Won’t drink? Can’t drink

SIR—We read with interest the letter from Primrose et al. [1] on indices of dehydration in elderly people. We offer our experience of one aspect of hydration in elderly patients in hospital: the ability to take a drink.

Older patients in hospital are vulnerable to dehydration, which exposes them to increased risk of thrombosis and confusion. In a pilot study we assessed the ability of older patients to take a drink, where ‘take a drink’ was defined as the ability to reach their cup, lift it, move it to the mouth and swallow safely.

We prospectively studied 150 patients on three afternoons (1400–1700 h). We documented the reason for being unable to take a drink. Thirteen patients had been assessed by ward staff as being unsafe to take oral fluids and were excluded from further analysis. Of the remaining 137 patients, 85 were on geriatric wards and 52 on rehabilitation wards.

The mean age was 81.5 years and 67% were women. Of those with a presumed safe swallow, 35 (25.5%) were unable to ‘take a drink’, the commonest reason (in 60%, 21/35) being that their cup was out of reach. Although most patients (90%, 123/137) had a cup near their bed or chair, only 50% had any fluid in their cup. Few patients had fluid balance recorded (15.3%, 21/137). There was a significant difference in the ability to take a drink in patients confined to bed (15/36 unable) compared with those in a chair (18/101 unable, \( P < 0.01 \)). There was no difference in any of the measures between the different areas of the wards.

One-quarter of older patients in our hospital are unable to take a drink. The commonest reason for this is the inability to reach their cup. This is a particular problem for patients confined to bed and appears to be independent of ward type. While the lack of fluid in the cups may have reflected the time of day at which the study was carried out (i.e. between lunch and dinner), simply paying attention to positioning of drinks and filling the cup regularly may reduce the risk of dehydration and its attendant complications, as well as promoting patient independence.

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Additional risk factors in atrial fibrillation patients not receiving warfarin

SIR—We read with interest the article by Wensley et al. [1] which concluded that most elderly patients with atrial fibrillation were not receiving warfarin. We made similar observations in our audit of 200 elderly (>65 years) patients with atrial fibrillation selected at random in our hospital. Of these, 184 (92%) were in the high-risk group for developing stroke (based on SPAF III study criteria). Only 16 (9%) of these had definite contra-indication to antithrombotic treatment. Of the remaining 168 patients, only 55 (33%) were treated with warfarin to maintain an International normalized ratio (INR) of between 2 and 3, five (3%) were not adequately warfarinized (based on last five INR readings) and 95 (57%) were treated with aspirin, leaving 13 (7%) on no stroke prevention.

Thus, despite the evidence from pooled data analysis (AF Investigators, 1994), less than half receive appropriate treatment [2, 3].

These results show a low morbidity: out of 65 patients on warfarin (263 years of treatment) only four had major bleeds and there were no deaths related to bleeding during this period. Hence anxiety about complications should not affect treatment decisions.

There is variation in the guidelines for anticoagulation treatment in the UK and there is a clear need for the development and dissemination of nationally agreed guidelines [4], as anticoagulation in atrial fibrillation is one of the most cost-effective preventive interventions in elderly patients [5].

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