Editor’s view

An editorial by Finbarr Martin (pp. 640–643) describes the new Department of Health Commissioning Toolkit for Falls and Bone Health. This has four objectives, to be implemented in a stepwise fashion, based on the size of their impact. The first objective is to improve the care and outcome of patients after hip fracture, by following the standards outlined in the British Orthopaedic Association and British Geriatrics Society ‘Blue Book’ on fragility fractures. The second is to respond to the first fracture and prevent the second fracture, by using fracture liaison services. The third objective is to target older people at high risk of fragility fracture or other injurious falls, though falls care pathways, linking acute and urgent care services to secondary prevention of further falls and injuries. The fourth is to prevent frailty, promote bone health and reduce accidents, by encouraging physical activity and healthy lifestyle and reducing environmental hazards. Although there is no additional funding available to support this initiative, an accompanying impact assessment signed off by the responsible minister confirms that the financial benefits outweigh the costs. This should prove useful when Commissioners are considering falls and fractures services in their locality.

Another editorial by Margot Gosney (pp. 644–645) highlights that cancer commonly presents in older people, but is less likely to be investigated, included in screening programmes, diagnosed or actively managed than in younger people. She suggests that Geriatricians need to be involved throughout the whole process of patient management, from diagnosis, through chemotherapy, radiotherapy, surgery and rehabilitation, to palliative care in hospital in some cases.

The increasing use of estimated Glomerular Filtration Rate (eGFR), calculated from a person’s age, gender and serum creatinine, has been a mixed blessing. On the one hand it highlights that an older patient with a serum creatinine in the normal range may have significant renal impairment, but has also resulted in many older people being labelled as having Chronic Kidney Disease. This in turn may have caused unnecessary alarm and inappropriate investigation in some cases. Nevertheless, the assessment of renal function is important in older people, when deciding on the dose of drugs excreted by the kidneys. A research paper (pp. 698–703) compares gentamicin clearance with eGFR calculated using the Modification of Diet in Renal Disease (MDRD) method and an optimised version of the Cockcroft–Gault method (CG_{opt}), which also includes the lesser of actual or ideal body weight. The authors report that overall MDRD overestimated gentamicin clearance by 29%, whilst CG_{opt} underestimated it by 10%. The overestimation by MDRD increased with advancing age, from 12% below the age of 65 years to 69% above the age of 80 years. They suggest that CG_{opt} may be more appropriate than MDRD for determining the dose of renally excreted drugs in older patients in hospital.

Despite the continuing improvement in life expectancy and the increasing proportion of the proportion who are above the age of 80 years, most drug treatments and other therapeutic interventions are formally evaluated in younger patients without co-morbidity. There is therefore often a delay before frail, older patients are able to benefit from advances in medical management, because of concerns about safety, efficacy and cost-effectiveness. A research letter in this issue (pp. 748–751) reports the outcome of percutaneous coronary revascularisation (PCR) in 74 octogenarians, who were assessed at baseline and six and twelve months after PCR. All patients were discharged home after a mean hospital stay of 1.8 days and only one required emergency coronary surgery. Over the subsequent 12 months, three patients died and 14 were readmitted with angina. There were significant improvements in functional status and quality of life after PCR, as assessed by the SF36 and Seattle Angina Questionnaire. Although this study was performed in a single centre and did not examine the effect of co-morbid conditions or investigate cost-effectiveness, it suggests that PCR is safe and effective in older people.

Chronic heart failure is a major cause of mortality and morbidity in older people, accounting for about a third of all admissions to hospital in this age group. It has been suggested that the high mortality is due in part to co-morbidity. A research paper (pp. 734–740) investigates if the Charlson Co-morbidity Index (CCI) predicts long-term mortality in people with heart failure. The paper reports the findings after 12-year follow-up in 1,332 men and women, who had taken part in a cross-sectional study in 1992 of 1,780 subjects aged 65 and older, recruited from the general population in Campania, Italy. Mortality was higher in subjects with chronic heart failure (79%) than in those without this diagnosis (54%). Although the CCI was a significant predictor of mortality in subjects without chronic heart failure, this was not the case in people with heart failure. The authors suggest that some conditions which are uncommon in older people are heavily weighted in the index, whilst the importance of common conditions such as chronic heart failure may be underestimated.

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