Editor's view

Data on the relationship between alcohol consumption and cognitive function in older people are conflicting. Although persistent alcohol abuse has an adverse effect on memory, modest alcohol intake may be associated with a lower risk of Alzheimer’s disease. Less information is available on the relationship between the type of alcoholic beverage consumed and the development of dementia in people above the age of 75 years. A prospective study has investigated the relationship between the quantity and type of alcohol consumed and the development of dementia over a 3-year period in 3,202 men and women aged 75 years and above (pp. 456–463). The authors report that after adjusting for potential confounders, moderate alcohol consumption (20–29 g/day; 2–3 units/day) was associated with a lower risk of developing dementia in general and Alzheimer’s disease in particular. A similar trend was seen whether the alcohol was consumed as wine, beer or mixed beverages. The authors acknowledge that the association does not prove that alcohol consumption protects against the development of dementia. With the potential increase in alcohol consumption in all age groups, we should continue to encourage older people to keep their intake within recommended limits.

Last year we published a Consensus Report from the European Working Group on Sarcopenia in Older People (Age Ageing 2010; 39: 412–423). This included a clinical definition of sarcopenia based on low muscle mass and reduced muscle strength or performance. Grip strength was recommended as a good measure of muscle strength, when performed under standard conditions with a dynamometer with normative data from the appropriate population, but the optimal method of doing this was not defined. A systematic review has now examined the measurement of grip strength (pp. 423–429). The authors found variation in the choice of equipment and protocol for measuring grip strength. The Jamar hand dynamometer was the most widely used instrument, but there were differences in how it was used, which could affect the results obtained. The authors suggest a standardised method of measuring grip strength, based on the American Society of Hand Therapists (ASHT) protocol, which would improve the assessment of sarcopenia. A research letter in this issue (pp. 523–527) reports a study of grip strength in 505 older native American Indians in four age groups (55–64, 65–74 and ≥75 years). Grip strength in the dominant hand was measured with the Jamar dynamometer using the ASHT protocol. As expected, the authors found that grip strength declines with age in both sexes, with higher results in men than women. Increasing age, lower educational attainment, the presence of co-morbid conditions, impaired activities of daily living and poorer Short Physical Performance Battery scores were all associated with lower grip strength. Other studies have shown that lower grip strength is also associated with slower walking speed and inability to rise from a chair. Perhaps the time has come when we should consider measuring grip strength in clinical practice.

Comprehensive geriatric assessment (CGA) has been shown to improve outcome for frail older people in an acute hospital setting. A systematic review has examined studies of CGA in older people who attend acute hospital settings, but are discharged home within three days (pp. 436–443). The authors identified five randomised controlled trials of adequate quality, but none of these evaluated CGA in older people being discharged from acute medical units as developed in the UK. The results showed no definite evidence of a benefit of CGA on readmission, subsequent institutionalisation, physical function, quality of life, cognition or mortality. Although the authors conclude that there is no clear evidence of benefit of CGA in frail older people being discharged from emergency departments or acute medical units, they point out that relatively few trials have been performed and that their overall quality was poor. They highlight the need for further well-designed trials of CGA in the interface between the acute setting and the community.

Smartphones are increasingly being used in medicine, as applications are developed for research use and clinical practice. A research letter highlights the potential use of an Android-based smartphone with triaxial accelerometers in the assessment of falls risk (pp. 516–519). One of the authors has developed an application in which a small blue ball is moved on a large white circle on the screen by tilting the ‘phone. The inclination of the phone is then determined by the triaxial accelerometers. The application is based on the ‘walking while carrying a ball on a tray’ task, which was previously shown to be a good predictor of falls risk. The authors recruited 318 community-dwelling older people, 90 of whom were considered to be at high risk of falls. All subjects were asked to keep the ball in the circle on the ‘phone screen for 15 s while stationary (single task) and during a 15-m walk (dual task), together with a number of other physical performance tests. The largest difference between subjects at high and low risk of falls was in the dual task score. This novel approach warrants further prospective study as a predictor of falls.

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