Let's not turn elderly people into patients Wanted
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Consider sex and stroke subtypes

The finding reported by Myint et al that lifestyle habits have beneficial effects on stroke occurrence is very reassuring and support previous results of large scale, US based cohort studies. 1–3 Several points merit further comment.

Firstly, while the authors show several multivariable models, their main relative risk estimates come from a model that also controlled for body mass index, systolic blood pressure, and cholesterol concentration. These factors are, however, strongly influenced by lifestyle habits and can be considered potential mediators of the association between lifestyle habits and stroke. In addition, controlling for potential direct consequences of exposure may lead to biased effect estimates. 4 Lifestyle habits may thus have an even stronger influence on stroke occurrence.

Secondly, the association between lifestyle habits and risk of stroke in the study is magnified in women. Compared with men who have a combination of all four lifestyle habits, women seem to achieve a similar risk reduction with a combination of all four lifestyle habits, women may thus have an even stronger influence on stroke occurrence.

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DIAGNOSIS OF HEART FAILURE

Ontological fallacy in heart failure

Echocardiography has resulted in the belief that heart failure and reduced ejection fraction are synonymous. Recently, however, the utility of ejection fraction in diagnosis has been undermined by epidemiological studies, which have shown that ejection fraction is continuously distributed in populations with heart failure, and that survival is the same irrespective of whether there is heart failure with normal ejection fraction (HFNEF) or with reduced ejection fraction (HFREF). In effect it is the clinical label of heart failure that drives prognosis, not the ejection fraction. The adoption of a dichotomous value (the division of cardiac function into normal and reduced ejection fraction) to describe a continuous variable is now outmoded and unhelpful.

The relative lack of benefit in studies in HFNEF may be a failure of the therapeutic modes of action of the drugs studied, since there is no physiological reason why afterload reduction in non-dilated hearts will produce prognostic benefit. We may be trying the wrong drugs because we do not fully understand the condition. We do not understand the condition because our terms of reference are those of echocardiography.

HFREF is characterised by ventricular dilatation and HFNEF by normal left ventricular end diastolic diameter. Both, however, display markedly raised left atrial pressure, although this is often difficult to measure with echocardiography. Brain natriuretic peptide, a marker of cardiac wall stress, is elevated in both conditions. HFREF and HFNEF also share many clinical features (usually characterised by congestion) and an equally poor prognosis.

Gale refers to the ontological fallacy into which we fall when we invent categories for our own convenience and then treat them as if they had a real existence. By bestowing diagnostic supremacy on an ontological fallacy in heart failure we have allowed the ejection fraction to usurp our thinking and warp our semantics (HFNEF, HFREF, etc). We need to reopen our minds to completely understand this fatal congestive syndrome.

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1 Lloyd G. Heart failure is in need of a diagnosis. BMJ 2009;338:b961. (9 March.)

Cite this as: BMJ 2009;338:b1304

DON'T TURN OLD PEOPLE INTO PATIENTS

Wanted: age adjusted outcomes

Who really knows what elderly individuals want and need in terms of health care? What outcomes matter to them, and their spouses and families? Once we know this we could try to gather evidence of effectiveness and cost effectiveness of treatment aimed at achieving goals that really matter to them. This would require taking a perspective that gave special attention to their limited life expectancy, limited functional and cognitive reserves, comorbid conditions, and their risks of experiencing an adverse outcome in the near future. A transition to a definition of appropriate health care based on desired outcomes seems warranted.

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1 Oliver M. Let's not turn elderly people into patients. BMJ 2009;338:b873. (3 March.)

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MRSA SCREENING

Clarity is needed on which sites to screen

Kluytmans and Struelens, in their clinical review on meticillin resistant Staphylococcus aureus (MRSA) in hospital, concluded that the most important site to screen for MRSA carriage was the nose and that screening other non-clinical sites (perineum, groin, or axilla) was not useful.

This is contrary to the practice in most UK hospitals, where the perineum and groin are also screened on the basis of the national guidelines published in 2006. Screening the nose alone will detect around 80% of carriers; including the perineum increases this to 93%.

Not only is the overall detection rate increased, but detection of perineal carriers is important because this is correlated with more heavy dispersal of MRSA into the environment.

This is an important issue for trusts having to implement the Department of Health’s requirement to screen all elective admissions by 1 April 2009. The two sets of operational guidance do not specify which sites should be screened apart from the nose, and it is left to the microbiologist and infection prevention and control teams to make the decision.

The guidance should be clearer and either accept that some heavy shedders of MRSA will be missed by screening the nose only, or include a perineal screen which will require both extra resources in nursing time to obtain the screen and laboratory cost and time to process the additional samples.

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Competing interests: None declared.

2 Guidelines for the control and prevention of meticillin-resistant Staphylococcus aureus (MRSA) in healthcare facilities by the joint BSAC/HIS/ICNA working party on MRSA. J Hosp Infect 2006;(suppl 1):63.