Letters to the Editor

Is it ever enough to die of old age?

SIR—Clare L. Hawley’s ‘Is it ever enough to die of old age?’ [1] is an interesting study which conveys a valuable and important message to medical practitioners. It is rather shocking to learn that old age was documented as a contributory factor to cause of death in 7% of 4,300 cremation papers studied. In my 7 years of experience as a hospital practitioner in the UK, I recall only once documenting ‘old age’ as a factor that may or may not contribute to immediate cause of death. I also remember suggesting to one of my junior colleagues that he could perhaps put old age as a contributory factor on one occasion. Both patients were over 85 years of age.

I could not agree more with the author that chronological age is not necessarily representative of biological age. In my personal view, the term ‘old age’ should only be used in a chronological sense on death certificates. We should not confuse ourselves further by considering biological age. The author did not report or compare the percentages or proportions of cremation papers where old age was given as the immediate cause of death (out of 4,300 studied) between hospital and community. This would provide an interesting comparison. I do agree with the author that old age should not be entered as a cause of death without careful consideration. One would argue that the fact that old age appeared as the only cause of death in 2–3% of cremation papers would not significantly underestimate the medical conditions.

In my opinion therefore, it should not have a consequent effect on national and international health policies, investment and statistics. Cardiovascular, cerebrovascular, cancer and infective deaths will still be on the top of the list with regard to mortality and morbidity, and will therefore be given priority in any health policies.

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Diastolic heart failure in China

SIR—As O’Mahony et al. [1] reported recently, diastolic heart failure (DHF) is common in elderly patients. That DHF is a global problem is evidenced by the findings that 30% [2] to 66% [3] of Chinese community patients with the diagnosis of congestive heart failure suffer from DHF.

Similar to the British study [1], female gender and old age are two important associated risk factors in the Chinese patients [2, 3]. Contrary to the British study [1], hypertension is the most important associated factor in the Chinese patients, although coronary artery disease which is the commonest cause in the British study comes next in the Chinese population [2, 3].

In heart failure due to coronary artery disease, diastolic dysfunction often precedes systolic dysfunction [4]. On the other hand, diastolic dysfunction can occur without systolic dysfunction [5]. On chest X-rays, patients with DHF show flash pulmonary oedema and a normal sized heart. The latter is a tip-off to the diagnosis. In myocardial infarction, although left ventricular dysfunction is usually systolic, diastolic dysfunction may also occur; the ischaemic left ventricle is usually stiff [6].

Recognition of DHF is important, because it has a prognosis rather different from systolic heart failure [7]. Furthermore, treatment for DHF is very different from that for systolic heart failure [8, 9]. While in most cases chest X-rays give a useful guide to diuretic requirement in the treatment of pulmonary oedema complicating acute myocardial infarction, in some the appearance may be misleading [10].

Patients with DHF represent the largest group of patients with a cardiovascular disorder of substantial public health impact who have not been systematically investigated [8]. With the ageing of the population in China as well as the rest of the world, DHF is likely to remain an important public health problem [8].

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