Editor’s View

The use of anti-hypertensive treatment is widely considered to be a risk factor for falls in older people, possibly mediated through the development of orthostatic hypotension. The results of studies examining the relationship between these treatments and falls have been inconsistent and few have investigated the effect of different classes of anti-hypertensive agents. A case–control study reported in this issue (pp. 592–597) examines the relationship between anti-hypertensive treatment and documented falls in older people, using data from The Health Improvement Network primary care database in the United Kingdom. The investigators identified 9,682 patients above the age of 60 years with a first fall documented between 2003 and 2006, together with up to six control subjects matched by age, gender and general practice. After adjusting for confounding variables, they report a small increased risk of falls in patients who were currently prescribed a thiazide diuretic, which was more marked in the 3 weeks after the first prescription. In contrast, there was a lower risk of falls in those currently prescribed beta blockers, but there was no relationship between other anti-hypertensive treatments and the risk of falls. Despite the limitations of the study highlighted in the discussion, the results suggest that older patients starting thiazides should be monitored closely in the first few weeks of treatment.

The HYpertension in the Very Elderly Trial (HYVET) investigated the risks and benefits of a thiazide diuretic (sustained release indapamide), with or without the angiotensin-converting enzyme (ACE) inhibitor perindopril, in the treatment of hypertension in older people aged 80 years and above. There was a significant reduction in stroke, heart failure, overall mortality and mortality from stroke and cardiovascular disease in participants treated with indapamide, with or without perindopril (N Engl J Med 2008: 358:1887–1898). As thiazide diuretics may reduce urine calcium excretion and improve bone density, one of the secondary outcome measures investigated in HYVET was fracture, details of which are provided in this issue (pp. 609–616). Among the 3,845 participants in HYVET, a total of 102 fractures were reported, 42 in the group receiving active treatment and 60 in the control group. Analysis of data from the 90 validated first fractures showed a marginally significant 42% reduction in fractures with active treatment, after adjustment for key baseline risk factors. The authors conclude that despite lowering blood pressure, treatment with a thiazide diuretic and an ACE inhibitor does not increase and may decrease the risk of fractures.

Bacterial infections are an important cause of morbidity and mortality in older people, but the presentation may be atypical in this age group, with an absence of tachycardia, pyrexia and leucocytosis. Appropriate antibiotic treatment of bacterial infection improves long-term outcome in older people, so early diagnosis and intervention are important. A research paper investigates the value of C-reactive protein (CRP) in the early detection of bacterial infection in older people (pp. 559–565). The authors prospectively recruited 232 consecutive patients aged 70 years and above admitted to hospital wards for older people. CRP was significantly higher in patients with infection than in the group without infection, and the authors report that a threshold value of 60 mg/l provides the best combination of sensitivity and specificity. Using this threshold value, there was a sensitivity of 80.7%, specificity 96.0%, positive predictive value 91.9% and negative predictive value 89.8% for the diagnosis of bacterial infection. The authors conclude that CRP is a convenient and useful test for the detection of early bacterial infection in older people, particularly in the absence of other markers of infection.

Palliative care initially developed in the hospice movement, to address the needs of people with malignant disease, including the management of pain and other symptoms and the provision of psychological, social and spiritual support. The role of palliative care has expanded to encompass patients with non-malignant conditions, such as dementia and heart failure. A research paper assesses the palliative care needs of patients with acute stroke, where the mortality rate approached 30% (pp. 554–559). Data were collected from 191 patients admitted to hospital with acute stroke, of whom 74.3% were above the age of 65 years. Participants completed the Sheffield Profile of Assessment and Referral to Care (SPARC), a screening tool for referral to specialist palliative care. About 80% reported symptoms related to tiredness, and 50% experienced pain, anxiety, low mood or poor concentration. Over 20% were worried about death or dying and 66% were concerned about losing independence and disability. Over 50% were concerned about the impact of stroke on their relatives. There were significant associations between the total SPARC score and Barthel Index, age and co-morbidities. The authors conclude that patients with acute stroke patients have a high prevalence of palliative care needs, which could be identified by the use of SPARC, particularly in patients with a Barthel Index less than 15 out of 20. Perhaps we should also consider using SPARC towards the end of life in older patients with other long-term conditions.