

Letters to the Editor

Anticoagulation of older patients

SIR—It is encouraging to note that the discussion about anticoagulation of older patients has now shifted from whether to anticoagulate to how to initiate and control anticoagulation with warfarin [1].

There are two groups of patients in clinical practice who are frequently anticoagulated. The first group comprises patients who have had a deep venous thrombosis and/or pulmonary embolus, who should be anticoagulated quickly. The regimen described by Gedge *et al.* [2] appears to be satisfactory for these people—especially as they are either inpatients or under the close daily supervision of community outreach from the hospital.

The regimen of Gedge and co-workers gives 10 mg on the first day of anticoagulation. While it is less likely to cause the international normalized ratio (INR) to rise above 4.5, this still happens in some patients but less often than with the higher dose regimens eg. Fennerty [3] or 10/10/5 regimens.

We have found in a group of 37 elderly patients (mean age 81.7 years) that starting anticoagulation with one of these high-dose regimens caused the INR to exceed 3 on day 4 in 25 subjects (68%) and at some time during the initiation in 30 (81%).

The second group comprises the increasing number of older people who are anticoagulated as prophylaxis against thromboembolism from an abnormal heart [1, 4, 5]. There is less urgency to reach the therapeutic range in these patients. They can have their warfarin initiated as outpatients with an appropriate initiation regimen. The high-dose initiation regimens associated with early over-anticoagulation are undesirable in these patients. The median dose of warfarin being used to maintain the INR between 2 and 3 in 61 of our elderly long-term anti-coagulated patients was between 2 and 3 mg/day.

We have found that a low-dose initiation regimen starting with 2 mg daily for 7 days followed by 1 mg adjustments of the dose every third or fourth day until the INR is in range achieves safe introduction of anticoagulation without any episodes of over-anticoagulation (INR > 3) on day 4. Only three (14%) of our first 21 patients anticoagulated using this regimen had a slight elevation (>3) whilst warfarin was being introduced. No patient had an INR > 4.5 and there were no adverse effects. The median interval to achievement of an INR in the therapeutic range (2–3) was 11 days (inter-quartile range 7–18 days).

Crawford *et al.* [6] have suggested starting with 1 mg daily with weekly adjustments. This is perhaps too low and too slow, as their mean interval to achieving the therapeutic range was 41 days. Lip and Li-Saw-Hee's Editorial suggested starting with 3 mg daily for 5 days.

Once the long-term anticoagulation has been safely initiated, the problem then changes to the avoidance of over-anticoagulation from patient concordance problems, prescribing errors, failure to monitor INR and drug interactions (particularly with antibiotics).

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SIR—We read with interest the editorial by Lip and Li-Saw-Hee [1]. They reported that among the reasons for warfarin under-use, there is concern about its safety in some elderly patients (i.e. those who are very old, frail or have a history of falls, poor mobility or poor concordance with medication or a risk of drug interaction).

Of 1227 consecutively admitted patients to our medical unit for the acute care of the elderly in the last 2 years, 138 had chronic atrial fibrillation (established arrhythmia lasting at least 6 months) and 27 had atrial fibrillation where the onset was less certain (lasting > 48h but < 6 months).

All patients potentially in need of anticoagulation to reduce the risk of thrombo-embolic strokes were considered according to recommendations of the most commonly cited trials [2–4]. Twenty patients who were at low risk of stroke and who did not meet the Stroke Prevention in Atrial Fibrillation eligibility criteria for anticoagulation received aspirin. Eighteen received neither warfarin nor aspirin because of important

clinical contraindications (six with recent gastrointestinal bleeding and four each with liver cirrhosis, end-stage malignancy and pleural effusion).

Of the remaining 127 patients, 58 (45.7%) received warfarin on discharge and 69 (54.3%) aspirin, on the basis of the clinical perception of inability to comply with anticoagulants. This decision was based on data obtained by geriatric assessment (evaluation of clinical, psychological and functional measures) [5]. We retrospectively observed that older age [76.7 ± 8.9 *vs* 82.8 ± 5.5, $P < 0.005$], rural living [$n = 16$ (27.6%) *vs* $n = 42$ (61.8%); $P < 0.005$], number of falls (≥ 3 within 12 months) [$n = 1$ (1.7%) *vs* $n = 18$ (26.1%); $P < 0.005$], cognitive impairment (Mini-Mental State Examination; 24.4 ± 5.5 *vs* 19.9 ± 7.0; $P < 0.005$), functional impairment (Barthel index; 85.6 ± 19.9 *vs* 69.5 ± 27.2; $P < 0.005$) and instrumental activities of daily living (functions lost; 2.4 ± 2.5 *vs* 4.9 ± 2.5; $P < 0.005$) were the variables associated with the choice of aspirin therapy.

At the 6-month follow-up, the rate of concordance for warfarin was very high (83%) and no major adverse events were documented. This high rate of concordance could be interpreted as a marker of adequate anticoagulation, and consequently the choice of warfarin for patients observed to be cognitively and functionally less frail could be a guarantee of good concordance.

In order to reduce disability in elderly people, we need to continue to search for the best treatment for selected populations of patients. Guidelines for prescribing best anticoagulation therapy for elderly patients are not yet available, but we have made important strides in recent years. Widespread adoption of geriatric assessment could help effect further progress. It is also important to explore possible alternatives to warfarin therapy—such as cardioversion followed by safer antiarrhythmic drugs—in elderly patients.

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Authors' reply

SIR—We thank Drs Rozzini, Sabatini, Bellelli and Trabucchi for sharing their experience of anticoagulation in the elderly population with atrial fibrillation and for raising some useful points.

Their experience and inclusion criteria for putting patients with atrial fibrillation on warfarin vindicate the observation in our Editorial that elderly patients with atrial fibrillation are frequently not anticoagulated because of advancing age, frailty, poor mobility, cognitive impairment, poor compliance with drug medications, drug interactions and falls [1]. Although these are factors that can potentially lead to complications with anticoagulation, the relative increase in risk posed may be outweighed by the beneficial effects of thromboprophylaxis provided by warfarin treatment [2]. Indeed, advancing age increases the risk of stroke, and this group of patients derives the most benefit from anticoagulation [2, 3]. As with many decisions in clinical medicine, it is often a question of assessing the risk–benefit ratio of therapy.

The main contraindications to warfarin include a known hypersensitivity reaction to coumarins or tendency to bleeding. Elderly people have a higher sensitivity to warfarin [4] and are more likely to be on multiple medications that can lead to over-anticoagulation. Cognitive impairment, frailty and poor mobility all contribute to failure of follow-ups and non-compliance with dosage instructions, as highlighted in our Editorial [1]. Falls, however, may not matter as much as previously thought [5]. Early cognitive impairment may well prove to be a relative rather than an absolute contraindication to anticoagulation in atrial fibrillation, although more work needs to be done in this field [6].

The most important factor in determining the suitability for formal anticoagulation is a person's baseline risk of stroke. This is increased in patients with co-existing diabetes mellitus, heart failure or hypertension and those with previous thromboembolism or stroke [3, 7]. In the absence of any contraindications, these people should be started on warfarin—dose-adjusted to achieve a target international normalized ratio (INR) of 2.0–3.0 [2, 3, 7]. Whilst the consensus conference on atrial fibrillation of the Royal College of Physicians of Edinburgh has

proposed a target INR range of 1.6–2.5 for elderly patients with atrial fibrillation aged >75 years [8], this strategy has not been validated in any prospective randomized controlled trials.

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Adherence to hip protector use in elderly people requiring domiciliary care is greater in fallers than non-fallers

SIR—In a study in Dorset of adherence with hip protectors in residential homes [1], several participants commented they felt more confident walking when wearing the protector. We were, therefore, interested in Professor Cameron's findings of improved falls self-efficacy in users of the protectors [2]. We report the results of a study that suggest that hip protectors are worn more frequently by fallers than non-fallers.

Individuals aged 65 years and over, living at home but referred to Poole Adult Social Services for domiciliary care during 1998, were assessed by home care officers for their risk of falling using a modified falls risk factor assessment (STRATIFY) questionnaire [3]. Subjects identified as being at high risk of falling (modified STRATIFY score of 2 or more) were given an information sheet and offered three pairs of hip protectors (SafeHip, Robinsons Healthcare, Chesterfield, UK) at no charge. During the following 3 months the subjects were interviewed to determine frequency of falling and how often they wore the hip protectors.

Sixty-one subjects were identified at high risk of falling over 1 year (mean age 84 years, female : male ratio 9 : 1). Of the 50 who agreed to take part in the study, 35 wanted to try hip protectors and 23 wore them on most days. Ten subjects fell between one and five times, three between six and 10 times and two more than 11 times during 3 months. Sixty-six percent of those who fell during the 3 months of follow-up wore hip protectors most of the time, compared with 27% of non-fallers ($P < 0.01$).

The results suggest that individuals who fall are more likely to wear hip protectors than non-fallers. This 'self-selection' might explain how a 50% reduction in hip fracture incidence can be achieved with an adherence of only 24–44% in clinical trials [4].

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Respite reward

SIR—We have changed the practice in the respite care wards in our hospital. Previously, any tablets brought from home by patients would be thrown away and fresh supplies provided by the hospital. Apart from being wasteful, this procedure meant that different preparations of the same drug were sometimes provided, which perplexed some elderly patients.

A group of geriatricians, pharmacists and nurses proposed several changes. A letter was sent to general practitioners, asking them to give patients enough medication for the 2-week respite period and also for the week after discharge. A similar information letter was sent to the patient or carer. On arrival at the ward, the patient's or carer's consent was obtained. An ethically-approved protocol was followed: nurses checked that the patient's medication containers were

clearly labelled. They also ensured that within the containers, no mixing of tablets had occurred. Nurses were not expected to identify individual tablets (for example, by the use of charts).

The nurses would sign the protocol form and then the same procedure would be followed by the admitting doctor. During the first week, the ward pharmacist would check the medication and also sign the protocol form. Because of staff shortages, it was not possible to ensure that the pharmacist would make the check on day 1. The patient's medication was recorded on a prescription chart and the nurses distributed this medication from a drugs trolley.

We have analysed 74 respite episodes. We did not enter 16 cases into the trial because they either did not bring any drugs with them or brought an insufficient medication. In three cases, medication was brought in but the container labels were unclear and subjects therefore not entered into the trial. In one case, mixing of tablets within a container was evident and the patient was excluded from the trial. Excluded patients were given medication from hospital supplies.

In the 54 subjects who passed the above checks, there were no instances where incorrect medications were given to patients during the trial. The trial has now run for over a year and no such incidents have occurred. We have made savings in the drug budget. This is difficult to quantify precisely, as the respite wards also have resident a variable number of continuing-care patients, who receive medication from hospital supplies. This dilutes the drug budget savings for these wards. The total drug budget for two successive years on the two respite wards has fallen from £22 270 to £19 390.

Replying to a questionnaire, most nurses found no increase in workload during the trial. They felt it helped cause less confusion to patients about what drugs they were receiving.

We feel that the potential savings, combined with the confidence that patients' safety is not compromised, support this change of practice on respite wards.

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Patent foramen ovale and survival in old age

SIR—Anatomical closure of the foramen ovale occurs shortly after birth. However, an incomplete seal may still exist in adults, and prevalences of 20–25% have been found [1]. At systematic *post mortem* cardiac examination of 3430 patients who died between 1975 and 1997 in the Geriatric University Hospital of Geneva, Switzerland, we were surprised to detect no more than seven cases of patent foramen ovale (PFO), a prevalence of only 0.2%. The mean age at death was 86.9 ± 4.8 years among those with PFO and 81.4 ± 8.2 years in the control group. The prevalence of history of strokes was 29% in the PFO group and 16% in the control group. At brain autopsy, ischaemic infarction was diagnosed in 43% of the PFO group and in 25% of the controls.

Paradoxical embolism in the presence of a PFO is an important cause of strokes in younger individuals, but the situation in elderly people is less clear. Using contrast echocardiography, Lechat *et al.* [2] detected a PFO in 54% of stroke patients under 55 with no identifiable cause or risk factors and in 10% of controls with no history of stroke ($P < 0.001$). Reviewing published echocardiographic findings from 1990 to 1995, Beattie *et al.* [3] determined an average PFO prevalence rate of 41% (range 24–73%) in patients younger than 45 years and an average rate of only 9% (range 3–15%) in patients over 45 years. Vella *et al.* [4] used contrast echocardiography to investigate PFO in 38 elderly patients (mean age 80 years) who had had a stroke with no obvious cause and 33 controls (mean age 81 years). They detected only one PFO (in one of the patients), and proposed several plausible age-related physiological and technical explanations for the low prevalence of PFO; their results accord with our *post mortem* findings in a large series of autopsied elderly subjects of comparable age.

Although PFO may be compatible with old age, we hypothesize that its extremely low prevalence in elderly people indirectly reflects the persisting risk of paradoxical embolism in subjects with this cardiac pathology. The importance of the impact of the inverse relationship between PFO prevalence and ageing on the survival of affected patients remains to be evaluated. Optimal treatment to prevent recurrence in cryptogenic stroke patients with PFO is not clearly defined. PFO is repairable, but closure does not consistently prevent recurrence of ischaemic events, particularly in older cryptogenic stroke patients [5]. Further research is needed to evaluate therapeutic approaches to improving the survival of PFO patients in advancing age.

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We thank W. McGee and C. Bourras for carrying out *post mortem* examinations.

Allocation of outpatient clinic time in geriatric medicine: a survey of responses to the Royal College of Physicians' guidelines

SIR—In June 1999 the Royal College of Physicians published *Consultant Physicians Working for Patients*, with the intention of supporting clinicians in their attempts to provide high standards of medical care [1]. The report recommended that 6–8 new patients or 15–20 follow-up patients should be seen by a geriatric medicine consultant working alone in a 3.5h session. This equates to an average time allocation of 26.25–35min for a new patient and 10.5–14min for a follow-up. Following further advice from the British Geriatrics Society, the recommendations were amended to 6–7 new patients (30–35min), 12 follow-up patients (17.5min) or a reduced mixture of both.

I have surveyed consultants in the British Geriatrics Society Yorkshire region to investigate current outpatient clinical practice and whether consultants felt able to work to these recommendations. I requested information on time allocated to new and follow-up patients, asked how much time the consultant felt should be allocated and sought opinions on the ability to deliver a consistently good standard of care to 6–7 new patients or 12 follow-up patients in a 3.5h session. Fifty-four of 62 consultants (85.5%) replied, one of whom did not have any outpatient clinics. Some did not complete all sections of the questionnaire. Seventeen of 52 consultants (32.7%) allocated more than 35min to a new patient. Times ranged from 20 to 60min (median 30min). Forty-eight consultants indicated how long they thought should be allocated to a new patient. Of these, 33 (68.8%) would give more time than would allow ≥ 6 new patients to be seen. Times ranged from 20 to 60min (median 40min).

Fifty of the 52 (96.2%) were able to meet the recommendation of seeing 12 follow-up patients in a session. Times ranged from 5 to 20min. Using the times that 47 indicated should be allocated, 21.3% would meet the 15–20 patient recommendation and 76.6% the 12 patient recommendation. Time allocation ranged from 10min to 30min.

Sixteen of 53 (30.2%) felt able to deliver consistently a good standard of care to 6–7 new patients in a 3.5h session. Thirty-seven of 53 (69.8%) felt able to deliver consistently a good standard of care to 12 follow-up patients in a session.

Several respondents highlighted case-mix as a problem that affected time allocation. This was felt to be particularly important in clinics dealing with both younger medical patients and older patients who often had multiple system and complex problems.

The subjective opinion of consultants on their ability to provide a consistently good standard of care is open to bias. There were wide variations in appointment times, which may reflect the case-mix encountered. It was not possible to confirm or refute this from the data.

Many consultants do not meet the College recommendations and some feel unable to deliver consistently a good standard of care if the recommendations are met. One explanation is that the recommendations are set at a too ambitious level and do not fully consider the wide case-mix variation in some clinics. The College indicated in the report that "it is self-evident that elderly patients require considerably more time in clinical diagnosis and treatment", yet the recommendations of 6–8 new patients or 15–20 follow-up patients per clinic exceed those of, for example, cardiology, neurology and rheumatology, where a maximum of 6 new patients or 15 follow-up patients per session was recommended.

A Government aim is for patients to be more informed about their care and treatment choices [2]. The satisfaction of consultation is partially dependent upon time. Longer consultations are required for patient enablement. Patients over 65, those with multiple problems and those with both social and psychological problems require a longer consultation [3, 4]. There are no published data on the effects of participative practice on the duration of clinic appointments to deliver an agreed standard of care. Research is required if allocation of time is to be made objectively, taking case-mix into account.

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Does frailty predispose to adverse drug reactions in older patients?

SIR—In patients 70 years and older admitted to hospital, a history of falls, gastrointestinal bleeding or

haematuria and the use of three or more drugs are associated with a severe adverse drug reaction [1, 2]. A fall before hospital admission may be an indicator or a presentation of a severe adverse drug reaction. We report data which support the association between a fall history and adverse drug reactions in older patients.

We recorded and evaluated defined adverse drug reactions [3, 4] in 228 patients consecutively admitted to five wards of a geriatric clinic, between 1 January and 30 March 1995. We included in the analysis only those adverse drug reactions that were followed by documented therapeutic consequences. We recorded admission and discharge drug prescriptions, applying a system previously used [5]. On admission, all patients underwent a 15-item screening test, including the history of falls in the 3 months before admission, poor nutritional state and chronic pain [6].

There were 53 adverse drug reactions in 42 patients (18.4%), involving 47 drugs: 14 reactions were gastrointestinal, 13 cutaneous, seven central nervous system, six cardiovascular and five were other manifestations. Cardiovascular drugs (16), psychotropic agents (eight), analgesics, non-steroidal inflammatory drugs and steroids (eight), antibiotics (six), and miscellaneous preparations (nine) were the medicines incriminated.

Adverse drug reactions were more frequent in patients with ≥ 5 drug prescriptions on admission (26.8% *vs* 8.6%, $P = 0.0004$) and those with a history of falls ($n = 30$, 36.7% *vs* 15.7%; $P = 0.0006$). Furthermore, there was a trend for a higher rate of adverse drug reactions in patients with chronic pain (28.6% *vs* 16.6%, P=0.09), poor nutritional state, (26.5% *vs* 16.2%, P=0.09) and urinary incontinence (25.4% *vs* 15.1%, P=0.09).

The patients with a fall history were older than those without (81.7 *vs* 76.5 years; $P < 0.001$), but they did not differ in their mean number of prescribed drugs on admission [4.56 ± 2.49 (95% CI 3.95; 5.16) *vs* 4.45 ± 2.56 (95% CI 4.07; 4.83)] and discharge [4.18 ± 2.48 (95% CI 3.80; 4.54) *vs* 4.23 ± 2.57 (95% CI 3.70; 4.96)]. We analysed 43 different medication groups and found the only differences in prescribing patterns between patients with and without falls was for antiparkinson medication (10.3% *vs* 2.9%, P=0.026) and heparin (41.2% *vs* 27.5%, P=0.05). Ten of the patients with a history of falls (33%) fell again during their hospital stay: there were records of one fall in four patients, two in five patients and three in one patient.

The number of patients we investigated was small, and not all results reached statistical significance. However, we conclude that markers of frailty, rather than a history of falls alone, may be useful indicators of an elevated risk of adverse drug reactions in older patients. Low body weight [7], for example, could be one indicator. As a consequence of frailty, minor challenges may compromise an elderly person's functional abilities [8], and exposure to many drugs may be one such challenge.

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Tiredness: a feature of coeliac disease

SIR—We report the case of a patient concomitantly affected by Paget's and coeliac diseases. These are common [1, 2], yet may be undiagnosed in older people. Their association may be more common than is generally appreciated.

An 84-year-old woman was admitted with progressive weakness, fatigue and slight weight loss. Six years earlier, a diagnosis of Paget's disease of bone was made at another hospital, based on slightly elevated (1.5×) serum alkaline phosphatase concentration, together with characteristic radiographic and scintigraphic findings. Despite reportedly adequate nutrition, a gradual weight loss of about 5 kg was noted in the following years. She consulted her general physician and attended an outpatient clinic on several occasions over this period, but no satisfactory diagnosis was established. She received a 4-month course of clodronate therapy for Paget's disease 6 months before admission to our hospital.

On examination, she was thin, with a body mass

index of 19. Routine laboratory tests showed a slight iron-deficiency anaemia: haemoglobin 10.2 g/dl, serum iron 5.37 μmol/l (normal range 6.27–28.3), transferrin 3.2 g/l (normal range 2–3.6) and ferritin 8 μg/l (normal range 5–96). Concentrations of both serum calcium (corrected for serum albumin) and phosphate were at the low end of the normal range (2.05 and 0.94 mmol/l, respectively); the total alkaline phosphatase concentration was 524 U/l (normal range 60–279), with the bone-specific isoenzyme making up 82% of the total (normal range 40–60%).

A more extensive evaluation of skeletal turnover revealed osteocalcin levels of 6.1 nmol/l (normal range 1.4–4.3), urinary pyridinoline and deoxypyridinoline of 158 and 42 pmol/pmol Cr (normal ranges 50–130 and 10–29). The parathyroid hormone level was 10.81 pmol/l (normal range 1.15–5.67). The serum 25-OH vitamin D concentration was 19.97 nmol/l. The 24-h urinary calcium was 1.49 mmol/day. Both radiographic and nuclear scan findings confirmed Paget's disease, localized to the pelvis.

Endoscopy of the upper and lower gastrointestinal tract were considered normal and we did not identify any source of blood loss. Thyroid hormones were normal, as was the serum cortisol level after ACTH stimulation. The presence of anti-gliadin antibodies of both IgA and IgG classes, and IgA anti-endomysial antibody provided strong serological evidence of gluten sensitivity. The radiographic examination of the small intestine showed thickened and nodular duodenal folds and dilatation of the small bowel. The upper gastrointestinal endoscopy was repeated for distal intestinal biopsy. In the biopsy specimens, the mucosal villi were short and broad, with inflammatory cells, including intra-epithelial lymphocytes, densely infiltrating the lamina propria.

After 1 year of gluten-free diet, together with iron, calcium, and vitamin D supplementation, the patient's complaints resolved. She refused further endoscopy. The features of iron deficiency, together with calcium, phosphate, parathyroid hormone and osteocalcin values, returned to normal, while alkaline phosphatase and pyridinoline levels remained slightly elevated. Anti-gliadin antibodies fell towards normal.

In this patient, the serum alkaline phosphatase concentration could have reflected the accelerated bone remodelling of Paget's disease. This diagnosis was supported by radiographic and scintigraphic findings, although there was a parallel increase of serum osteocalcin [3]. However, elevated alkaline phosphatase also occurs in up to 94% of patients with osteomalacia [4]. This laboratory finding, together with secondary hyperparathyroidism and iron-deficiency anaemia, suggests the presence of malabsorption (which would be consistent with the patient's complaints). However, the diagnosis of Paget's disease could have provided a satisfactory explanation for the increased alkaline phosphatase level.

We hypothesize that the physicians caring for the patient focused their attention on this biochemical finding and overlooked her complaints. The main cause of the delay in reaching the correct diagnosis was probably the common tendency to underestimate the prevalence of coeliac disease in the older people [2]. The clinical presentation of coeliac disease in adults may be non-specific, often without gastrointestinal symptoms, and it is frequently undiagnosed [5].

This case suggests that in elderly patients undergoing an upper gut endoscopy for unexplained iron-deficiency anaemia, both serology for gluten sensitivity and duodenal biopsy are mandatory. Subclinical vitamin D deficiency is quite common in older people; if this is overlooked, the administration of bisphosphonates could cause their deposition in unmineralized osteoid tissue, which further worsens the mineralization process. In our patient, the administered clodronate could have bound to calcium salts, reducing their availability in the gut lumen and therefore worsening calcium absorption.

In this woman the diagnosis of asymptomatic Paget's disease was supported by evident biochemical and imaging data. Her long-standing history of tiredness and non-specific complaints which remained unheeded for many years were caused by coeliac disease.

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Looking back

SIR—I well remember the scenes which my contemporary, Tony Clark, described so vividly in 'Looking back' [1]. We all encountered similar problems in those early days of geriatric medicine in the 1950s. Looking back over 45 years, much has changed, but how much has actually been achieved? Can old people feel confident that they will receive the best possible health care in the year 2000?

During the past 18 months I have received two

letters from England which are relevant to raising this question. I quote part of each letter.

The first was from a brother:

> "We received the very sad news that X [a cousin] died this morning. She had been in hospital for a few days with acute pains due—it was thought—to sciatica, which it was hoped to control. She was found to have serious constipation and partial kidney failure. At the weekend, an X-ray of her abdomen revealed one or more ruptured ulcers, probably in the colon. The surgeon consulted felt he could not operate safely because of her weak condition and so the decision was taken to manage her conservatively with 'TLC' [tender loving care]."

The cousin, who was in her late seventies had suffered from moderately severe Parkinson's disease for some time.

The second was from a great friend of my late mother-in-law:

> "In early February, I had a very bad fall indoors, and had multiple injuries and was rushed to hospital, where I was kept on the trolley for 6 hours and the first I knew it was 12 o'clock and my arm was in plaster. Apparently I broke my hip, my arm, fractured my hand and my pelvis—so was in a pretty bad way. Well, a couple of days after, they got me out of bed to try and walk—but I was in such pain, I said I couldn't do it. They took no notice of me. I was getting worse all the while and after 2 weeks I asked to see the doctor. He re-read my X-ray plates and said they had discovered my broken hip but in the first reading it didn't show, so I was 2 weeks in agony and I couldn't make them understand it; as a result I was rushed to the theatre for my hip replacement. Altogether I was in hospital for 9 weeks . . . I am now in a lot of pain, can't walk without a frame and have no use in my left hand. I need another op but, because I'm nearly 96, they won't do it."

This letter was written in November as a Christmas message.

The letters describe different but relatively common geriatric situations, both of which have been inadequately managed. This surely represents a failure on our part as pioneers to establish sound principles of geriatric care which should have become permanent parts of accepted medical knowledge. Clearly, we still have a long way to go.

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