Editor’s view

There is great media interest in the potential benefits of stem cell therapy in the management of a wide range of medical conditions. The use of haematopoietic stem cells in bone marrow transplantation is well established, but stem cell therapy is now being investigated in neurological disorders, ischaemic heart disease and peripheral vascular disease. A review in this issue explores the potential use of stem cell therapy in the management of ischaemic stroke (pp. 7–13). After outlining the large number of strokes each year and the associated mortality and disability, the authors highlight the narrow time window for thrombolysis and the small number of patients receiving this treatment after ischaemic stroke. They then explore the regenerative potential of brain cells and possible approaches to stem cell therapy in ischaemic stroke, including the use of neural stem cells, immortalised cell lines and bone marrow-derived stem cells. Small clinical studies of these potential interventions have been completed or under way, but the review highlights the major issues that need to be addressed before proceeding to larger studies. For older physicians who remember the days when patients with stroke were largely ignored, the introduction of thrombolysis and long-term potential for stem cell therapy is welcome and exciting!

Delirium is common in older people, where it is associated with increased mortality, morbidity, prolonged hospital stay, subsequent long-term care and high health and social costs. Risk factors for the development of delirium include advancing age, cognitive impairment, acute illness and recent hip fracture. A systematic review has examined the relationship between different medications and the risk of delirium in hospital in-patients or long-term care residents (pp. 23–29). The authors found a significant 2–3-fold increased risk of delirium with opioids, benzodiazepines and dihydropyridines. They therefore suggest that in older people at risk of developing delirium, benzodiazepines should be avoided if possible and opioids should be used with caution, but point out that severe pain may trigger delirium. Caution is also advocated in the use dihydropyridines, such as amlodipine and nifedipine, where an individual assessment of risk and benefit should be performed.

Vaccination against influenza is now recommended in the UK for all people above the age of 65 years, as it is an effective way of preventing the associated mortality and morbidity. A research paper investigates the factors influencing the uptake of influenza vaccination in a random sample of 2,033 community-dwelling older people from two adjacent areas in Northern Ireland and the Irish Republic (pp. 35–41). Overall, the uptake of vaccination was good at 78 and 72%, respectively, but was higher in older subjects and in people who were widowed or had functional impairment. It was also higher in people with regular contact with their GP and users of chiropody, meals on wheels, social work and occupational therapy. The authors conclude that exposure to health services may enhance trust in health care, resulting in a higher uptake of influenza vaccination. It is also likely that contact with social services may have a similar benefit, particularly when health and social service are delivered in an integrated manner.

Fragility fractures are a major cause of excess mortality, morbidity and health and social service in older people. A research letter has examined postural sway as a risk factor for fracture in 769 community-dwelling Japanese women aged 69 and above (pp. 132–135). Baseline investigations performed in 2003 included measurement of postural sway, forearm bone mineral density (BMD) and serum 25 hydroxyvitamin D (25OHD). During the 6-year follow-up period, 50 subjects reported having sustained a fracture after minor trauma, which was confirmed by X-ray review. Women with fractures had a significantly lower BMD and serum 25OHD than those without fractures. Subjects in the highest quartile of postural sway had a significantly increased risk of fracture, which persisted after adjustment for potential confounders, such as age, body mass index, BMD and vitamin D status. The results reinforce the need not only consider intervention to improve BMD, but also to implement measures to prevent falls in older people at high risk of fragility fractures.

Older people with dementia are at increased risk of falls and fractures and have a worse outcome after hip fracture. A retrospective cohort study using anonymised electronic medical records from The Health Improvement Network (THIN) in the UK has investigated Alzheimer’s disease (AD) as an independent risk factor for hip fracture (pp. 49–54). The incidence of hip fracture among 10,052 patients with AD was 17.4/1,000 person-years, compared with 6.6/1,000 person-years in the same number of subjects without this diagnosis. The 3-fold higher risk of hip fracture in patients with AD persisted, even after adjusting for potential confounders. Furthermore, the mortality after hip fracture was higher in patients with AD than in control subjects. The authors suggest that patients with AD and their carers should be offered advice on the prevention of hip fractures and more attention should be given to AD patients undergoing rehabilitation after a hip fracture.

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