Letters to the Editor

Pseudomonas arthropathy in an older patient

SIR—The case report by Keynes et al. [1] published in Age and Ageing suggested that only one case of *pseudomonas aeruginosa* septic arthritis affecting elderly people is currently in existence in the literature. May I point out that, in addition to the one case mentioned by the author [2], there are several such cases in the literature as highlighted below.

Vickers and Price reported a case of recurrent septic arthritis due to *pseudomonas aeruginosa* involving two different joints [3]. Similarly Dan et al. reported two episodes of infectious arthritis due to *pseudomonas aeruginosa* separated by a 6-year interval [4], and Grieco reported five cases, of whom two cases were aged 65 and 75 years [5].

In a retrospective study of patients hospitalised with septic arthritis between 1979 and 2002, Gavet et al. reported septic arthritis in two patients between the ages of 60 and 80 years to have been caused by pseudomonas [6]. In another retrospective study of 52 patients with septic arthritis of the wrist diagnosed between 1994 and 2004, Rashkoff et al. reported two to have been due to pseudomonas, although the age of those two cases was not reported by the authors [7].

There are also reports of other pseudomonal joint infections. MacFarlane and Oppenheim, for instance, reported a case of recurrent, and persistent, septic arthritis due to *pseudomonas putida* in a neutropenic patient aged 66 years [8]. Also Matteson and McCune reported a patient with osteoarthritis developing knee sepsis due to *pseudomonas cepacia* following intra-articular corticosteroid injection [9].

Septic arthritis due to pseudomonas is not very common, but does exist. It particularly affects intravenous drug users, immunodeficient patients, patients with infections elsewhere, patients with chronic coexistent diseases as well as arthritic joints and patients receiving frequent broad-spectrum antibiotics [10]. The elderly, with multiple pathology, prone to have these last four characteristics and are at risk.

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Visual impairment following stroke: do stroke patients require vision assessment?

SIR—We have read with interest the article by Rowe et al. [1] published in Age and Ageing and will like to make the following comments. There are people who do not get referred or assessed by orthoptist for various reasons. These are listed below:

(i) People discharged to nursing homes are less likely to be referred to the service.
(ii) The lack of awareness by the stroke team looking after the patient to refer to orthoptist.
(iii) Patients fail to attend the clinic because they have been informed their visual field defect may not improve, hence, they may not see the need to attend.
(iv) Patients with disability may find it difficult to attend several clinic visits.

Our recommendations are as follows: Each hospital should establish a close link with orthoptists. All patients


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