Editor’s View

Management of spasticity revisited

In 2008 one of our most downloaded papers was Mike Barnes’ review article on the management of spasticity published ten years earlier (Age Ageing 1998; 27: 239-245). The Editorial Board therefore commented that there was a need for an updated review on this topic, to include the latest information on the epidemiology, pathogenesis, clinical presentation and management of spasticity. I am therefore delighted that this issue includes an updated review of spasticity written by Laura Graham, one of Mike Barnes’ successors in Newcastle (435-41). This emphasises that spasticity is common after stroke and other neurological conditions, where it restricts function and impairs quality of life. The modification of factors which may aggravate spasticity and the use of physical therapies addressing muscle tone, posture and positioning are essential in the management of the condition, as existing pharmacological interventions have only limited effect. Nevertheless, there does appear to be some benefit from the targeted use of botulinum toxin injections. The article underlines the importance of a multidisciplinary holistic approach to the management of patients with spasticity. It also highlights that the relative lack of good outcome measures and the heterogeneity of clinical presentation have hindered the development of randomised controlled trials of therapeutic interventions. Hopefully this article will not only provide useful advice on the management of spasticity, but also encourage further research into this distressing problem.

HIV Infection in older adults

A research paper examines the effect of age on the presentation, use of anti-retroviral therapy (ART) and mortality in adults with HIV infection (520-26). The authors have analysed national surveillance data from the Health Protection Agency on adults aged 15 years and above diagnosed with HIV infection between 2000 and 2009. During this time, 63,805 adults were diagnosed with HIV in England, Wales and Northern Ireland, of whom 9% were aged 50 years and above and 4% were 70 years or older. Comparing data from people aged between 15 and 49 years at diagnosis with those aged 50 years and above, the older group were significantly more likely to be white, male and heterosexual. The older group were also more likely to have a very low CD4 count (<200 cells/mm³), AIDS at diagnosis and a higher mortality at one year. Among people with a CD4 count <200 cells/mm³, ART use was similar in both age groups, whereas when analysing the data using the more recent treatment threshold of a CD4 count <350 cells/mm³, proportionately more older adults received ART. The authors also investigated the effect of CD4 count at diagnosis and ART on mortality in both age groups using Cox proportional hazards models. They report that although the relative risk reduction in mortality with ART initiation at a CD4 count <200 cells/mm³ was similar in both age groups, the absolute risk reduction was higher in older adults, so that the number needed to treat to prevent one death was two compared to eight in the younger group. They conclude that the benefit of ART is greater in older than younger adults and suggest that this age group should be considered as a target for HIV testing, as early diagnosis and treatment, earlier is likely to substantially reduce mortality in this group. Although the use of the age threshold of 50 years to define the younger and older age groups may have been necessary to generate sufficient numbers in the latter, improvements in the management and survival of people with HIV infection mean that increasing numbers of older people will inevitably be seen by Clinicians in Geriatric Medicine.

Mortality in the oldest old

A study from Finland investigates the predictors of mortality in 888 people aged 90 years and above in 2001 (mean age 92 years), who were taking part in the Vitality 90+ Study (468-75). During the nine year follow up period 97.3% of the men and 94.3% of the women had died, with a longer mean survival time in women (3.4 years) than men (2.9 years). The authors report that older age, male gender, impairment in mobility and activities of daily living (ADL), poor self-rated health and institutionalisation all increased the risk of death. In age-adjusted Cox regression models, impaired ADL and mobility were stronger predictors of mortality in men than women. A second paper from Denmark examines changes in the rates of hospitalisation, surgery and subsequent mortality in two cohorts of people aged 85 years and older, who were born in 1895 and 1905 (476-81). The authors found that the 1905 cohort were admitted more frequently to hospital, more frequently and underwent surgery, but they had a shorter length of stay than the 1895 cohort. Despite the higher rate of hospitalisation and surgery, there was no increase in post-operative and in-hospital mortality in the 1905 cohort.

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