Letters to the Editor

was defined using a reported version of the Edmonton Frail Scale, a validated scale for use by non-clinicians that assesses cognition, health attitudes and mood, medication use, nutrition, continence, burden of medical illness, social support and functional independence [2]. Furthermore, our study found a significant difference in the rates of embolic stroke and death between patients deemed frail and those deemed non-frail. The study also found that frail patients were more likely to have a haemorrhage event 3 and 6 months post-discharge. Frailty was associated with age but not directly related to age. In fact frailty was better correlated with disability and co-morbidity than with age.

Our findings support the view of Drs Khan and Myers that age alone should not (and does not) determine prescribing of antithrombotic medication for older patients with AF. A previous interventional study in the same hospital acknowledged this issue by specifically excluding age per se from the decision-making process, and instead focussing on medical, functional, cognitive, iatrogenic and social factors affecting the use of antithrombotics [3]. The present study follows from this in evaluating additional factors that may help determine the optimum treatment for older patients with AF. We found that frailty may be a useful risk stratification tool for such patients. Most of the factors that Drs Khan and Myers advocate considering in anticoagulation of older patients would be assessed using the frailty tool that was applied in our study.

Differences in the event rates observed between our studies may relate to the populations studied: our participants all had AF, were recruited from acute care wards, were followed over 6 months and were not all anticoagulated; while their participants had a range of conditions, were followed for an average of 3.78 years in the community and were all anticoagulated. It is possible that there was a higher prevalence of frailty in our study (64% of participants) than in the population reported by Drs Khan and Myers, which may contribute to the higher rates of adverse events we observed. Risk stratification tools such as frailty are valuable when prescribing for older patients, who have wide inter-individual variability, and potentially have much to gain from medication as well as a high risk of adverse drug reactions.

Conflicts of interest

None declared.

VIDYA PERERA1,2, BEATA V. BAJOREK3, SLADE MATTHEWS2, SARAH N. HILMER1,2,∗
1Departments of Aged Care and Clinical Pharmacology
Royal North Shore Hospital, St Leonards, NSW, Australia
2Sydney Medical School, University of Sydney
Sydney, NSW, Australia
Email: shilmer@med.usyd.edu.au
3Faculty of Pharmacy, University of Sydney
Sydney, NSW, Australia
∗To whom correspondence should be addressed


doi: 10.1093/ageing/afp163
Published electronically 12 September 2009

Dispelling myths regarding the safety of ‘bronchoscopy in octogenarians’

SIR—Bronchoscopy is an important diagnostic and therapeutic tool used for the management of respiratory conditions in older patients [1]. The advent of ‘interventional’ techniques continues to develop and older patients should not be precluded from access to such medical advances arising from unsubstantiated risks of complications associated with the procedure [2]. Therefore, we believe consideration of some of the recent issues highlighted in Age & Ageing by Rokach et al. [3] merit further consideration.

Rokach et al. report several issues in their large series of patients, both older and younger, undergoing bronchoscopy. However, we feel that they may leave the reader with the impression that bronchoscopy in octogenarians is more frequently prone to complications than is commonly the case in clinical practice.

Our principal concern relates to the lack of precise definition of complication in this study. Rokach et al. report that each pulmonologist was responsible for defining the presence of a bronchoscopy related complication. However, most studies examining bronchoscopy tolerability use specific cut-off points (e.g. oxygen desaturation beneath 90%) to define whether or not a complication has occurred. In addition several other determinants of complication during bronchoscopy (e.g. duration of bronchoscopy) are not detailed. The 11.5% complication rate quoted by Rokach et al. may be a low complication rate for a series of patients if their mean oxygen saturation pre- procedure was low and their mean duration of procedure longer than average for example. However without this data some readers may form a view that for many of their older patients an 11.5% complication rate for bronchoscopy is unacceptably high.

We also believe that more information about pre-medication prior to bronchoscopy would be helpful. While several different pre-medication regimes have been shown to be equally effective, injudicious use of centrally acting medication can influence the complication rate of bronchoscopy [1, 4]. More detailed information in this regard would help allay fears that the 11.5% complication rate was not influenced by this factor.
Finally we believe it is important to dispel the myth that higher complication rates (11.5% in this case) occur in older patients as a consequence of their age [5]—a point that the authors do allude to in the discussion of their article. In fact many older adults find bronchoscopy more tolerable and comfortable than younger adults, which reflects differences in age-related pain sensitivity. In order to ensure that readers of this study do not gain an inaccurate perception of the safety of bronchoscopy in older adults we believe that they should keep in mind that individual determinants of complications of bronchoscopy, such as pre-procedure oxygen saturation and procedure duration, play a much more significant role in determining the safety of this procedure than does advanced age.

S SANJAY H. CHOTIRMALL1, MICHAEL WATTS2, ALLAN MOORE1, FIONA KEARNEY1, LINDA BREWER1, NOEL G. MCELVANEY1, CIARAN F. DONEGAN1,∗

1Department of Medicine, Beaumont Hospital, Dublin, Ireland
2Mid-Western Regional Hospital, Limerick, Ireland
Email: ciarandonegan@beaumont.ie
∗To whom correspondence should be addressed


do: 10.1093/ageing/afp180
Published electronically 1 October 2009

Re: Jenni Burt, Rosalind Raine. The effect of age on referral to and use of specialist palliative care services in adult cancer patients: a systematic review. Age and Ageing (2006). Received 1 November 2005; accepted in revised form 2 February 2006 (pp. 1–8).

SIR—We are writing regarding the review on the effect of age on referral to specialist palliative care by Burt and Raine (2006). Burt and Raine state:

Burt and Raine are referring to our paper (Ahmed et al., 2004) as one of the reviews which they assert failed to apply a quality assessment. In fact, as an extract from our systematic review published in Palliative Medicine 2004 shows, we did in fact apply a rigorous process of quality checking:

Assessment of included papers

All papers were assessed for quality independently and disagreements resolved by the research team, who represented a range of professional and disciplinary perspectives. A data extraction form that covered 10 areas was used based on a previous method developed by Payne et al. and Hawker et al.; each area was rated on a 4-point scale from 1 (very poor) to 4 (good). The areas covered were: title and abstract; introduction and aims; method and data; sampling; data analysis; ethics and bias; results; transferability or generalizability; implications and usefulness. For each paper it was possible to calculate a total score (10 very poor-40 good), which indicated its methodological rigour. As the studies used different methods, outcome measures and samples, it was not appropriate to combine data across studies for meta-analysis. [Reference: Hawker S, Payne S, Kerr C, Hardey M. Powell J. Appraising the evidence: reviewing disparate data systematically. Qual Health Res 2002; 12: 1284–99.]

We have very clearly described how we rated ALL the included papers for quality and even mentioned why we did not use conventional Cochrane scoring. So we believe that the ‘rejection’ of our paper on these grounds was unjustified. We do not recall being contacted by Burt and Raine for details to clarify our search and quality strategy, which is customary when information is missing from papers being included in a systematic review.

Furthermore, the authors have referred to this as ‘a review’, when in actual fact it was a very thorough systematic review. The quality assessment was applied to all included studies, the outcomes of which have been reported in the paper. To publish a systematic review without undertaking an assessment of quality of included studies would be a major flaw in study design, and we feel that readers should be made aware of this correction.

Whilst we welcome feedback on the systematic review and areas for improvement, on this occasion the criticism about not applying a quality assessment to the included studies was completely unfounded. We understand that this error has taken some time to come to our notice, but in the interests of maintaining the highest standards of scientific rigour, we