Let's not turn elderly people into patients Wanted

Buskens, Erik

Published in:
British Medical Journal

DOI:
10.1136/bmj.b1309

IMPORTANT NOTE: You are advised to consult the publisher's version (publisher's PDF) if you wish to cite from it. Please check the document version below.

Document Version
Publisher's PDF, also known as Version of record

Publication date:
2009

Link to publication in University of Groningen/UMCG research database

Citation for published version (APA):

Copyright
Other than for strictly personal use, it is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), unless the work is under an open content license (like Creative Commons).

Take-down policy
If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

Downloaded from the University of Groningen/UMCG research database (Pure): http://www.rug.nl/research/portal. For technical reasons the number of authors shown on this cover page is limited to 10 maximum.
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. 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. Lifestyle habits may thus have even a 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 merely two such habits. Lastly, the EPIC-Norfolk data do not allow differentiation between ischaemic and haemorrhagic stroke. Data from the Women’s Health Study show that a lifestyle considered to be healthy was associated with total stroke events, irrespective of subtypes. However, the observed relations seemed to be over and above the impact on these potential mediators on stroke risk.

We also agree that the underlying pathophysiology differs between ischaemic and haemorrhagic stroke and that it is possible that men and women may differ. Nevertheless, the assertion by Kurth, based on findings from the Women’s Health Study, that haemorrhagic stroke was highest for women with healthiest lifestyle requires further exploration given the small number of outcomes in their study with reported adjusted hazard ratio of 1.27 (95% confidence interval 0.37 to 4.29; P=0.62 for trend) with non-significant results for haemorrhagic stroke. Although it is possible that differences exist between health behaviours and stroke subtypes in men and women, the current study did not have adequate power to examine this. However, it is reassuring that the relations were observed with total stroke events, irrespective of subtypes.

Until further evidence provides support for Kurth’s assertion, the overwhelming evidence supports the role of positive health behaviours to prevent stroke. We agree with Kurth that having deeper insight into and a better understanding of differences between the sexes and potential effect of lifestyle behaviours on different stroke subtype would be the way forward.

Authors’ reply

We agree with Kurth that intermediate risk factors for stroke such as body mass index, systolic blood pressure, and cholesterol concentration are influenced by the lifestyle factors that we examined. This could lead to the attenuation of our results, as highlighted by Kurth. The observed relations seemed to be over and above the impact on these potential mediators on stroke risk.

We also agree that the underlying pathophysiology differs between ischaemic and haemorrhagic stroke and that it is possible that men and women may differ. Nevertheless, the assertion by Kurth, based on findings from the Women’s Health Study, that haemorrhagic stroke was highest for women with healthiest lifestyle requires further exploration given the small number of outcomes in their study with reported adjusted hazard ratio of 1.27 (95% confidence interval 0.37 to 4.29; P=0.62 for trend) with non-significant results for haemorrhagic stroke. Although it is possible that differences exist between health behaviours and stroke subtypes in men and women, the current study did not have adequate power to examine this. However, it is reassuring that the relations were observed with total stroke events, irrespective of subtypes.

Until further evidence provides support for Kurth’s assertion, the overwhelming evidence supports the role of positive health behaviours to prevent stroke. We agree with Kurth that having deeper insight into and a better understanding of differences between the sexes and potential effect of lifestyle behaviours on different stroke subtype would be the way forward.

Phyo Kyaw Myint clinical senior lecturer in ageing and stroke medicine, School of Medicine, Health Policy and Practice, University of East Anglia, Norwich, NR4 7TJ phyo.k.myint@uea.ac.uk

Kurth's assertion, the overwhelming evidence supports the role of positive health behaviours to prevent stroke. We agree with Kurth that having deeper insight into and a better understanding of differences between the sexes and potential effect of lifestyle behaviours on different stroke subtype would be the way forward.

Authors’ reply

We agree with Kurth that intermediate risk factors for stroke such as body mass index, systolic blood pressure, and cholesterol concentration are influenced by the lifestyle factors that we examined. This could lead to the attenuation of our results, as highlighted by Kurth. The observed relations seemed to be over and above the impact on these potential mediators on stroke risk.

We also agree that the underlying pathophysiology differs between ischaemic and haemorrhagic stroke and that it is possible that men and women may differ. Nevertheless, the assertion by Kurth, based on findings from the Women’s Health Study, that haemorrhagic stroke was highest for women with healthiest lifestyle requires further exploration given the small number of outcomes in their study with reported adjusted hazard ratio of 1.27 (95% confidence interval 0.37 to 4.29; P=0.62 for trend) with non-significant results for haemorrhagic stroke. Although it is possible that differences exist between health behaviours and stroke subtypes in men and women, the current study did not have adequate power to examine this. However, it is reassuring that the relations were observed with total stroke events, irrespective of subtypes.

Until further evidence provides support for Kurth’s assertion, the overwhelming evidence supports the role of positive health behaviours to prevent stroke. We agree with Kurth that having deeper insight into and a better understanding of differences between the sexes and potential effect of lifestyle behaviours on different stroke subtype would be the way forward.

Authors’ reply

We agree with Kurth that intermediate risk factors for stroke such as body mass index, systolic blood pressure, and cholesterol concentration are influenced by the lifestyle factors that we examined. This could lead to the attenuation of our results, as highlighted by Kurth. The observed relations seemed to be over and above the impact on these potential mediators on stroke risk.

We also agree that the underlying pathophysiology differs between ischaemic and haemorrhagic stroke and that it is possible that men and women may differ. Nevertheless, the assertion by Kurth, based on findings from the Women’s Health Study, that haemorrhagic stroke was highest for women with healthiest lifestyle requires further exploration given the small number of outcomes in their study with reported adjusted hazard ratio of 1.27 (95% confidence interval 0.37 to 4.29; P=0.62 for trend) with non-significant results for haemorrhagic stroke. Although it is possible that differences exist between health behaviours and stroke subtypes in men and women, the current study did not have adequate power to examine this. However, it is reassuring that the relations were observed with total stroke events, irrespective of subtypes.

Authors’ reply

We agree with Kurth that intermediate risk factors for stroke such as body mass index, systolic blood pressure, and cholesterol concentration are influenced by the lifestyle factors that we examined. This could lead to the attenuation of our results, as highlighted by Kurth. The observed relations seemed to be over and above the impact on these potential mediators on stroke risk.

We also agree that the underlying pathophysiology differs between ischaemic and haemorrhagic stroke and that it is possible that men and women may differ. Nevertheless, the assertion by Kurth, based on findings from the Women’s Health Study, that haemorrhagic stroke was highest for women with healthiest lifestyle requires further exploration given the small number of outcomes in their study with reported adjusted hazard ratio of 1.27 (95% confidence interval 0.37 to 4.29; P=0.62 for trend) with non-significant results for haemorrhagic stroke. Although it is possible that differences exist between health behaviours and stroke subtypes in men and women, the current study did not have adequate power to examine this. However, it is reassuring that the relations were observed with total stroke events, irrespective of subtypes.

Until further evidence provides support for Kurth’s assertion, the overwhelming evidence supports the role of positive health behaviours to prevent stroke. We agree with Kurth that having deeper insight into and a better understanding of differences between the sexes and potential effect of lifestyle behaviours on different stroke subtype would be the way forward.

Authors’ reply

We agree with Kurth that intermediate risk factors for stroke such as body mass index, systolic blood pressure, and cholesterol concentration are influenced by the lifestyle factors that we examined. This could lead to the attenuation of our results, as highlighted by Kurth. The observed relations seemed to be over and above the impact on these potential mediators on stroke risk.

We also agree that the underlying pathophysiology differs between ischaemic and haemorrhagic stroke and that it is possible that men and women may differ. Nevertheless, the assertion by Kurth, based on findings from the Women’s Health Study, that haemorrhagic stroke was highest for women with healthiest lifestyle requires further exploration given the small number of outcomes in their study with reported adjusted hazard ratio of 1.27 (95% confidence interval 0.37 to 4.29; P=0.62 for trend) with non-significant results for haemorrhagic stroke. Although it is possible that differences exist between health behaviours and stroke subtypes in men and women, the current study did not have adequate power to examine this. However, it is reassuring that the relations were observed with total stroke events, irrespective of subtypes.

Until further evidence provides support for Kurth’s assertion, the overwhelming evidence supports the role of positive health behaviours to prevent stroke. We agree with Kurth that having deeper insight into and a better understanding of differences between the sexes and potential effect of lifestyle behaviours on different stroke subtype would be the way forward.

Authors’ reply

We agree with Kurth that intermediate risk factors for stroke such as body mass index, systolic blood pressure, and cholesterol concentration are influenced by the lifestyle factors that we examined. This could lead to the attenuation of our results, as highlighted by Kurth. The observed relations seemed to be over and above the impact on these potential mediators on stroke risk.

We also agree that the underlying pathophysiology differs between ischaemic and haemorrhagic stroke and that it is possible that men and women may differ. Nevertheless, the assertion by Kurth, based on findings from the Women’s Health Study, that haemorrhagic stroke was highest for women with healthiest lifestyle requires further exploration given the small number of outcomes in their study with reported adjusted hazard ratio of 1.27 (95% confidence interval 0.37 to 4.29; P=0.62 for trend) with non-significant results for haemorrhagic stroke. Although it is possible that differences exist between health behaviours and stroke subtypes in men and women, the current study did not have adequate power to examine this. However, it is reassuring that the relations were observed with total stroke events, irrespective of subtypes.

Until further evidence provides support for Kurth’s assertion, the overwhelming evidence supports the role of positive health behaviours to prevent stroke. We agree with Kurth that having deeper insight into and a better understanding of differences between the sexes and potential effect of lifestyle behaviours on different stroke subtype would be the way forward.
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.1 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 2006.2 Screening the nose alone will detect around 80% of carriers; including the perineum increases this to 93%.3 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.4,5

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. Simon F Hill consultant microbiologist Poole Hospital NHS Foundation Trust, Poole, Dorset BH12 3XA simon.hill@poole.nhs.uk

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.

DIAGNOSIS OF HEART FAILURE

Ontological fallacy in heart failure

Echocardiography1 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,2 and that survival is the same irrespective of whether there is heart failure with normal ejection fraction (HFNEF) or with reduced ejection fraction (HFREF).3,4 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 outdated 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 HFREF 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.1 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.

Hugh F McIntyre consultant physician, East Sussex NHS Trust, Conquest Hospital, Hastings TN37 7RQ Hugh.mcintyre@esht.nhs.uk

Competing interests: None declared.

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

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.

Erik Buskens professor of medical technology assessment, University Medical Center Groningen, 9700 RB Groningen e.buskens@epi.umcg.nl

Competing interests: None declared.

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

Cite this as: BMJ 2009;338:b1304