PREVALENCE of LEG CRAMPS IN THE ELDERLY; DRUG and DISEASE ASSOCIATIONS

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To determine the prevalence of leg cramps and its association with any underlying diseases and drug intake, we conducted a questionnaire survey in an out-patient setting. Patients aged 65 years and over were invited to participate in the study. A total of 365 patients completed the questionnaire. Mean age was 78.5 years (range 66 - 93). The sex ratio was 5:3 in favour of females. The prevalence of leg cramps was 50%. Cramps were more common in females (56%) than in males (40%). The frequency of leg cramps was variable among patients, occurring monthly in 27%, fortnightly in 10%, weekly in 22%, and daily in 18%. Of the latter, only 3 patients (1.5%) experienced cramps more than once daily. More than 15% of patients reported cramp episodes occurring less than once monthly. Similarly, the duration of each cramp episode varied widely between patients ranging between 30 seconds to 60 minutes (mean 8.4 min). Although leg cramps were reported to occur anytime throughout the 24 hours, they were most prevalent at night (82%).

In many patients, cramps were a long standing complaint: 20% had been suffering with them for more than 10 years. In contrast only 9% of patients reported them first starting within the last 6 months. Only 40% (n= 73) of patients had informed their GP and of these 53% (n=39) received treatment. Of those receiving treatment 87% (n=28) gained benefit. Quinine was the treatment in 62%. Leg cramps were most strongly associated with peripheral vascular disease (p< 0.001), arthritis (p< 0.001), and surgical intervention on the legs (p<0.05). Heart failure, hypertension, diabetes mellitus and cerebrovascular events were not significantly associated. Similarly no positive association could be demonstrated with the use of any classes of drugs (diuretics, anti-failure drugs, aspirin, analgesics, corticosteroids, hypnotics and anti-depressants).

In conclusion leg cramps are a very common complaint in the elderly. It is both underreported and undertreated. Although it was associated with certain diseases, surprisingly we could not demonstrate any significant association with drug use especially diuretics.

FREQUENCY OF MISSED MEDICATION DOSES IN ACUTE ELDERLY MEDICAL WARDS

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AIM: To determine the frequency of missed medication doses on Acute Elderly Medical wards.

METHOD: Casenotes and prescription charts of 122 consecutive patients discharged from six wards were studied. A missed dose was defined as a regularly prescribed medication that was not administered at the appropriate time for whatever reason. For each missed dose a record was made of the type of medication, time omitted and the reason, ie doctor, patient, nurse or pharmacy related problem (a section for omission of medication is available on prescription charts in Portsmouth).

RESULTS: 8904 doses were prescribed and 678 (7.6%) of these were not administered appropriately. The reason for omission was not recorded in 45%, patient related in 32%, pharmacy related in 10% and other reasons in 13%. 87% of missed doses were outside normal pharmacy opening hours. A wide variety of drug types were omitted but importantly this included bronchodilators (11%), antibiotics (9%), diuretics (6%), anti-hypertensives (5%) and peptic ulcer healing drugs (8%).

CONCLUSION: Medication is regularly missed on Acute Elderly Medical wards and this could potentially have a significant impact on patient care. A number of recommendations including better education, communication and review of ‘stock’ medication should improve quality of care.

THE USE OF ANTIBIOTIC THERAPY IN ELDERLY MEDICINE

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The use of intravenous antibiotics remains commonplace for the first line treatment of many infections. A recent study has questioned the validity of this practice, with up to 65% of such treatment being judged inappropriate. Savings of up to £176,000 per year have been estimated if unjustified intravenous antibiotic use was avoided (Chan et al. 1995, BMJ. 310,1360-2). We undertook a retrospective audit to analyse antibiotic prescribing practices in our department. We aimed to identify the justifications for using intravenous antibiotics rather than an oral formulation, using preset criteria. This enabled us to identify any unjustified use of intravenous antibiotics and therefore to assess the financial implications of our practices. All patients admitted to our department during a three month period were identified and data was collected on all patients who received antibiotics. During the study period, 341 patients were admitted to our department. 146 patients (62%) received oral antibiotics only whilst 88 (38%) received intravenous therapy at some stage. Of the patients who received intravenous antibiotics, 25 (28%) were judged to have received them inappropriately. On comparison with patients who received intravenous therapy at some stage. Of the patients who received intravenous antibiotics, 25 (28%) were judged to have received them inappropriately. On comparison with patients who received oral antibiotics for illnesses of similar severity, the intravenous route offered no additional benefit in terms of outcome, but had a deleterious effect in terms of cost. We were able to calculate an unjustified cost expenditure of £15,942-20 per annum, due to inappropriate intravenous antibiotic use. In today’s modern health service, doctors are increasingly being asked to justify their actions. Whilst intravenous antibiotics remain an essential weapon in our pharmacological armoury for certain clinical situations, we believe that many patients can be safely and adequately treated with oral antibiotics and the routine use of intravenous antibiotics without clearly defined indications can no longer be justified.