In our patient, feeding was successful and uneventful before the suction and he deteriorated suddenly afterwards. Therefore, it is unlikely that the tube was misplaced before the suction.

Many patients, however, unknowingly pull out the tube, which can prove to be fatal should the tube get dislodged into the airway. This potential complication cannot be over-emphasised whilst training the staff and therefore a close vigil is important if such patients are fed via a nasogastric tube. However, this may not always be possible given the lack of nursing staff in many hospitals across the country. There is a need for further prospective studies in the field of nasogastric tube feeding.

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Re: ‘Avoidance hierarchies and preferences for anticoagulation—semi-qualitative analysis of older patients’ views about stroke prevention and the use of warfarin’

SIR—We read with great interest the study by Fuller et al. [1]. Although we agree with their suggestion that understanding patient preferences and decision making are important in the uptake of warfarin therapy in patients with atrial fibrillation (AF), we beg to differ on the following points. First, it is well documented that chronic diseases (including AF) have a profound effect on the patients’ perception of their quality of life [2]. Unsurprisingly, the authors noted that patient preferences were often based on their personal experiences. So, the perceptions and decisions on warfarin therapy of a group of elderly patients who do not have AF cannot be assumed to be the same as those with AF. Secondly, while assessing the effect of increasing risk of intracerebral haemorrhage (ICH) on decision making, the authors have stated a risk of up to 4%/year and have used the corresponding patient response in drawing their final conclusion. Trials both at research and clinical settings have pointed to this risk being around 1% [3]. Even in ‘The Stroke Prevention in AF’ (SPAF II) trial, which had one of the highest complications with ICH, it stood at 1.8%/year in patients above the age of 75 years. The authors report that 61–66% of the patients would accept warfarin therapy of a group of elderly patients who do not have AF and their conclusions were based on the appropriate risk–benefit response. Recent studies have also suggested that dependency and associated cognitive and functional impairment rather than age itself increase the risk of warfarin-related bleeding [5].

In view of the ageing population, AF is going to be an increasing public health issue and, given the fact that there is known effective treatment to reduce the risk of secondary strokes, there is an ongoing consideration to set up a screening programme to detect AF in the community. However, it should be emphasised that any screening programme must be followed by optimal treatment. An understanding of how patients feel about warfarin therapy is important, as this might be a potential reason for non-compliance and indeed refusal. The study by Fuller et al. might have potentially contributed to this regard, only if it were conducted on patients with AF and their conclusions were based on the appropriate risk–benefit response.

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Reply

SIR—We welcome the comments raised by Choudhury et al. in response to our recent paper on preferences for anticoagulation [1]. We agree that the emerging atrial fibrillation (AF) ‘epidemic’ is a major challenge to physicians worldwide [2]: seeking effective treatment solutions to reduce stroke risk, whilst balancing the need effectively to communicate risk and benefit information about treatment strategies, and to allow patients to make their preferences for treatment known is clearly complex. Developing programmes to screen for AF in community-dwelling elders is important, but equally so is the acknowledgement of patient choice for treatment, rather than a framed presentation of ‘optimal’ treatment.