Letters to the Editor

Predictors of delirium during in-hospital rehabilitation in elderly patients after hip arthroplasty

SIR—In their article published recently, Freter et al. [1] assessed the feasibility of incorporating the Delirium Elderly At-Risk (DEAR) instrument into routine nursing care of elective orthopaedic patients and evaluated its usefulness to predict post-operative delirium. We would like to contribute to this topic with personal data. We assessed predictors of delirium during in-hospital rehabilitation in elderly patients who underwent an elective hip arthroplasty. All patients (n=244) consecutively admitted to our unit for this reason from 1 January 2002 to 28 February 2004 underwent a multidimensional assessment including sociodemographic (age, gender, living condition), Geriatric Depression Scale (GDS), Charlson Index, body mass index and Barthel Index (BI) referring to 1 month before surgical intervention (BI pre-surgery) and to admission (BI admission). Delirium was ascertained on admission and during in-hospital rehabilitation according to the DSM IV criteria using the Confusion Assessment Method (CAM) [2]. The Mini-Mental State Examination (MMSE) was administered within 72 hours of admission or, in the case of delirium, after 3 consecutive days of negative CAM. Appendix 1 (available as supplementary data on the journal’s website, www.ageing.oxfordjournals.org) shows the characteristics of all patients stratified into two groups (delirium and no delirium). In comparison with the others, patients with delirium were significantly older, predominantly male, more impaired in cognitive and functional status, and had a higher comorbidity detected with the Charlson Index. When the effect of all variables that were significantly associated in the univariate model was tested in a multiple logistic regression, male gender (OR =13.7, 95% CI 2.8–65.5, P=0.001), greater comorbidity, as measured by a Charlson Index score ≥3 (OR =9.4, 95% CI 1.3–66.9, P=0.02), a MMSE score <29/30 (OR =6.6, 95% CI 1.1–39.6, P=0.03) and a BI pre-surgery score <100 (OR =3.8, 95% CI 1.1–15.0, P=0.05) significantly and independently predicted onset of delirium. Our study only partially supports that of Freter et al. Indeed, although it indirectly confirms that delirium is a common event in post-operative patients and that the identification of those at risk is possible with a routine multidimensional assessment, it also emphasises the need to assess comorbidity, which appears to be difficult for nurses. On the basis of our data we are persuaded that a standardised multidimensional geriatric assessment may be more useful than a specific pre-operative instrument.

GIUSEPPE BELLELLI1,2*, SALVATORE SPECIALE1,2, MARCO TRABUCCHI3
1Rehabilitation Department, ‘Ancelle della Carità’, Hospital Cremona, Cremona, Italy
2Geriatric Research Group, Brescia, Italy
3University Tor Vergata, Rome, Italy
*To whom correspondence should be addressed
Email: bellelli-giuseppe@poliambulanza.it


doi:10.1093/ageing/afi134

Re: Prevention of falls—a time to translate evidence into practice

SIR—Jackie Close admonishes commissioners and claims an apparent disconnection between the academic world and those with a responsibility for commissioning and providing services for older people who have fallen [1]. In Bradford we are in the process of achieving her vision in a unique way. Since 2001 a major collaboration between all potential professional groups has occurred. This has not only been across traditional health and social service boundaries, but more importantly has involved older people who have fallen, peer mentors, public health specialists, ambulance services, community pharmacists, home care managers and employees in residential homes. The project was initiated through Bradford’s involvement in the Pursuing Perfection Initiative [2], led by the director of Social Services and fully supported by the chief executives of the three local PCTs and the Acute Trust. This led to excellent administrative support with professional chairing of meetings ensuring goals were met. Each Trust and Social Services appointed a person to lead on falls.

We started from scratch exploring what happens to older people when they fall; service gaps were recognised and an ideal pathway for Bradford proposed. It was recognised that the majority of developments had to be community based. A multi-factorial risk assessment tool was developed (evidence based of course), nurses trained in its administration and clear action plans agreed so that the right people were referred onto OT, physiotherapy, general