**Editor’s view**

Falls have long been recognised as an important cause of mortality, morbidity and health and social service expenditure in older people, as a result of serious injury such as hip fracture. It is also increasingly apparent that fear of falling, which is more common in older people who have fallen previously, may limit mobility and restrict everyday activities. More recently, the concept of falls-related self-efficacy has developed, which reflects an individual’s perception of their ability to mobilise without losing their balance and falling. Two papers in this issue, both from the University of British Columbia in Vancouver, Canada, investigate two aspects of this topic. The first examines the relationship between falls-related self-efficacy and quality of life in 135 community-dwelling older women taking part in a randomised controlled trial of resistance training (pp. 340–346). Falls-related self-efficacy was assessed using the Activities-Specific Balance Confidence (ABC) Scale and health-related quality of life measured by calculating Quality Adjusted Life Years (QALYs) using the EuroQol-5D questionnaire. The authors report a significant relationship between the ABC scale and QALYs, which persisted after adjustment for age, co-morbidity, mobility, cognitive status and falls risk. Although this is a small study in relatively healthy older women, it suggests that fear of falling and impaired falls-related self efficacy has a significant impact on quality of life in older people.

A second paper reports the results of a systematic review and meta-analysis of randomised controlled trials of interventions to improve balance confidence in adults aged 60 years and above without neurological disorders such as stroke or Parkinson’s disease (pp. 297–306). The major outcome measure in these trials was balance confidence or falls efficacy, assessed using the ABC scale, Falls Efficacy Scale (FES) or modified FES. The trials included in the meta-analysis evaluated exercise regimens directed at improving strength and balance, Tai Chi or multi-factorial intervention aimed at reducing falls. A modest beneficial effect was noted with studies using exercise and multifactorial interventions, but the greatest improvement was seen with Tai Chi. The latest Cochrane Review of interventions to prevent falls in community-dwelling older people also shows a 37% reduction in the rate of falls and a 35% decrease in the risk of falling with Tai Chi. Perhaps, the time has come to encourage Tai Chi more widely in the older population in general and in our patients at risk of falls in particular.

Measurement of glomerular filtration rate (GFR) remains the gold standard for assessing renal function, but most of us are aware of the limitations of measuring creatinine clearance in older people. Estimating GFR using serum creatinine, age and gender, with or without weight or body surface area, has become increasingly popular, encouraged in the UK by the inclusion of chronic kidney disease (CKD) as an indicator in the Quality Outcomes Framework of the General Medical Services contract for General Practitioners. A research letter examines investigates the outcome and implications of using different equations for calculating GFR in 567 participants in a population-based cohort study of men and women aged 80 years and older (pp. 401–405). Estimated GFR (eGFR) was calculated using the Cockcroft-Gault (CG), abbreviated Modification of Diet in Renal Disease (MDRD), Chronic Kidney Disease Epidemiology Collaboration and Chronic Kidney Disease Epidemiology Collaboration 2 Cystatin C equations. There were considerable discrepancies in the eGFR calculated using the various equations, resulting in differences in the prevalence of impaired renal function. So, for example, using the CG equation, 61% of participants had an eGFR between 30 and 60 ml/min/1.73 m² and 10% had an eGFR <30 ml/min/1.73 m², compared with 38 and 6%, respectively, with MDRD. As the authors acknowledge in the discussion, they did not measure GFR using a gold standard method, so were unable to establish the most accurate and precise method for estimating GFR in this age group. Furthermore, they only performed measurements on a single occasion, whereas multiple measurements are required to assess CKD.

Another paper investigates the relationship between renal function and quality of life in 2,967 community-dwelling men and women aged 75 years or more taking part in the Medical Research Council Trial of the Assessment and Management of Older People in the Community (pp. 381–387). The MDRD equation was used to calculate eGFR and quality of life was assessed using four domains from the Sickness Impact Profile (home management, mobility, self-care and social interaction) and the Philadelphia Geriatric Morale Scale. After adjustment for age and co-morbidity, eGFR <45 ml/min/1.73 m² was associated with poorer mobility, home management and social interaction, compared with those with eGFR ≥60 ml/min/1.73 m². Men with eGFR <45 ml/min/1.73 m² had low morale, whereas women with eGFR <45 ml/min/1.73 m² reported problems with body care. This study highlights that Stage 3b CKD is not only common in older people, but is also associated with impaired quality of life.

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*Editor, Age and Ageing*