Letters to the Editor

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, applying 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; 4.90)). 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.

WOLFGANG VON RENTELN-KRUSE, NINA THIESEMANN, RUDIGER THIESEMANN, HANS PETER MEIER-BAUMGARTNER
Reha-Zentrum Reuterstrasse, Geriatrie Klinik, Reuterstrasse 101, D-51467 Bergisch Gladbach, Germany
Fax: (+49) 22 02 127 311
Email: renteln.kruse@mhk-bgl.de
1Albertinen-Haus, Zentrum für Geriatrie, Hamburg, Germany


Tiredness: a feature of coeliac disease

SIR—We report the case of a patient comitantly 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

Downloaded from https://academic.oup.com/ageing/article-abstract/29/5/462/36365 by guest on 03 February 2019
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 clofibrate 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.

Vincenzo Carnevale¹, Paola Filabozzi¹, Piergiorgio Cela¹, Alfredo Scillitani¹
Departments of ¹Internal Medicine and ²Endocrinology, Ospedale ‘Casa Sollievo della Sofferenza’, IRCCS, 71013 San Giovanni Rotondo (FG), Italy
Fax: (+39) 0882 410492


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