Letters to the Editor

When do elderly in-hospital patients fall?

SIR—Vassallo et al. [1] reported about falls in elderly patients admitted to rehabilitation wards in a non-acute geriatric hospital. There were 201 fallers out of 1,025 patients, 77 of whom fell during the first week after admission. These early fallers were more likely to have a history of falls, confusion, an unsafe gait, and be admitted from medical wards. Patients with fractures of the lower limb were less likely to be early fallers.

We would like to contribute information about the time of falls’ occurrence during hospital stay in elderly patients. From 1 January 2000 until 31 December 2002, fall events were prospectively recorded in patients admitted to the five wards of our geriatric clinic (145 beds) which is part of an academic teaching hospital in Hamburg [2]. There were 1,015 out of 5,946 patients (17%) who had 1,596 falls, which is comparable with the study of Vassallo and co-workers. The frequencies of falls recorded were not different between wards, and did not differ between the 3 years of recording.

Thirty-two falls (2%) occurred on the very day of admission, and 399 fall events (25%) happened during the first week. The fall rate per 1,000 hospital days was different in patient groups according to the main diagnosis. It was highest in patients with Parkinson’s disease (57.0), followed by patients with a psychiatric diagnosis, mainly dementia (55.0), patients with fractures/fall sequelae (45.0), stroke (38.0) and cardiovascular diseases (36.0).

We also did an analysis of the time course of falls during hospital stay by using the Kaplan–Meier method. Falls occurred most early in patients with a psychiatric diagnosis. This was earlier than in patients with stroke and patients with fractures ($P<0.000$). In addition, falls in patients with right hemispheric stroke occurred earlier than falls in patients with left hemispheric stroke ($P=0.042$). In general, the frequencies of falls dropped during the second week of hospital stay. However, this decrease was most remarkable in patients with a psychiatric diagnosis. Furthermore, there were different time patterns in the maximum frequencies of falls according to the diagnostic group. Patients with stroke had their maximum of falls between 9.00 and 12.00 a.m., patients with fractures during 0.00–3.00 a.m., and patients with cardiovascular diseases between 3.00 and 6.00 a.m., respectively.

As revealed from the fall protocols, confusion was most frequently recorded with fall events in patients with a psychiatric diagnosis compared to patients with fractures, 58 versus 44% of fall events ($P=0.007$), and other diagnostic groups ($P<0.000$). In addition, confusion was more often recorded with fall events in patients 80 years and older compared with patients younger than 80 years, 43.5 versus 32.6% ($P<0.000$), and also more often with falls during night than during day, 45.3 versus 32.5% ($P<0.000$). There were eight out of 812 fall events in patients 80 years and older, and one out of 784 in patients younger than 80 years ($P=0.022$), which resulted in 10 fractures.

In agreement with Vassallo and co-workers, we believe that there is no value in trying to distinguish between early and late fallers, as any fall event may complicate and prolong hospital care of elderly patients [3]. Therefore, an identification of patients at risk should take place very early after admission.


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The dilemma of disclosing the diagnosis to an adult with dementia

SIR—I read with interest the short report by Fahy et al. [1] investigating carer and patient characteristics relating to the disclosure of a diagnosis of dementia to the affected adult. However, I would question that the authors’ conclusion ‘the carers’ perspective implied that disclosure is not necessarily ethical or beneficial’ can be drawn from the study’s findings.

This interpretation of the data raises epistemological questions regarding philosophical ethical enquiry and what can be inferred from the carers’ perspectives. That is, what is to count as fact in the examination of perspectives and the evaluation of assumptions underlying right and wrong, good and bad?

What do the data tell us about the carers’ perspective? Perspectives are structured by the perceptual effect of the metaphor they use to construe the events in question. The same events are seen in different ways in terms of their own...

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1. Fahy SE, Lusby D, McMillan C, Thompson A. Perspectives are structured by the perceptual effect of the metaphor they use to construe the events in question. The same events are seen in different ways in terms of their own...
Letters to the Editor

Nitrofurantoin lung injury

SIR—A recent New Zealand case report of fatal interstitial lung disease resulting from long-term nitrofurantoin treatment [1] highlights the need to be vigilant for pulmonary toxicity of this drug and many others.

Pulmonary hypersensitivity reactions to nitrofurantoin can be life-threatening and nitrofurantoin should be stopped immediately on occurrence of symptoms. Impaired pulmonary function may remain even after cessation of therapy. Deaths as a result of severe hypoxia and of alveolar haemorrhage have been reported [1, 2].

We present a patient on long-term nitrofurantoin treatment for recurrent urinary infections, who developed a clinical picture of interstitial lung disease and improved significantly soon after its discontinuation.

Case report

A 76-year-old female non-smoker presented with a 6-week history of worsening breathlessness, cough, anorexia and fatigue. She had started a course of nitrofurantoin for a recent urinary tract infection (UTI). Past medical history included hypertension, hypothyroidism and recurrent UTIs.

Her UTIs were treated with nitrofurantoin for 14 months. On presentation, she was tachypnoeic and tachycardic with coarse dry late inspiratory crackles over both lung fields, and there was no evidence of clubbing or cyanosis. The chest radiograph showed patchy abnormal interstitial shadowing involving all lobes consistent with pulmonary fibrosis or pneumonitis. Lung function tests were performed with an FEV1/FVC ratio of 91% (predicted range of 75%). Total gas transfer factor (TLCO) could not be measured because of breathlessness. There was no eosinophilia.

A subsequent high resolution computed tomographic (HRCT) scan of the thorax showed extensive reticular shadowing involving all lobes with associated bronchiectatic changes.

Nitrofurantoin-induced lung disease was suspected, and the causative drug was stopped and the patient commenced on oral steroids. Two weeks later, she had improved significantly, feeling much less breathless and her lung function tests were, if anything, slightly better.

She continued on a reducing dose of prednisolone with general improvement in her condition. The use of steroids in this condition was anecdotal and there was no evidence in critical literature review.

Follow-up chest films proved marked improvement with resolution of shadowing in both lung fields. HRCT also showed marked reduction of parenchymal abnormalities.

Comment

- As nitrofurantoin is still widely used for recurrent urinary tract infections, knowledge of this drug’s potential lung toxicity is essential.
- Vigilance for pulmonary toxicity in patients on long-term nitrofurantoin treatment, who present with cough or shortness of breath, should indicate the need for further investigations including chest X-ray and spirometry.
- Withdrawal of nitrofurantoin and treatment with an oral corticosteroid results in not only improvement of clinical...