges that using `acopia’ as a diagnosis is associated with `poor clinical knowledge and skills in the practitioner’, and points out that the `use of the term as the sole diagnostic formulation for a patient will irritate and rapidly identify to others the limitations of the clinician who used the term’. We hoped that by pointing out that `acopia’ is a diagnosis with a high mortality rate (22%) [3], we would further emphasise this point.

It is evident from our failure in eradicating the term acopia over the past decade that it is here to stay. We extend the suggestion of embracing this label, as a means to change the paradigm in which our medical colleagues view it, not merely as a `Red Rag’ to geriatricians, but rather as a `Red Flag’ for patients who potentially have life-threatening medical illnesses. Much as `failure to thrive’ is used in children where there may either be a potentially life-threatening medical or a combination of medical and social problems, we hope that `acopia’ may in time be viewed in a similar manner. We are encouraged by the discussion that this has generated, and hope it goes some way in achieving our common goal for improved patient care for the elderly.

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doi: 10.1093/ageing/afp062
Published electronically 6 May 2009