Editor’s view

Delirium

Delirium and frailty are both associated with increased mortality in older people admitted to hospital. An article in this issue examines the relationship between delirium and frailty in older in-patients and investigates their effect on mortality (pp. 412–416). The authors performed a prospective cohort study in 273 older patients admitted to hospital, who were followed for 5 years. Participants were screened for delirium on admission and on alternate days during their in-patient stay, whereas frailty was assessed by an index of accumulated deficits. Delirium was identified in 37% of the patients, while 41% were classified as frail. Patients with delirium had a significantly higher mean Frailty Index than those without delirium, and the majority were classified as frail. Survival was lower in patients with frailty or delirium, but was lowest in those with both conditions. The authors suggest that identification of frail patients using the Frailty Index, derived from routinely collected data, could enable preventive measures to be directed on those at high risk of delirium.

Another article examines the cost-effectiveness of multi-component intervention to prevent delirium in older people admitted acutely to hospital (pp. 285–291). The authors emphasise that delirium is associated with an increased risk of hospital-acquired complications, prolonged hospital stay, the need for institutional care and excess mortality. They also highlight that the National Institute for Health and Clinical Excellence (NICE) Clinical Guideline suggests that although systems of care to treat delirium do not improve outcome, multi-component interventions, which address cognitive impairment, sleep deprivation, immobility, impairment of vision and hearing and dehydration, may prevent a third of episodes of delirium and the associated adverse outcomes in older hospital patients. The authors compared multi-component interventions with standard care using a model based on a decision tree analysis. They report that multi-component intervention is cost-effective when compared with standard care, with an incremental net monetary benefit of £2,200 using a cost-effectiveness threshold of £20,000 per QALY. They conclude that implementation of strategies to prevent delirium in older people admitted to hospital could result in savings to the NHS and social care services, but highlight that this may mean investment by the acute sector to save costs to the wider public sector.

Urinary incontinence after stroke

Incontinence is one of the ‘Geriatric Giants’, but we have received and published few articles on this topic over the past 5 years. I am therefore particularly pleased that this issue contains an article reporting the results of a prospective study of urinary incontinence after stroke (pp. 371–376). The investigators administered a standardised questionnaire asking about urinary symptoms to patients enrolled in the North-East Melbourne Stroke Incidence Study 3 and 12 months after a first stroke. Over 80% of the participants reported urinary symptoms at each time point, with nocturia documented by over 75% of subjects. Fewer than 15% of subjects reported urinary incontinence before their stroke, but the prevalence after stroke was 43.5% at 3 months and 37.7% at 12 months. Independent risk factors for urinary incontinence at 12 months were higher age at the time of stroke, female gender, pre-stroke incontinence and severe stroke, although there was an interaction between stroke severity and age, such that the effect of stroke severity was amplified by advancing age. The authors conclude that urinary symptoms are common after stroke, with many patients developing urinary incontinence in the first year. They suggest that further investigation of the factors contributing to these symptoms, which are likely to affect quality of life, may help to establish the most appropriate treatment and care for these patients.

Discharge prediction after hip fracture

Hip fractures are associated with an excess mortality of 20% at 1 year, with substantial morbidity, delayed discharge and the need for residential or nursing home care in a proportion of the survivors. The Nottingham Hip Fracture Score (NHFS) has previously been shown to predict mortality 3 months and 1 year after hip fracture. The research team who developed the NHFS have now investigated its role in the prediction of discharge from acute hospital care and return to home after hip fracture (pp. 322–326). They have analysed data from 6,123 patients with hip fracture, of whom 60% were discharged from acute hospital to their own home. There was a strong correlation between the NHFS and return to home and to the proportion of patients discharged to their own home 7, 14 and 21 days after surgery. The authors conclude that NHFS is a reliable tool for predicting return to home, so may be useful for discharge planning and in the design of future research trials.

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